Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors

This module helps service providers build their knowledge of the prevalence of sexual victimization among persons with disabilities; understand risk factors that contribute to the prevalence; identify barriers that perpetuate those factors and prevent reporting; and discuss what agencies and communities can do to help reduce those risks.

Key Points

- In the overall U.S. population, one in six women and one in 33 men have been the victims of an attempted or completed rape in their lifetimes.[1] Additionally, the stark reality has been that persons with disabilities may be at a significantly higher risk for victimization than those without a disability.
- In West Virginia, about one in six women (ages 18 and over) and one in 21 men (ages 18 and over) reported having been the victims of an attempted or completed rape. Sexual victimization among state residents with disabilities is significantly higher (14 percent) than among residents without disabilities (9.6 percent).[2]
- It is not the disability itself that increases the risk of sexual victimization, but societal and situational factors. Commonly cited risk factors for sexual victimization for people with disabilities include the following: negative public attitudes towards persons with disabilities; social isolation; lack of accessible transportation; reliance on others for care; communication barriers; lack of knowledge about healthy intimate relationships; type of disability; lack of resources/lack of knowledge of existing resources; poverty; lack of control of their personal affairs; perceived lack of credibility when they disclose sexual victimization; lack of caregiver support; and alcohol and drug abuse by perpetrators.
- Service providers also need to be aware of related barriers that may prevent reporting by sexual violence victims with disabilities, such as accessibility, situational factors, fear and educational/socialization factors.[3]
- Communities must counter attempts at victim-blaming by holding offenders fully accountable for their behavior and seeking to prevent sexual victimization of persons with disabilities. Increasing protective strategies for at-risk individuals has proven to be one way to help reduce the risk of victimization. Risk reduction is also the responsibility of service providers, as they can proactively identify resources and address obstacles to reporting and accessing services. This can be done by developing policies that provide increased protection or by increasing access that persons with disabilities have to services. Community leaders and service providers can challenge the factors that contribute to vulnerability to sexual victimization rather than complacently accept that the victimization of many persons with disabilities is inevitable.

B1. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors

Purpose

This module is designed to help service providers build their knowledge of the prevalence of sexual victimization among persons with disabilities; understand the risk factors that contribute to the prevalence; identify barriers that perpetuate those factors and prevent reporting; and recognize what agencies and communities can do to help reduce those risks.

In order to provide a sense of the scope and nature of the problem of sexual violence against persons with disabilities, this module presents a significant number of statistics. An effort has been made to include very concise summaries of pertinent points from statistical studies and encourage discussion of the implications of this research data for service providers.

Objectives

Those completing this module will be able to:

- Understand, in general, the prevalence of sexual victimization among persons with disabilities;
- Discuss demographics specific to West Virginia that contribute to the prevalence of sexual victimization for persons with disabilities;
- Identify factors that contribute to the risk of sexual victimization among persons with disabilities;
- Identify barriers to reporting sexual victimization for persons with disabilities; and
- Identify specific strategies that agencies and communities can initiate and support to reduce the sexual victimization of persons with disabilities.

Part 1: CORE KNOWLEDGE

What does vulnerability to sexual victimization mean?

In an effort to understand and prevent sexual violence, numerous studies have been conducted on incarcerated sex offenders to determine how they select their victims. This body of research—inherently flawed because it only studied offenders who were actually caught and convicted, which would tend to be the more violent offenders—offered the first “window” into the minds of perpetrators of sexual violence. Studies conducted in the late 1970s by Dr. Nicholas Groth and H. Jean Birnbaum identified three categories of offenders, two of which targeted victims based on *availability or vulnerability*.[4]

The perspective that sex offenders target those whom they perceive as vulnerable makes sense on many levels. For example, a burglar will choose the house without the dog or the alarm system—whatever reduces his chances of getting caught and increases his likelihood of success. However, the issue of vulnerability to sexual victimization needs to be raised, if not challenged, particularly in terms of victims with disabilities. It may be perceived that there is

little hope that persons who are vulnerable due to a disability can prevent becoming another rape statistic. Communities must counter such a misconception by placing blame for sex offenses on the offenders and holding them fully accountable for their behavior. In addition, community leaders and service providers can proactively seek out ways to decrease vulnerability to victimization for people with disabilities. They can challenge the factors that are contributing to vulnerability rather than complacently accepting that victimization is inevitable. This can be done by developing policies that provide increased protection (e.g., mandatory screening of care providers) or by increasing access that persons with disabilities have to services. *For the purposes of this module, the term "vulnerability" is used to indicate increased risk due to the situation, not a person's disability.*

What is the risk of sexual victimization for persons with disabilities?

