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Disabled Sexual Assault Victims: Perceptions of Sexual Assault Professionals on Barriers to Providing Services to Disabled Sexual Assault Victims

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Disabled Sexual Assault Victims: Perceptions of sexual assault professionals on
barriers to providing services to disabled sexual assault victims.

by

Melody L. Gorden, B.S.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for the MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota, and is conducted within a nine month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Inspired by Dick Sobsey 's early work with disabled victims of abuse and the integrative ecological model, the current study addresses the barriers that sexual assault professionals encounter when working with developmentally disabled victims. The participants of this study are made up of 3 sexual assault female professionals, one being an advocate and two being Sexual Assault Nurse Examiners. This study is qualitative in nature and the data was obtained by using a semi-standardized interview. Using phenomenology as a research design, the investigator used qualitative questions to gain understanding of being a sexual assault professional. The data was analyzed by utilizing content analysis and themes were chosen that related to service barriers for the developmentally disabled victim and the perceptions of the sexual assault professional regarding what further training they felt they needed when working with the developmentally disabled. The implications of this study indicate that barriers to providing services to the developmentally disabled victim can be communication, vulnerability as well as others. Further training was suggested for not only sexual assault professionals, but for all professionals that touch the lives of developmentally disabled.

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Introduction

Sexual violence is a serious problem in Minnesota and the whole country. Every two minutes, someone is sexually assaulted in the United States (RAINN, 2013). Disabled individuals, especially women, make up the majority of those victims. Disabled men and women are more likely to be sexually assaulted than their non-disabled counterparts (Strauser, Lustig, Uruk, 2007). The rate of violence for males with disabilities was 42 per 1,000 in 2011, compared to 22 per 1,000 for males without disabilities. For females with disabilities, the rate of violence was 53 per 1,000 in 2011, compared to 17 per 1,000 for females without disabilities. (Bureau of Justice Statistics, 2012).

In Minnesota, 405 rapes were reported to the 87 county sheriff's offices or 24.6 rapes per 100,000 people and 1,667 were reported to Minnesota's 2,221 municipal police departments; equaling 44.7 rapes per 100,000 people in 2011. (Minnesota Department of Public Safety, Bureau of Criminal Apprehension, [BCA] 2012). However, disability status for rape victims may be underreported. In fact, when identifying bias or discriminatory crimes, race and sexual orientation rated highest as the reason for bias crimes and disability ranked the lowest (Minnesota Department of Public Safety, 2012). However, these statistics may be skewed, as it may be difficult for an officer to ask proper questions to identify whether someone has a disability if the victim does not self identify as a disabled individual, or the police personnel don't ask at all.

Considering these alarming statistics regarding sexual assault, especially when related to those with disabilities, it is important to understand the importance of crisis centers and providers. Provider networks must ask the critical question, "What is being done to assist those sexual assault victims that suffer from a disability."

Sexual assault crisis centers are set up to respond to the critical needs of sexual assault victims 24 hours per day 7 days per week. Advocates are the point of contact when a victim reports to the

hospital after an attack and may work with the victim throughout their journey through medical and criminal proceedings. In previous studies, advocates have specifically stated that disabled and elderly victims are difficult to work with given communication challenges because it is difficult for those populations to navigate the proper services through the medical and legal systems. These challenges are compounded because this population also has difficulty communicating their needs, making it difficult for sexual assault staff working with the victims (Ullman & Townsend, 2007). Without proper training and understanding of people with disabilities, sexual assault advocates may unwittingly contribute to the disabled victim to remain an under-served population compared to those without disabilities. Those with disabilities have the right to be served in the same manner as their non-disabled counterparts and remaining under-served victims is not necessarily in congruence with The American Disabilities Act (ADA) as it states that all people deserve the same service. For example the ADA states that:

Public entities must provide programs and services in an appropriate integrated setting, unless separate or different measures are necessary to ensure equal opportunity. Ensure that communication with person with disabilities is as effective as communication with others and furnish appropriate services to afford equal opportunity (e.g. providing qualified interpreters, assistive listening headsets, television captioning, readers, taped texts, large print materials, etc.). Make reasonable modifications in policies, practices and procedures when necessary to avoid discrimination (e.g. rescheduling hearings, allowing a support person to sit with the individual with a disability, allowing service animals, etc.) (American Disabilities Act, 1990).

Based upon the disproportionate lack of services available to them and literature regarding developmentally disabled sexual assault victims, this limited study will focus on sexual assault programs and services in Minnesota and how they provide services to developmentally disabled sexual assault

victims. Minnesota sexual assault volunteer advocates are required to complete a 40 hour training to become crisis workers for a sexual assault agency. However, only a few minutes of this training pertains to working with people with disabilities, as it concentrates on assisting the victim with navigation through the medical and legal systems and does not necessarily concentrate on the background or communication barriers of the victim. However, local agencies are encouraged to concentrate services on marginalized victims (Minnesota Coalition Against Sexual Assault, 2012).

Providing quality services to these marginalized victims and any victims for that matter, is important to the social work profession as there is a duty to serve vulnerable populations. Also in question is the obligation as a mandated reporter in relation to vulnerable adults. To ensure quality services are being provided to disabled sexual assault victims, it is important to understand the perceptions and needs of sexual assault service providers and to ascertain in what areas they feel they need further training to provide high quality services.

This paper contains a review of relevant literature and a description of the methodology required to better assess the training needs of current sexual assault staff in various counties in Minnesota. This is to not only improve services for disabled victims; but to identify what areas are in need of further research and training for sexual assault advocates and staff to provide better quality services to all.

Literature Review

Statistics

Rape and sexual assault remains a problem in the United States today. According to the Federal Bureau of Investigation, an estimated 84,767 forcible rapes were reported to law enforcement professionals in the United States in 2010. This estimate was 5.0 percent lower than the 2009 estimate and 10.3 percent and 6.7 percent lower than the 2006 and 2001 estimates respectively. Forcible rapes in 2010 were estimated at 54.2 per 100,000 females. Rapes by force

comprised 93.0 percent of reported rape offenses in 2010, and attempts or assaults to commit rape accounted for 7.0 percent of all rapes that were reported (Federal Bureau of Investigation, 2011).

While all rape was once considered forcible, rape now is defined as "the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim" (Kilar & Fenton, 2012) and the word forcible is used to differentiate from statutory rape, which is defined as "consensual, non-forcible sexual intercourse with or between people who are younger than the age of consent" (Sachs, Weinberg & Wheeler, 2008).

Though forcible rapes are decreasing it remains a problem in this country and those with disabilities are more likely to suffer violent victimization. Moreover, few statistics are available to assist this population, thus making it more challenging to provide services to this already underserved population. Police statistics do not contain disability status of victims (MN BCA, 2011) and there is a significant lack of research about disabled sexual assault victims. During a previous informal interview, a sexual assault advocate in northern Minnesota noted that the biggest area, in which she was lacking, was in providing services to disabled victims (M.L. Gorden, personal communication, July 1, 2012).

This literature review sets out to address this topic by defining sexual assault, discussing abuse towards those with disabilities and the role of the sexual assault professional. It will also briefly address the tensions between mental health providers and crisis intervention staff. Gaps in the literature are also identified to suggest some areas in which more research can be done.

Defining Sexual Assault

Rape is not the only form of sexual assault. The National Crime Victim Survey defines rape as:

Forced sexual intercourse including both psychological coercion as well as physical force.

Forced sexual intercourse means penetration by the offender(s). Includes attempted rapes, male as well as female victims, and both heterosexual and homosexual rape. Attempted rape includes verbal threats of rape (National Crime Victim Survey, 2008).

The Office of Justice Programs Bureau of Statistics goes on to determine sexual assaults as:

A wide range of victimizations, separate from rape or attempted rape. These crimes include attacks or attempted attacks generally involving unwanted sexual contact between victim and offender. Sexual assaults may or may not involve force and include such things as grabbing or fondling. It also includes verbal threats (Bureau of Justice Statistics, 2012).

Rape is about intimidation, threats and forceful behavior of at least one person against another (Sexual Assault Program of ** [SAP] 2010). According to a 2010 sexual assault advocate training manual in a small sexual assault agency in rural Minnesota:

The single incident of rape is the most degrading, demeaning, and humiliating violation perpetrated by one human being against another because it is about loss of control, loss of ownership, and loss of power over the one thing that is yours and no one else's: your body (SAP, 2010).

When trying to get a victim to disclose their assault, a sexual assault professional can encounter an insurmountable amount of emotions within the victim including feelings of shame and blame, fears of retaliation by the abuser, dependence and isolation. Sexual trauma can include rape, incest, sexual assault and ritualistic abuse (Brown, 1991, Sobsey, 1994). Typical societal treatment of sexual abuse victims is blaming the victim, sexual exploitation and removal of treatment for the trauma (Sobsey, 1994). If those without disabilities are treated this way after being victimized, adding the stigma of a disability might measurably exacerbate the trauma.

Sexual assault and the disabled

While being sexually assaulted can be very traumatic, being disabled and sexually assaulted may be twice as traumatic. Symptoms of trauma can include depression; difficulty sleeping and some symptoms could last up to a year or more. Two types of reactions to sexual trauma described in the literature; hysterical, which can be crying, confusion and agitation or, a numbing reaction which can be shock or a perceived casual attitude regarding the incident (Brown, 1991).

Developmentally disabled individuals can be more vulnerable to sexual abuse because of communication problems, dependence issues and comprehension of the definition of sexual abuse. Compliance issues can also be an issue as they may feel an obligation to please their abuser (Peckham, 2007). Identifying trauma can be very difficult within a developmentally disabled victim as many times a person with a cognitive disability may not be able to communicate that they have been abused.

The literature primarily addresses learning and developmental disabilities regarding sexual assaults and literature on physically disabilities is extraordinarily limited. Because of these limitations, this study will focus its efforts on those with developmental or cognitive disabilities.

Defining Developmental Disability

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, (DSM-IV TR), defines developmental disability as intellectual disability (or mental retardation according to DSM-IV TR) and defines it as a disability consistent with a person with an Intelligence Quotient (IQ) of 70 or below. A person is assessed in adaptive functioning areas and also needs to be deficient in 2 of the following areas: self-care, social or interpersonal skills, use of community resources communication, functional academic skills, home living, self-direction, work, leisure, health, and safety. The DSM-IV also stipulates that the onset of disability must occur before the age of 18 years old (Patel, Greydanus, Calles and Pratt, 2010).

One particular study found that 39 to 68% female developmentally disabled residential clients and 16 to 30% males residents were sexually assaulted before the age of 18 (Mahoney & Poling, 2011).

Martin, Ray, Sotres-Alvarez, Kupper, Moracco, & Dickens (2006) showed that young women were more likely to be sexually assaulted than older disabled women and that women of color reported more sexual assaults than white women. While this study did not show significant difference in sexual assaults between genders, it did show that out of all the groups, men and women with and without disabilities, women with disabilities reported significantly more sexual assaults than the rest of the test subjects. Sexual assault services should ensure that services are appropriate for all, especially for women with disabilities (Martin, et. al, 2006).

Another study concentrated on those that work within disabled residential homes. It was pre-test/ post-test model in which 124 direct care providers from West Virginia were asked about their knowledge of sexual assault symptoms with the intervention being a training presentation to direct care providers regarding identification of sexual assault symptoms, risk factors of HIV/AIDS, factors that contribute to sexual abuse and prevention program training. It also included an assessment of attitudes towards those with disabilities. The post test showed that that knowledge of sexual assault symptoms increased, but that only 60% of the participants were still able to identify symptoms of sexual abuse. There was also a relatively low participation rate with only 71 out of the 124 completing the study. This study found absolutely no previously published literature regarding developmentally disabled sexual assault prevention programs for providers of care to developmentally disabled adults (Bowman, Scotti & Morris, 2010).

Research regarding adults with disabilities that have been sexually assaulted did not begin until the 1980s. Some literature from the early 1990s suggested that there was a limited amount of research

regarding sexual assault and it suggested that research regarding those with disabilities needed to increase insurmountably throughout the decade and into the 2000's (Mansell, Sobsey & Calder, 1992).

This research is inspired by the work of Dick Sobsey and his novel, *Violence and abuse in the lives of people with disabilities: The end of silent acceptance*. He was the first person to write a book extensively regarding those with disabilities and sexual assault. He also created the integrated ecological model which is a theoretical model that discusses abuse and the disabled from the ecological perspective which will be discussed further at a later time in this paper.

Sobsey (1994) reported that support services and training for sexual assault victims and their caregivers often excluded those with disabilities and treatment facilities often did not accommodate disabilities.

This was in contrast with newer research, which suggests that literature has increased significantly since then, especially in the areas of those developmentally disabled who sexually offend, are sexually abused, and the perceptions of service providers, especially in the criminal justice field (Gill, 2010). However, support services and training for developmentally disabled victim service providers is still lacking today in the area of sexual assault.

Role of the Sexual Assault Agency

To address the needs of disabled sexual assault victims, the role of the rape crisis center or sexual assault agency must be reviewed. Not only was a historical account of the movement investigated, but also the current advocacy procedures at the local level. As a trained sexual assault advocate, this investigator had access to a sexual advocacy training manual, which was also utilized to study the current information regarding the treatment of sexual assault victims from a volunteer crisis intervention perspective.

It's very important for victims to have family or a strong support system such as paid caregivers. Many times a disabled person may rely on that support system to provide daily care and support.

Unfortunately, a lot of times their attacker is within that support system. This situation is often unique to the disabled victim and they can be afraid to report their abuse because they could lose the very person that they need to rely on to survive (Ullman & Townsend, 2007, Sobsey, 1994). Fear of removal of care is paramount to reporting when abuse is occurring. Even though females are at higher risk for sexual assault, boys in institutions are more likely to be sexually assaulted in that type of setting than in other settings (Sobsey, 1994).

Similar to the Sobsey (1994) research, recovery can also be delayed for someone with disabilities, because shelters are often not equipped for possible assistive technologies and direct care staff. Due to lack of funding, many protective domestic and sexual abuse shelters are not handicapped accessible or equipped for developmentally disabled victims (Curry, Hassouneh-Phillips & Johnston-Silverberg, 2001).

The need and establishment of rape crisis centers emerged in the 1970s out of the feminist movement. Rape crisis centers began as grassroots organizations that offered a variety of direct services to rape victims and provided community education. Early rape crisis centers also had a mission for social change (Clemans, 2004), and their primary focus was to try and eliminate rape and secure legislation that would give rape victims more rights and protections. The current training in sexual assault supports this, as one of its primary goals is to keep its feminist perspective (SAP, 2010).

The mission of rape crisis centers has transformed over the years, especially as they began to accept public funds. Volunteers remain essential to sexual assault agencies and programs, especially as budget reductions affect justice and victim program funding which decreases the ability to hire an adequate number of paid staff members to fulfill the various needs of victims served (Maier, 2011).

The goals of the current anti-rape movement are to retain the movement, broaden the vision and the services, provide services within the flesh industry and focus on elimination of racism. This equates to re-defining power, and creating true equality and providing access to decision making for all people (SAP, 2010).

Ullman & Townsend (2007), stated that rape crisis centers, to be called sexual assault agencies in this literature from here forward, offer 24 hour crisis hotlines and individual and group counseling, and offer medical and legal advocacy. They also attempted to identify organizational barriers and found that lack of funding, environmental factors and the increasing professionalization of mental health providers can lead to staff burnout and barriers to direct service. Barriers to direct service were defined as lack of availability of services, secondary victimization from other systems for disabled and non-disabled sexual assault victims, and limits of previous research and agency review (Ullman & Townsend, 2007).

As advocacy gives way to professionalization it is a move away from the original feminist movement's social action oriented history of domestic violence as a whole, and has lead to debate in feminist and domestic violence literature. One side of the argument being that professionalization of those working with victims loses touch with the feminist activist and the other side of the debate proposing that increased professionalism leads to increased funding for victim services (Wies, 2008).

The role of the advocate is key to a smooth functioning sexual assault agency. The sexual assault advocate job duties reviewed in the training manual included answering crisis calls, crisis intervention, following up on medical or law enforcement calls, attending court dates and tracking pending criminal cases and personal one-on-one advocacy with current survivors. Each advocate is required to complete 40 hour training by law. The training also includes a client bill of rights, but the rights of those with any type of disabilities are not addressed specifically (SAP, 2010).