In the overall U.S. population, one in six women and one in 33 men have been the victims of an attempted or completed rape in their lifetimes.[5] Statistically, an additional reality has been that, **depending on the type of disability, persons with disabilities may be at a significantly higher risk for victimization than persons without disabilities.**

- The 2007 National Crime Victimization Survey for the first time detailed crimes specifically against persons with disabilities. The survey found that persons with a disability had an age-adjusted rate[6] of victimization that was more than twice the rate of persons without a disability.[7]
- One study estimated that approximately 49 percent of people with developmental disabilities who are victims of sexual violence will experience 10 or more abusive incidents.[8]

Data on sexual victimization in West Virginia indicates a high risk for sexual victimization based on the demographics of the state. The West Virginia Bureau for Public Health, Health Statistics Center, 2008 *Behavioral Risk Factor Surveillance System* (BRFSS) survey found the following:[9]

- About one in six women (ages 18 and over) and one in 21 men (ages 18 and over) reported having had sex or someone attempted to have sex with them without their consent.
- Sexual violence victimization among residents with disabilities is significantly higher (14 percent) than among residents without disabilities (9.6 percent).

With the estimated high victimization rate for people with disabilities, many residents in West Virginia are at risk. The 2000 census demographics showed that *West Virginia had the highest percentage of population of persons with disabilities of all 50 states.*[10] In addition, West Virginia has many other factors that contribute to increased risk of sexual victimization. (See the section below on risk factors.)

What do we know about the reporting of sexual victimization?

Historically, sexual victimization has been vastly underreported. On the national level, the *National Crime Victims Survey* found that most sexual assaults go unreported. Rape/sexual assault and simple assault were the violent offenses least likely to be reported to law enforcement.[11] In 2003, the *National Crime Victimization Survey,* a survey conducted annually by the U.S. Department of Justice, showed that only 39 percent of sexual assaults were

reported to law enforcement—not a large increase from the 32 percent reported in a similar study in 1994. *The Rape in America* survey, conducted as a part of the National Women's Study, found that only 16 percent of rapes were reported to law enforcement or other authorities.[12] Data from the National Survey of Adolescents indicated that only 14.3 percent of sexual assaults had been reported.[13] Collectively these national studies indicate that only about 14 to 39 percent of all sexual assaults or rapes are ever reported to law enforcement.[14]

The reporting of sexual victimization by persons with disabilities is even less frequent. One study found that only 3 percent of sexual abuse cases involving people with developmental disabilities were reported.[15] A study conducted in Canada found that almost 75 percent of sexual abuse cases involving victims with disabilities were not reported.[16] In a 2005 survey of people with disabilities in the Tucson area, 60 percent reported having been sexually victimized, yet almost half never revealed the assault. When a disclosure was made, it was most often to friends (58 percent) or family members (54 percent), rather than Adult Protective Services (APS), law enforcement or a social service agency.[17]

In West Virginia, the low rate of reporting of sexual violence against persons with disabilities is evidenced in data provided by APS. For example, the total number of APS reports in 2009 for sexual abuse *for the entire state* was only 78, despite the significant population of persons with disabilities. This statistic indicates a disconnect between persons identified or estimated to be at risk and those actually reporting victimization and being served. Service providers can help bridge this disconnect by assisting persons with disabilities in (1) identifying the risks for victimization and barriers to reporting, (2) addressing those risks and (3) increasing accessibility for reporting and obtaining services.

What risk factors for sexual victimization exist for persons with disabilities?