In the sexual assault training manual that was reviewed, only three PowerPoint slides in the 40 hour training included information regarding treating those with disabilities. Those slides included:

- *There are many reasons perpetrators choose to victimize people with disabilities, including thinking they can “get away with it”; no one will believe they could do such a thing, and that people with disabilities can’t/won’t understand what’s happening to them, so it won’t hurt them.*
- *99% of perpetrator show commit sexual violence against people with disabilities are known to the victims/survivor.*
- *Some of the reasons that people with disabilities may not report sexual violence include fear of being institutionalized; and education that used positive and negative reinforcements, leading them to believe that they did something wrong to cause the assault.*
- *An estimated 90% of men and women with developmental disabilities have been sexually victimized within their lifetime, yet only 3% of the assaults are reported.*
- *Many misconceptions about people with disabilities and sexual violence committed against them undermine efforts to provide support services to this community (SAP, 2010).*

Because fear of the removal of caregiver services is paramount to reporting when abuse is occurring, an advocate being aware of this possible added fear of the developmentally disabled victim should be addressed in training. The Martin (2006) study also concluded that sexual assault services should ensure that services are appropriate for all, especially for women with disabilities.

To increase the knowledge of sexual assault professionals regarding treating those with disabilities and change the above statistics, training needs and barriers to service must be identified and

possible referrals to other professionals may need to be made to provide the quality service each victim, whether disabled or not, deserves.

Mental Health vs. Advocacy

As mentioned earlier, most sexual assault programs operated primarily with volunteer advocates providing frontline, direct services to victims with oversight from paid, professional staff. Sexual assault advocates are volunteers and lack of funding has decreased the ability to hire professionals and an advocate may need to refer out to another agency for extensive counseling services. In the beginning days of sexual assault programs, there was a negative view of mental health providers due to its feminist beginnings and the patriarchal beginnings of psychoanalysis (SAP, 2010, Woody & Beldin, 2012). Currently, there continues to be two schools of thought regarding the mental health of sexual assault victims.

One school of thought when counseling a rape trauma victim is that the rape itself doesn't need to be addressed, but the symptoms or behavior changes after the rape. Brown (1991), even suggested that trauma should not be diagnosed just by the specific act of rape but that the behaviors the victim displays after the assault are what should be treated, such as substance abuse or emotional disturbances.

From a sexual assault advocate's viewpoint, treating the trauma of the act needs to be addressed before the symptoms of drug abuse or trauma induced mental health disorders. In fact, a specific slide in its training presentation suggests that some counselors are not educated in the origins of rape and states that the psychological and emotional symptoms may lead a professional to treat the symptoms instead of dealing with the rape itself (SAP, 2012).

Woody & Beldin (2012) identified several increasing tensions between mental health professionals and sexual assault workers as more mental health providers become professionalized. It was found that sexual assault program staff identifies that mental health professionals as a potential

barrier to providing services, and that mental health professionals are unsure of the role of the crisis worker and identify a lack of empirical evidence in crisis intervention. For example, many crisis workers sampled believed that mental health professionals were unaware of the services offered by sexual assault advocates and that many made referrals to sexual assault agencies when they should have provided trauma services themselves (Woody & Beldin, 2012).

With either mindset, whether it is on the mental health side or advocate side, if victim-centered services are to remain the top priority of treatment, then collaboration not tension, should be the focus of all victim service providers and sexual assault staff to provide the utmost professional and appropriate services to victims (Woody & Beldin, 2012).

Gaps in Research

Many studies reviewed identified that disabled persons had a higher chance of becoming victims of sexual assault. However, there seemed to be a lack of research regarding training programs for crisis staff when working with disabled victims, despite the statistics that show there is a definite need for increased communication when addressing developmentally delayed victims. There also seems to be a need for information regarding what other barriers sexual advocates have encountered, and what prevention programs they are aware of regarding working with developmentally disabled. Of those studies that have been completed on services to disabled sexual assault victims, those studies have been limited to those with disabilities that have at least moderate communication skills, as it has proven difficult to test prevention programs on those with disabilities that have poor or no communication skills (Mahoney & Poling, 2011). Increased communication between crisis workers and professional mental health workers also seems to be an area in need of increased research.

Summary

In summary, sexual assault of disabled people is a serious problem in this country and around the world. The literature in this review pertained solely to the United States and focused primarily on adults and not children. While lack of communication between professionals and information regarding disabled victims remain areas for further research, there also seems to be a significant need for development of programs specifically designed for prevention of sexual assault for disabled clients. There also seems to be a need for training specifically designed for crisis intervention providers on how to treat developmentally disabled victims.

As this is a limited study, this work sets out to address some of the gaps in research regarding sexually assaulted disabled individuals by assessing the perceptions of crisis interventionists and professionals in Minnesota that work directly with victims and by asking the following research questions:

1. What barriers do sexual assault workers encounter when providing services to disabled victims?
2. In what areas do sexual assault workers identify the need for more training to better serve those sexual assault victims that are disabled?

These questions will be asked in the context of agency, bureaucracy and within the disability caregiver community as a whole. All with the hopes of possibly improving knowledge of services needed for those sexual assault victims in the developmentally disabled community.

Conceptual Framework

To begin to understand the needs of disabled sexual assault victims and intervention providers, it is important to understand the theories of abuse and how they affect those with disabilities. There are

many theories that can be applied, but the integrated ecological model, which combines systems theory and the ecological model, seems to be the framework which best fits this study. This model will be considered through three different viewpoints, including theoretical, professional and personal.

Integrated Ecological Model

There have been many models of abuse used in the past, including the dependency-stress model, the counter-control model and the social learning theory model. Sobsey (1994) reviewed these models and using parts of these models and the ecological model, created the integrated ecological model which will be utilized in this research.

Based on the *Ecology of Human Development* by Urie Bronfenbrenner, the ecological model sets forth that a child is not only effected by their individual relationships as they develop, but is also affected by larger relationships, such as extended family, community, society and culture (Ceci, 2006).

As the ecological model integrates individual characteristics, relationships and environmental factors, it is broken down into systematic themes, such as the micro, mezzo and macro systems (Belsky, 1980, Sobsey, 1994). While these systems are parts of the ecological model, the integrated ecological model breaks these systems into three larger groups; relationship, environment and culture and this is the systemic theory that this study will be using to investigate abuse of disabled individuals.

Theoretical Viewpoint

Created specifically for abuse prevention in disabled individuals, this model does not rely on the systems themselves as in the ecological model, but more on the relationships of the victims with their abusers and community within the cultures and environments affecting them.

The culture aspect of the theory provides for the support of power inequities within the relationship of abuse based on the victim's culture and can be considered the macro system of the model, as it is the largest piece of the model whether it is the genetic culture of the victim or the culture of being disabled within itself.

The environmental aspect of the system is the area or space in which the victim and abuser interact; whether it is in a residential area, the larger community or society as a whole, and serves as the mezzo system of the theory.

The third system in the integrated ecological model is the individual needs of the victim, or micro system. This concentrates solely on the needs of the victim, whether it be social, assistance with legal and medical systems or counseling needs after an assault. Basically, the integrative ecological model is like three circles within each other; with the small circle in the middle serving as the client's individual needs, the middle circle representing the client's relationships within the environment in which they live, and the outer circle representing the culture of the victim.

The integrative ecological model is strictly not meant to blame the victim (Sobsey, 1994, Curry et.al, 2001). However, there may be certain characteristics of a disabled individual which may make them more vulnerable to abuse within their relationships with others; and understanding these relationships and the cultural and environmental factors that affect those relationships may be important when attempting to understand the context of abuse against disabled individuals.

These include dependence on others whether family and/or care providers, which can lead to an increased fear of retaliation if an incident is reported. Lack of similar experiences, education of acceptable sexual behaviors and desire for approval may also lead a developmentally disabled person to be unable to distinguish between appropriate and inappropriate sexual behavior (Curry, et. al., 2001). Both of these characteristics exist within the environments and cultures of all victims and their abusers.

The main viewpoints of this model in which this research is taking are the environmental and cultural factors and characteristics of potentials victims, with less of a focus on the characteristic of the offender. It will attempt to gain the perceptions of sexual assault crisis workers and their awareness of disabled victim's cultural relationships and environmental factors and what effect, if any, that has on the services that they receive.

With the heightened negativity of their environment, increased vulnerabilities to abuse and the possibility of abuse from either an intimate relationship or a random caregiver in which a potential disabled victim may need to rely on for daily needs, it is no wonder that disabled persons are more sexually abused than any other group. It is with professional interest in the topic of sexual assault that the investigator chose to pursue this topic.

Professional Viewpoint

In a previous informal interview with a sexual assault program coordinator in a small rural agency, one of the barriers to effective service to victims was identified as a lack of training when working with a disabled victim. She went on to describe how she was unsure how to communicate with disabled clients, developmentally disabled clients specifically, and how difficult it was to explain to care providers the rules of confidentiality (M.L. Gorden, personal communication, July 1, 2012).

As pointed out in previous review of literature, victims are seldom dealing with one system, and when confronted with increased environmental systems, such as the legal and medical systems as well as law enforcement, it may be difficult to help a developmentally disabled victim navigate through the various justice systems without being victimized repeatedly.

From this investigator's point of view, it can be hard sometimes for developmentally disabled person or someone who suffers from mental illness to get through a regular day, let alone be exposed to this kind of secondary traumatization.

To combat this secondary traumatization, it may be important to understand what is needed in the field of sexual assault crisis intervention services to create prevention programs or advocacy training protocols that are specifically targeted to disabled victims. This investigator has worked with developmentally disabled populations in the past and experienced personal satisfaction from that work.

Personal Viewpoint

From a personal viewpoint, the investigator has always enjoyed working with the developmentally disabled whether in an in-home setting or out in the community. Witnessing firsthand the negative responses that this population many times receives when out in public or navigating the social systems.

The developmentally disabled individual can have a hard time navigating through the various systems such as public assistance, family dependence and lack of caregiving resources. With low pay and many times low expectations, turnover for developmentally disabled caregivers is high and the training is minimal. The day to day experience of the developmentally disabled person can be very difficult and to add trauma services to overworked direct care personnel would be too much to ask,

hence the need for highly trained crisis interventional workers and sexual assault prevention programs for disabled individuals.

This study will be viewed through a conceptual framework of the integrated ecological model which states that the disabled abuse victim is affected by three systems; individual needs and the relationships within victim culture and environment. The environment and culture of sexual abuse was investigated through interviews with crisis intervention staff in two metro areas within the state of Minnesota and will attempt to identify the specific traits or characteristics in disabled individuals that crisis intervention staff has a difficulty working with and how to overcome those barriers by identifying the training needed to address this issue. From this investigator's point of view, we cannot overcome the specific barriers to providing quality services to disabled sexual assault victims until we identify them and understand the possible cultural and environmental factors that affect the victim's services.

Methods

Research Design

Phenomenological research methods were employed for this study. The purpose of the study was to obtain the perspectives of sexual assault advocates when working with developmentally disabled victims. The study identified both; and areas of improvement in service delivery to this vulnerable population. The remainder of this section explains phenomenology and how it was applied to this study, the sample, protection of human subject, data collection and analysis.

Phenomenology is a method that attempts to understand the participant's views and perspectives of social realities (Leedy & Ormrod, 2001). Phenomenology focuses on the lived experiences of more than one participant. The researcher interpreting the interview content looks for universals across the participant interviews for shared themes. The goal of phenomenology is to describe the phenomenon, refraining from any pre-conceived notions that the researcher may have had before asking the questions;

in this case, attempting to understand the phenomena of being a sexual assault professional working with a developmentally disabled victim (Groenewald, 2004). To establish such an understanding of what the sexual assault professional's job is; the first non-demographical question of the interview asked each participant to describe a situation in which they have worked with a developmentally disabled victim in the past without revealing confidential victim information. This was an attempt to gain a better understanding of the phenomenon of working with a disabled victim. Those questions and responses are attached to this study to give more insight into each case that was presented so that the reader may gain a better understanding of the work of each participant and the different types of functioning levels that the sexual assault professional may encounter (Appendix D, E &F).

Sample

A minimum of 8-12 advocates who provide crisis interventions to sexual assault trauma victims in sexual assault agencies were sought. One sexual assault advocate and two sexual assault nurse examiners agreed to take part in the research. All three participants interviewed were required to have worked with at least one developmentally disabled victim and have at least one year experience in victim services. The Minnesota Coalition against Sexual Assault was asked to provide information regarding sexual assault agencies within the state and they submitted the flyer (Appendix A) over their listserv. Participants were sought from various parts of Minnesota, to create as much diversity in victim populations as possible, especially urban and rural populations, but only those within urban areas responded.

The ending sample consisted of urban area sexual assault professionals and included only people that have worked with developmentally disabled sexual assault victims.

Protection of Human Subjects

Prior to the study beginning, the research proposal was reviewed and submitted for approval by the St. Thomas Institutional Review Board (IRB). To reduce coercion, possible research participants were provided with the consent form and interview materials before participation in the study was decided upon by a potential participant.

This consent form was read and signed before the interviews were completed and oral questions were asked of the possible participants to ensure that they understood what they were signing. The professionals were made aware that they may end the interviews at any time if they so desire, or refuse to answer any questions they may choose. All interview transcripts, data and consent forms will be kept locked in a file cabinet at the study investigator's place of employment. This data will be destroyed in the form of shredding on June 1, 2013.

Instrument

The interviews consisted of fifteen questions created by the principle investigator of the study. (Appendix A) The investigator asked demographic questions first about the sexual assault professional's gender, years of experience, and previous and current work with sexual assault victims and developmentally disabled victims.

The interview questions were generated by themes from the literature and the integrated ecological perspective which was discussed in the previous conceptual framework section. Questions sought to gain insight on the difficulties sexual assault professionals face when providing crisis interventions to developmentally disabled victims, what training they have received regarding this population, what further training they feel they need, and the ways in which collaboration with mental health professionals can be increased.

Data Collection

The data was collected using the following steps. The investigator contacted the Minnesota Coalition against Sexual Assault and requested that they flyer be distributed via their listserv. A letter of support was received by the Minnesota Coalition Against Sexual Assault and the flyer was distributed by the agency (Appendix C). The flyer was re-distributed to randomly chosen agencies from the list on their website as well. Agencies were eliminated that work with dual programs such as domestic abuse, and the concentration was on sexual assault only agencies.

The investigator contacted all professionals that responded to the flyer via phone and asked if she could send information regarding the interviews. The investigator distributed the interview questions (Appendix A) and consent forms (Appendix B) to the three sexual assault professionals that responded to the flyer electronically.

The investigator arranged interviews to take place in a quiet setting where privacy and confidentiality were secured as much as possible as phone conversations were recorded via speaker phone, in a private office with the door closed was utilized to verify the privacy of the participant.

The investigator explained the consent form before interviews were conducted. The investigator did not conduct interviews until all consents were received with signatures and reviewed over the phone once again.

Three audio recorded interviews then took place and lasted approximately between 20-35 minutes.

Data Analysis

Data was analyzed and interpreted through the utilization of content analysis. Content analysis is a way to code and interpret human communications in order to find patterns, themes, biases, and meanings (Berg & Lune, 2012). It is a commonly used method that can be used to analyze many forms of data including narratives, and other types of media (Julien, 2008). The themes can be

identified prior to the interview or after analyzing the data. Interviews were conducted over the phone, recorded and then transcribed by the investigator following completion of the interview utilizing a speaker phone and live scribe electronic recording pen.

Phenomenology and content analysis were used in conjunction with each other within this study because content analysis is a systematic research method that can describe and quantify phenomena and can be a means of analyzing documents. Content analysis is used to gain meaning from the information that is gathered during the interviews and within the transcripts; to make sense of the data and learn what is going on within it (Elo & Kyngas, 2007). To become fully immersed in the interviews, the investigator read the transcripts several times attempting to fully understand the meanings and descriptions of the participants with an attempt to identify themes and gather data by content categories. In this case, transcripts were used to create and analyze themes in an attempt to find relationships between collected data and the theoretical framework.

The theoretical framework was used to guide the questions and the thematic categories to follow the integrative ecological model using the categories of environment, culture and individual needs of the disabled victims through the eyes and experiences of sexual assault professionals (Attachment B).

Investigator Bias

The investigator may be biased based on previous knowledge and interactions with developmentally disabled clients and sexual assault advocates in a rural setting. This bias may have influenced the investigator when questions were created, but may have assisted the study as the investigator has firsthand knowledge of work with the developmentally disabled and sexual assault victims. This may help by building rapport during the interviews. To reduce this bias, the committee members were asked to provide feedback regarding the interview questions. This was done by presenting the questions to the research committee and chair for revision, and they approved the

questions regarding bias and were confident that the questions were not leaning toward any pre-conceived investigator bias. The rural vs. urban bias was taken out of the equation as all participants were from urban areas.

Findings

The data that was received for this study reflects what the literature review presented; that information regarding developmentally disabled sexual assault victims is very limited (Mansell, Sobsey & Calder, 1992, Sobsey, 1994).

Three participants agreed to participate in this study. All were female, with only one being a sexual assault advocate and two being Sexual Assault Nurse Examiners (SANE). Both worked with developmentally disabled sexual assault victims in the past and had almost 30 years of work experience collectively.

To become fully immersed into the phenomenon of being a sexual assault professional, each participant was asked to give an example of a time that they worked with a sexually assaulted developmentally disabled person, so that the researcher could gain an understanding of a specific case and attempt to increase understanding of victim functioning and cognitive abilities.

This review of each case facilitates use of the integrated ecological model (Sobsey, 1994) discussed in the literature review. The themes were chosen due to their relevancy within the conceptual framework or if it seemed poignant or relevant to the phenomena of being a sexual assault professional that works with developmentally disabled victims.

Following content analysis, themes were also chosen if they seemed to be similar entities or could be considered conceptual categories (Julien, 2008). These could be a series of comments from all participants or one significant comment from just one that gives meaning to providing advocacy to a

disabled sexual assault victim. The case that each participant shared when asked about a certain victim will be summarized and the participant's direct comments will be presented verbatim as recorded.

1st Interview

The case discussed by the advocate in the interviews was a 20 year old victim that had been assaulted by two perpetrators. Her current environment is a residential home, but her mother's home was her environment at the time of the assault. The advocate described her level of functioning as high, as the young lady held a job and drove a car. The advocate was unaware of the victim's cultural background other than her race.

When asked about the relationship interactions within the family, the advocate stated that the victim's mother was present and that she only spoke to her to get a sense of the victim's level of functioning and then did not speak to the mother again as she felt it was a confidentiality issue because the victim was deemed to be functioning high enough to communicate with the advocate on her own. However, it was stated that the mom was the relational support system for the victim.

2nd Interview

The second interview was with a sexual assault nurse from an urban area. The victim that she discussed was also a twenty year old female but of Somali descent. This was not what was significant regarding this case however. The rare significance of this case was that this victim had been seen twice by the same nurse for two separate incidents of sexual assaults within a year. The nurse believed that the victim had the functionality of a 3 to 4 year old, and the victim also had very limited language abilities.

The Somali culture was an integral part of the interactions with this victim. The victim's mother was unable to speak English and many interactions needed to be handled via interpreter or the victim's sister who spoke some English.

The first time she was seen, she had been assaulted by someone she had met on Facebook in an apartment and the second time she was found in a bathroom of a recreational center without her clothing.

3rd Interview

The third case is of a Caucasian male in his 30s that was assaulted on his first night in a new group home. The culture of the victim was unknown other than his race, however, this victim arrived at the hospital with his family and the nurse believed that she witnessed such positive interactions she felt that it was a nurturing environment. The victim arrived with this mother and father that did not live together, but he went home to his father after the incident as he no longer felt safe in his new home.

Themes

As noted previously, the transcripts were analyzed through content analysis, attempting to create categorical clusters of data or similarities among the interviews. The following themes were found in the transcripts of the interviews: communication, extreme vulnerability of victims, high incidence of abuse in group homes, evidence of family supports, collaboration and training needs. The themes were chosen if the researcher felt they were relevant to understanding the environment, culture or individual needs of the client as well as the relevancy of the research questions regarding barriers that professionals face and the training needs that they feel are not being met.

Regarding barriers, communication and extreme vulnerability were chosen as a theme. Barriers were not only discussed as residing in group homes was mentioned, as well as family interactions. Additional training needs were also mentioned as they were extremely relevant to answer the research question regarding perceived additional training needs for professionals.

Communication

Every sexual assault professional mentioned some type of communication as an important characteristic of providing quality services to developmentally disabled victim, whether it be communication between the victim and crisis worker or crisis worker and family members and support systems. The case presented with the most communication barriers was the case that not only had to overcome limited communication skills, but also language barriers as well. During the first visit for example: “Her mother doesn’t speak English, and her [victim’s] speech is so limited that she almost speaks English better than Somali.”

The amount of limited communication is even more pronounced after the rare incidence of where this nurse sees the same victim after a second and separate incident of sexual violence; of which the nurse has more of a recollection as she testified at her trial. She states:

At this time, she is a year older but she could still only speak in short sentences such as “bad man”, “white shirt”. Like that kind of thing where she couldn’t really tell me a lot about what was going on, she could only giggle and point and say “bad man” and pointed to her genital area. Super challenging.

Communication does not only exist between the victim and the sexual assault crisis worker. It can also cross cultural and familial systems as well, as the second visit with the Somali girl points out.

And then here I am, her mom can’t speak English, she can’t speak Somali, and her interpreter is male behind the curtain and only interpreting for me and her mom and not

really her and I could tell that he was very uncomfortable with not only the situation but also with her limited ability. And he was getting irritated with that and it was really hard to get her to focus and to give me any details of what happened, which are really important with a sexual assault. So law enforcement was called to get involved and she was doing well and then the law enforcement officer asked her if he put his penis inside her and then she, totally like a little kid, says her name and says done and puts her head down and stops talking.

The other two cases did not experience difficulty communicating with the case that they discussed, however, they both acknowledged communication, whether positive or negative is important when working with developmentally disabled clients. The second SANE nurse stated that

It really complicates things in the areas of communication especially if they can't verbalize what happened to them so you have to learn to look for non verbal cues such as pointing and you can't always be sure unless they disclose so you have to learn how to look for it.

However, she did point out that when her client communicated plainly with her, it didn't necessarily match the maturity level that she had been given:

It was rather easy to communicate with him because like a 9 year old boy he was very honest and just plainly told me what happened to him..... I expected him as a 9 year old level as I picture a 9 year old boy as laughing and playing and he wasn't like that at all.

Communication as a barrier for not only the victim but within justice system as well was mentioned regarding a third party conversation a SANE nurse had with a co-worker:

In fact a co-worker had an older (40s) client that kept getting off her transport van from her daily outings and was abused with other marks on her and she eventually had to be sedated to be examined because she was not verbal at all, and just think about the perpetrator, they have no worries about getting caught because they have no one to report on them.

Communication between SANE nurses and advocates were also mentioned as a SANE nurse presented this personal statistic:

But we don't get advocate our statistics are like 40% of the time does an advocate come and that is really disappointing for us as it really helps us a lot even more so they help the patient just by distracting them and by having one they have someone they can talk to on an on-going basis which they can't do with us as we only see them the one time.

Vulnerability

Vulnerability of the developmentally delayed population also emerged in each interview, as each professional either used the description to describe their own client or the population as a whole.

When asked if she wanted to add anything at the end of the interview, the sexual assault professional stated that, "I just think this is a great idea to get more ideas to work with this population, especially one so vulnerable."

The first SANE nurse interviewed made a comment regarding vulnerability as well, comparing the developmentally disabled to other sexual assault victims that may not be as culturally accepted:

It's interesting how there are more topics as "sexy topics" such as transgender, or what's in at the time, but I'm not downplaying any population, it's just that those with developmentally disabilities are so vulnerable and it doesn't seem as glamorous if that makes sense.

The second SANE nurse mentioned vulnerability when speaking specifically about the male client that she examined as she asked the parents questions regarding his developmental functioning level: "I felt it was very important to know about his vulnerability."

Group home

Two out of the three victim cases that were discussed were residents of group homes and two of the professionals had either worked in a group home prior to becoming a sexual assault worker or had experience seeing victims from group homes during previous employment. As mentioned previously during interview three, the victim was assaulted at his new residential group home. The SANE nurse even states that she released the man home to his family "because he didn't want to go back to the group home." She also mentioned however that he had a very supportive family as she stated "his family seemed very appreciative and I felt like that the mother and step father both were very nurturing and caring and wanted the very best for their son."

One nurse suggested that vulnerability and living in a group home were tied together as this topic also came up again for this nurse when I asked her about any previous training she had received working with sexual assault.

She stated as she mentioned that she had worked at a genetics clinic:

No, there was not so called sexual assault training for staff, but I did see patients in the clinic that had been sexually assaulted at their group homes, so I was already aware that

because of their vulnerability they were at a higher risk for that before I even started being a SANE nurse.

The sexual assault advocate volunteered to take part in the survey because of her work in group homes: “I should state that the reason that I took part in this survey is that I have a background in working with group homes because I worked in a group home in college with females.”

Family Interactions

Family was mentioned throughout each interview, and within the family dynamic of the where the Somali girl was assaulted twice, the SANE nurse mentions interactions with the sister and mother during the first examination and only interactions with the mother during the second interaction, but supportive environment was not mentioned during her sharing of the experience. However, two of the three professionals did mention that including the family in the healing process was very important. A SANE nurse mentioned in that she wanted the family in collaborations when she said, “Well, I feel like the family is huge as it is a crisis for the family too” and continued to speak of the client’s family as integral part of the care he received: “And his family seemed very appreciative of that and I felt like that the mother and step father both were very nurturing and caring and wanted the very best for their son.”

Additional training needs

While transcribing and coding, many interesting topics came up and while they were not categorically the same and could not be placed in an exact theme, it is worth mentioning the other main topics that came up during the interviews when the participants were asked if they had any ideas on future training or collaborations that were needed and when they were asked what type of supports they received at work.

The sexual assault professional stated that she received weekly case consultations and one SANE nurse mentioned that she has informal case consultations with her co-workers. The trainings that were

felt were needed were training across cultures, and one of the SANE nurses suggested having collaborative meetings with all parties involved in the case:

Well, I feel like the family is huge as it is a crisis for the family too. Anyone that has contact with the victim needs to have familiarity with this type of population including law enforcement, the physician, the prosecuting attorney all have to have some kind of information regarding developmentally delayed individual.

Contradictory Referrals

While thematic codes were chosen in regards to relevance to the theoretical framework or research questions, a question was also created to address the category found in the literature review regarding sexual assault professionals and their interactions with mental health professionals. As two SANE nurses were added to the research, it was difficult to find thematic codes regarding referrals to mental health professionals as sexual assault advocates work with the victim continuously after the crime and generally a SANE nurse only sees a patient one time. This is illustrated when a SANE nurse stated:

That's a hard one we only refer if there is a psychiatric crisis or they are not safe to themselves or other we don't get involved with mental health as we only see the patients on a limited basis.

We only see them for 2 to 3 hours and only send them on as I said if they are suicidal, we have them evaluated by psychiatry.

This was the opposite situation that the sexual assault advocate where she has many referral resources:

We are very fortunate in... and have a lot of resources and I received a specific referral for the current client to a professional and they get along very well. All clients are referred for mental health counseling in..., I have a great relationship with the mental health community in I

also have signed releases with all support systems working with the client such as the DD professionals and I have an open release with all social workers within the county.

The topic of referrals to mental health counseling was not chosen as a theme because of its contradictory nature between sexual assault advocate and SANE nurses, and because of this sample size and its limitations, this topic will be discussed further in the discussion section of this work. However, one SANE nurse did comment on the need for more collaboration with developmentally disabled professionals:

I have all sorts of information about where to send people who need an interpreter with different languages and know all the mental health professionals that speak all of the languages that I have encountered. I have no idea where I would send a developmentally disabled client, and I always go right home and research where to send a client to meet their needs. I don't know where I could send them. In fact, I was in a meeting yesterday with... County and I met with someone on this committee that is a Developmentally Disabled community worker and I know her very well and we have never talked about this and I still don't know what they do. That says a lot and I am really an engaged person if I took care of let's say a Russian person I would investigate that immediately, so I feel if I don't have the information, I feel that nobody does.

Discussion

This study set out to answer two questions: What barriers do sexual assault workers encounter when providing services to disabled victims, and in what areas do sexual assault workers identify the need for more training to better serve those sexual assault victims that are disabled?

The next section forms a discussion of the findings based on the ecological model and systems theory, as they relate to working with developmentally disabled sexual assault victims. The findings will be further discussed within family systems and feminist theory as well because the integrated

ecological model does not necessarily address the various levels of systems theory when encountering domestic violence as a whole. The discussion is followed by limitations of the study and implications for social work practice.

The data will be discussed through each of the micro, mezzo and macro systemic lenses to gain perspective of the limited research obtained in this study. While there will be significant discussion regarding the environmental and cultural aspects of the three interviews studied in this research, these were interviews with the sexual assault professional working with the victims and not the victims themselves. There will a discussion regarding the abuse-victim dyad, concentrating more on the supports needed for the victims after the abuse.

On a micro level, Sobsey (1994) believed that to understand abuse of the disabled individual, you must understand the person's relationships and individual needs. Also within the micro level, the data gives insight into how the victim individually moves through their personal systems whether they be with their family, sexual assault professional or law enforcement. For example, it appears that the gentleman victim in interview number three had a strong family support system.

The research suggested in the literature review that developmentally disabled sexual assault victims are often victimized by a member of their caregiver support system or a family member and are afraid to report that abuse because their livelihoods or ultimate survival depends on not reporting the victimization (Peckham, 2007; Martin, et.al, 2006). This is not the case within this research project, as each victim narrative given by the participants were abused by strangers.

Family systems theory fits into this discussion because treating a developmentally disabled patient requires concentration on the interpersonal relationships that the victim experiences as they begin to heal. Unless a developmentally disabled victim is a ward of the court system, there will be some type

of interaction with the victim's support system and the sexual assault professional. As the SANE nurse in interview three put it previously, "the family experiences crises as well as the victim."

On a mezzo level the interviews with the sexual assault professionals identify the changes needed on an agency level and suggests that group home staff and all professionals working with disabled victims need more training. As mentioned in the additional training needs section, this could be done by including all law enforcement and other professionals that may work with the developmentally disabled population.

Family systems theory speaks to the mezzo system as well because it speaks to the family environment of domestic abuse in systemic terms, but does not address the reasons why some families contain domestic abuse and some do not (Zosky, 1999).

Zosky's (1999) research has also suggested that feminist theory contributes to the macro level of abuse work because it proposes that roles of power are unequal and based on gender where men are viewed as the power broker and women are inferior.

Feminist theory speaks to the macro level of systems theory as it shows the levels of power inequality between men and women as discussed earlier in the literature review when it stated that up to 39 to 68% of women in residential homes were sexually assaulted before the age of 18 compared to those and 16 to 30% of males (Mahoney & Poling, 2011). However, this theory is not as relevant as the ecological theory as this subject matter is not as much about the power inequalities of the genders, but of the developmentally disabled population as a whole.

Within the integrated ecological model, the macro system is represented by the cultural factors affecting the victim, including other's beliefs about people with disabilities, such as they don't have feelings, or that they are asexual (Sobsey, 1994). The mezzo system is the environmental portion of

where the victim resides, such as communities, institutions or private homes and the micro system would be the abuser-victim dyad or interpersonal relationships that the victim has in their life.

Each system will be presented through the systemic lenses of the integrative ecological model because of the similar nature of each of the theories previously discussed as it addresses many characteristics of each theory and each system within the ecological model.

Macro/Cultural Lens

Sobsey's (1994) claim was that it is within the macro system of culture where we must identify or combat feelings of prejudice against those victims that are developmentally disabled.

Each participant that was interviewed was asked the same question regarding what they knew about the cultural backgrounds of the victim that they discussed. Culture was not easily ascertained in this research as both the SANE nurse in the third interview and the sexual assault advocate during interview one did not ascertain a lot of information regarding the victim's cultural background. The male victim in interview three and the female victim in interview one were identified culturally only by their race, or "white."

However, culture played a significant role in the second interview where the Somali culture was discussed in limited details regarding how the communication between the victim and the SANE nurse was very limited when dealing with the Somali victim. She described being able to communicate better with the sister, in the first interaction because she could speak English. Ultimately though the culture of disability was what made the Somali language interpreter uncomfortable.

While we cannot ascertain the feelings toward rape in the Somali culture from this excerpt, we certainly can ascertain that the nurse perceived tension from the interpreter regarding the victim's limited ability.

Mezzo/Environmental Lens

We are made aware that two out of the three victims discussed in the findings are living in or have lived in group home settings. It was mentioned several times within the literature review that those living in group home settings were more likely to get abused than other developmentally disabled individuals with the higher amount of the victims being male (Sobsey, 1994). The other frightening statistic that was mentioned in the literature review was that in particular study that studied group home caregivers; only 60 % of participants in the training group were able to identify sexual assault abuse symptoms after the training.

In fact, interview one illustrates that the sexual assault advocate volunteered to take part in the survey because of her work in group homes.

Interview number three also provides evidence to support the statements regarding that sexual assault in group homes happen to men as well as one of the case victims described in our literature actually was abused in a group home on his first night. This SANE nurse also mentioned that she was made aware of sexual assaults numerous times during her tenure as a nurse in genetics clinics, as mentioned previously in the findings. This leads us to the final system in the integrated ecological model, the individual needs or supports needed for the victims themselves.

None of the three examples presented by the participants in this research were abused by a caregiver or supportive person in their lives. On the contrary, at least two out of the three reported that they released their victims to their family members or support system after meeting with them. Even in interview one where the SANE nurse mentioned that there was a major communication barrier between the mother and the daughter, she was aware that the family was the support system and that the mother seemed to be the head of the household.

While all of the research found in this article does contradict those statements regarding caregiver abuse in previous literature, one must take into account the small sample of this paper and the fact that this qualitative study is in no way representative of all sexually assaulted developmentally disabled victims or the sexual assault professionals that work with them, whether they be a sexual assault advocate or Sexual Assault Nurse Examiner.

Professional Service Providers for Victims of Sexual Assault.

Crisis care in a hospital setting has not been always readily available for sexual assault victims. Before the feminist movement and the introduction of rape crisis centers, hospital treatment was often denied to sexual assault survivors (Fehler-Cabral, Campbell and Patterson, 2011).

To combat these phenomena, the Sexual Assault Nurse Examiner (SANE) program was developed in 1974. While most take place in hospitals, with about 10 % being community based stand-alone sites. SANEs are specifically trained to use specialized techniques and equipment to collect forensic evidence and help victims learn about treatment and prevention of pregnancy and Sexually Transmitted Diseases. They also receive training in crisis intervention so that they may be able to respond to the emotional needs of the victim and provide medical treatment and counseling referrals to properly respond to victim's emotional needs and provide referrals for counseling (Fehler-Cabral, Campbell and Patterson, 2011).

The main difference between a sexual assault advocate and a SANE nurse can be explained in the findings of this research. When the nurse in interview three was asked a question regarding victim referrals to sexual assault agencies, as she stated previously: "We only see them for 2 to 3 hours and only send them on as I said if they are suicidal, we have them evaluated by Psychiatry." which was the exact opposite of what the sexual assault advocate stated, as she stated that she referred all of her clients to mental health counseling and had signed releases with all support staff working with the client.

Also, having personal experience as a sexual assault advocate in a rural setting this researcher is aware that advocates can work continuously with a victim throughout their healing period or their court case, and a nurse may only see the victim during their hospital stay.

Study Limitations and Future Research Recommendations

The investigator's past work with developmentally disabled individuals proved to be strength within this study. With this understanding, the investigator was able to answer questions regarding the definition of a developmental disability as asked by a participant as well as build rapport with the participant during the interview. As the investigator has participated in sexual assault advocate training in the past, the previous knowledge of the training also proved to be strength when interviewing the professionals.

Lack of literature regarding developmentally disabled sexual assault victims and lack of information regarding possible prevention programs was a limitation to the study, as it was hard for professionals to identify the training that they feel they need as there are no specific training programs available to them.

As mentioned previously, the main limitation of this study was the small sample size. While even the original research design goal of 8-12 sexual assault participants, there was an actual total of three participants. However, this also allowed the investigator to increase her understanding of the needs of further communications within the sexual assault crisis interventionist community so that quality care can be given throughout varied populations and more studies can be done.

Also, more one-on-one contact with each sexual assault agency with more of an in-depth explanation of the anonymity of the victim and advocate and confidential nature of the interview may have increased participation and sample size. A greater understanding of diverse populations may have been gained if the sample had been larger, but this research does attempt to understand metropolitan

sexual assault professionals. Further study on rural versus urban sexual assault professionals could be utilized in the future to gain further understanding of diverse populations of sexual assault victims.

Including SANE nurses into the research, while helpful to increase sample size, may also have been a limitation to this study as they only work with a victim for a few hours and often do not see a victim after the initial hospital visit unless they have to testify in court. They do not follow the victim through the various legal and mental health systems. This is important as the literature reviewed suggested that disabled and elderly victims have a hard time navigating through both the medical and legal systems, creating an extra barrier for the advocate to help them overcome (Ullman & Townsend, 2007).

However, the SANE nurses also were an integral part of this study, as they brought insight into the world of the sexual assault professional from the initial point of contact with the victim. The nurses also have many years of experience working with developmentally disabled victims and may assist victims navigate through court systems, especially if they are asked to testify on their behalf.

The recommendations for future studies would perhaps be to utilize an on-line anonymous survey that would just take a few minutes of the advocate's time. This accommodation may have allowed for greater participation.

Another recommendation for further study would be to gain perspective on how often advocates and SANE nurses work together. While in the investigator's practice within a rural advocate setting and advocate is almost always present at the hospital, the SANE nurse in case three suggested that there was an advocate present about 40% of the time she meets with a patient in her urban area.

Implications for social work practice

Throughout the literature review, theoretical research design and data collection, it was apparent that information regarding communication barriers, treatment and providing counseling to

developmentally disabled and cognitively delayed individuals is sorely lacking, and even more so when those individuals have been sexually assaulted or abused.

Overcoming communication barriers is key to further research in this field, which may be just as simple as trying to identify what those communication barriers are with each individual developmentally disabled person and to train those that are their support systems to be aware of the symptoms of sexual assault characteristics.

For those that reside in group homes and institutions, it seems essential to have more training in place for caregivers in these setting so that they can identify the sexual assault symptoms as mentioned above. Furthermore, it seems paramount that these places continually be investigated for misconduct and mistreatment as well as identifying sexual predator behaviors in residents as well, which can also mean that the perpetrating disabled individual was assaulted once as well.

It is also important that social workers, sexual assault advocates, SANE nurses and other medical and mental health professionals form coalitions for the developmentally disabled sexual assault victim. So that they are receiving treatment that is, if not superior, at least equal to their non-disabled counterparts. Developmentally disabled victims are entitled to safety just as much as those without communication and dependence barriers; if not in the name of the systemic theories, family systems or feminist teachings, but in the name of social justice.

Conclusion

The overall purpose of this study was to gain the perspectives of sexual assault advocate's needs to overcoming barriers when working with developmentally disabled individuals and it became a small study with one advocate participating with two SANE nurses.

While the literature pointed out repeatedly that there was a very limited amount of information available regarding the developmentally disabled sexual assault victim, this study did offer a unique

perspective into three different scenarios of what can happen to the developmentally disabled victim because they are so vulnerable and unprotected in the world. Through the lens of Richard Sobsey's integrated ecological model, we were able to see what effects that sexual abuse can have on not only on the developmentally disabled victim, but their environment, culture and relationships as well.

All three professionals interviewed stated that they agreed to participate in this research because they felt that this population is so vulnerable and that it needs to be discussed further. In fact, one such participant suggested that she was going to try to connect more with a developmentally disabled professional in her area and her collaborative groups to learn more about this population to try and improve the care and referrals that they receive.

Developmentally disabled victims continue to be a vulnerable and targeted population for sexual predators, out of control caregivers and domestic abusers. A focus on improved training and prevention programs regarding sexual assault symptoms in group homes is recommended as well as future studies in collaboration between SANE nurses, advocates and mental health professionals that specialize in work with the developmentally disabled. Future research is necessary to improve the lives of those that cannot speak for themselves and whom live in group homes, institutions and in the homes of those who abuse them.

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Appendix A

Interview questions

Demographic questions

1. What is your job title?
2. How many years have you been working with sexual assault victims?
3. Would you describe your client area as rural or urban?
4. Have you ever worked with a developmentally disabled victim?
5. How much education have you had?
 - High School
 - Technical College
 - Bachelor Degree
 - Master's Degree
6. What is your gender?

Qualitative Questions:

7. Without revealing any particular information regarding a victim, can you describe a time when you worked with a developmentally disabled victim?
8. Were you made aware of the environmental and/or cultural background of this victim?
9. Without revealing any specific personal information regarding the victim, did you have any interactions with this person's relationships, such as a caregiver, or family members?
10. Did you receive any training regarding developmentally disabled victims prior to working with this victim?
11. What type of training would you like to receive to better serve the developmentally disabled client?
12. What supports do you receive from your immediate supervisor or co-workers when working with developmentally disabled victims?
13. What areas do you feel could be improved when referring clients to mental health professionals for further counseling?
14. What types of collaborations do you feel are required when working with developmentally disabled professionals?
15. Would you have referred this person to some kind of mental health professional?

Appendix B

RESEARCH INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating sexual assault advocate's perspectives of services provided to developmentally disabled sexual assault victims, the training needed to improve those services and ideas to improve collaborations between advocates, mental health professionals and developmentally disabled service providers.

The investigator of this study is Melody Gorden, a student of the school of social work at the University of St. Thomas, under the supervision of Dr. Felicia Sy, a faculty member.

You were selected to take part in this project because you are a sexual assault advocate who has worked with a developmentally disabled sexual assault victim. Please read this form completely and feel free to ask questions any questions that you may have before you decide whether to complete the survey.

Background Information:

The purpose of this study is to understand sexual assault advocate's perspectives of providing quality services to developmentally disabled sexual assault victims. It is expected that 8 to 12 advocates will participate in this research.

Procedures:

Those that choose to participate in this study will be asked to take part in a audio taped confidential one-on-one interview with the investigator. The study investigator and advocate will decide jointly where the interview will take place, with an emphasis on confidentiality and privacy.

The interview process should take approximately 25-55 minutes.

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Risks and Benefits:

There are no risks or direct benefits to you for participating in this research.

Compensation:

There is no compensation for participation in this study.

Confidentiality:

Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. The professionals who referred me to you will not know of your participation in the study. I will keep the research results in a password protected computer and/or a locked file cabinet in my home and only I and my advisor will have access to the records while I work on this project. Audio recordings will be accessed only by myself, and will also be kept in a locked file cabinet in my home. I will finish analyzing the data by May 31, 2012. I will then destroy all original reports and identifying information that can be linked back to you.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University/University of St. Thomas in any way. You may refuse to answer any question in the interview if you choose. If you decide to participate, you are free to stop at any time without affecting these relationships, and no further data will be collected.

New Information:

If during course of this research study I learn about new findings that might influence your

Appendix B

Willingness to continue participating in the study, I will inform you of these findings.

Contacts and questions:

If you have any questions, please feel free to contact me, Melody L. Gorden, ***-***-***. You may ask questions now, or if you have any additional questions later, the faculty advisor, Dr. Felicia Sy, ***-***-****, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the investigator(s), you may also contact Eleni Roulis, Associate Vice-President of Academic Services and Special Programs/IRB Administrator/Professor of Education, ***-***-***. You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

I consent to participate in the study and agree to be audiotaped.

Signature of Participant Date

Signature of Investigator Date

Appendix C

Invitation Flyer

Have you ever provided crisis services to developmentally disabled sexual assault victims?

If so, you are invited to participate in an interview study.

Disabled Sexual Assault Victims: Perceptions of sexual assault advocates on barriers to providing services to disabled sexual assault victims.

The study is being conducted by Melody L. Gorden, graduate student at the School of Social Work, at the University of St. Thomas, under the supervision of Dr. Felicia Sy, a faculty member at the school.

The purpose of this study is to gain perspectives of sexual assault advocates regarding barriers that may or may not exist when working with developmentally disabled sexual assault victims.

Interview and Study Details

25-55 minute audio taped interview

Interview will take place in a confidential location convenient to the participant

Participation is voluntary and all identifying information will remain confidential

Interested in participating?

Please contact:

Melody L. Gorden, University of St. Thomas MSW Student

Telephone: ***-***-****

E-mail: gord7536@stthomas.edu

Appendix D

Advocate's answer to question # 7

Without revealing any particular information regarding a victim, can you describe a time when you worked with a developmentally disabled victim?

Sure, she is 20 years old and her maturity is that of 15 years old and there were 2 perpetrators and her vulnerability was a factor in the crime. The most recent DD victim that I worked with was a 20 year old girl with the mentality of what I felt was a 15 year old; I am currently working with her. I was not her original intake worker but I was on call in the morning. She is living in a residential home, but she does drive and function as normally as she can. She was sexually assaulted by two perpetrators.

Appendix E

SANE nurse #1's answer to question # 7

Without revealing any particular information regarding a victim, can you describe a time when you worked with a developmentally disabled victim?

I=Investigator

P=Participant

P: I'm not sure if this is the kind of patient you were looking for and if it isn't, let me know and I will think of another one. This lady was a 20 year old Somali female that I have seen twice which is kind of random. I happened to be on call both times that she came in which is very rare, but this also ensures that I know this patient more than most. She is short in stature and very round She probably has the thinking capacity of 3 to year old, maybe 5 but that is probably too old.

I: Wow, 3 to 4 and you've seen her twice?

P: Yes it is very sad she is the sweetest thing pretty delayed. The first time I worked with her, she can only speak in 2-3 word sentences at most and she giggles a lot. And when I walk into the room she is giggly and smiles a lot. She met this young man on Facebook who is also Somali and she was 19 with hormones raging. She lives in a very limited environment. Her mom does not speak English and her speech is so limited that she almost speaks English better than in Somali. And huh, she meets this guy on the internet which I feel she must have had help with and he picks her up and takes her to an apartment where he anally assaults her. And mom finds out because she has so much pain and with her broken English with broken sentences and I don't remember much about that situation as it was a few years ago and it was in the middle of the night. Then about a year later I am called to see her again and she had been with her mom at the **** and her mom left her alone for a few minutes and she was sexually assaulted in the bathroom of the *. I remember this one more clearly because I testified during her trial and I have it all memorized. At this time, she is a year older but she could still only speak in short sentences such as "bad man" "white shirt" Like that kind of thing she couldn't really tell me a lot about what was going on, she could only giggle and point and "bad man" and point to genital area super challenging. And then here I am, her mom can't speak English, she can't speak Somali and her interpreter is male behind the curtain and only interpreting for me and her mom and not really her and I could tell that he was very uncomfortable with not only the situation but also with her limited ability. And he was getting irritated with that and it was really hard to get her to focus and to give me any details of what happened which are really important with a sexual assault so law enforcement was called to get involved and she was doing well and then the law enforcement officer asked her if he put his penis inside and then she totally like a little kid and then says her name and says done and puts her head down and stops talking ; so she shuts down.

Appendix F

SANE nurse #2's answer to question # 7

I=Investigator

P=Participant

I= Without revealing any particular information regarding a victim, can you describe a time when you worked with a developmentally disabled victim?

P=Yes, I am trying to think of who will be the best. He had just moved into a new group home and his first night there he was sexually assaulted by a male resident and he was significantly delayed, so he was brought in by his mother and step father and I asked them what they felt his function ability and they stated that he was at a 9 year old level.

I= And you performed the exam? And did you feel that he was at a 9 year old level?

P=That is the hard part with developmentally delayed patients because some areas they are functioning are differently. I expected him as a 9 year old level as I picture a 9 year old boy as laughing and playing and he wasn't like that at all but I guess the other hard part is we see them for such a short time that it is really hard to get a really good feel of where they are at. How would you say he communicated It was rather easy to communicate with him because like a 9 year old boy he was very honest and just plainly told me what happened to him but I do remember that when we interview the patient about what happens we don't have any one else in the room no families members are in there because if we go to court they might feel like family members or a friend coached the patient minimize or exaggerate the incident and I do remember promising him that whatever he told me I was not going to tell his mom or step dad and I remember him being really embarrassed and not wanting to tell his mom and dad.

I= So he was very forthcoming with the details?

P=Once the family was out of the room yes.