Commonly Cited Risk Factors for Sexual Victimization of Persons with Disabilities[18]

- **Negative public attitudes toward persons with disabilities—**While social and legal reform since the 1960s has improved public attitudes towards individuals with disabilities, this population still faces considerable prejudice and discrimination. Society still has a tendency to devalue and dehumanize people with disabilities and suppress their voices. Some people believe that people with disabilities receive unnecessary "special" treatment, such as favored parking spaces and priority in affirmative action hiring, while ignoring how such treatment enables persons with disabilities to remain independent. (See *Disabilities 101. Self-Advocacy* and *Victims with Disabilities.*)

  Too frequently considered physically weak, emotionally unstable and/or intellectually incompetent, persons with disabilities may be viewed by perpetrators as easy targets for victimization. Perpetrators may trust that first responders won't believe these victims or know how to help them. Perpetrators may also think it unlikely that a conviction would be pursued, especially if it might disrupt an agency's current practices (e.g., cause an investigation of a nursing home staff person at a time when staffing is already limited), challenge an agency's policies (e.g., not screening home health care workers), or require an agency to make costly changes in its policies or practices.

- **Social isolation—**Sexual assaults most often occur in the homes of victims or perpetrators. The assaults usually are at times when victims are isolated from other people, particularly if the family culture is heavily self-reliant and closed. Persons with certain

disabilities often may be socially isolated, with limited access to outside communications and interactions.

- **Lack of accessible transportation—**One reason people become socially isolated is the lack of accessible transportation. Many communities do not have public transportation or transportation with a chair lift. Even if transportation options are available, they may be difficult to access.
- **Reliance of people with disabilities on others for care—**Individuals with disabilities sometimes depend on others for assistance with their personal needs. This reliance on others may increase their vulnerability and exposure to sexual violence. One study found that, *for victims with disabilities, 33 percent of their abusers were acquaintances, 33 percent were natural or foster family members, and 25 percent were caregivers or service providers.*[19] Many also may lack control of their personal affairs, which can contribute to learned helplessness.
- **Communication barriers—**A person with a disability that creates communication challenges may have difficulty reporting sexual victimization. Lack of an interpreter or assistive technology, difficulty articulating thoughts or having a limited vocabulary can all contribute to an individual's inability to disclose sexual victimization. (See *Disabilities 101. Accommodating Persons with Disabilities.*)
- **Learned compliance of people with disabilities—**Persons with disabilities, particularly in group homes or institutional settings, are often taught to be compliant, passive and quiet to meet the expectations of a "good" resident/client. Inherently, many persons with developmental disabilities or mental retardation are very trusting, desire to please others and seek acceptance—factors that can increase their risk for sexual victimization.
- **Lack of knowledge about healthy intimate relationships—**If persons with disabilities have not experienced healthy intimate relationships, they may be unclear about the differences between healthy relationships and sexual exploitation. Some individuals with disabilities may also lack knowledge about their own bodies and how to reduce their risk of sexual violence. Programs for persons with disabilities seldom provide adequate information about sexual assault prevention and sexuality education.
- **Nature of the disability—**The risk for sexual victimization may in part depend upon the type of disability. Persons with disabilities who do not require caregivers have a lower risk than those who require assistance with their daily needs. One study found that, *among adults with developmental disabilities, as many as 83 percent of females and 32 percent of males were victims of sexual assault.*[20] In another study, *40 percent of women with physical disabilities reported sexual assaults.*[21] Persons with cognitive disabilities also tend to have a higher risk for victimization.
- **Gender—**Just as females without disabilities are more likely to be sexually victimized than males without disabilities, females with disabilities have a higher risk of victimization than males with disabilities. Overall, one study estimated that 83 percent of women with disabilities will be sexually victimized in their lifetime.[22] Another study found that males with disabilities were twice as likely as males without disabilities to be sexually victimized in their lifetime.[23]
- **Lack of resources and/or lack of knowledge of existing resources—**Victims with disabilities often remain in unsafe or abusive situations because they are unaware of

alternatives or feel they have no safe alternatives.

- **Poverty—**Limited finances can result in limited alternatives and resources (options to change caregivers, enhance home security, flee from a perpetrator, relocate, call for help, etc.). Data from the Disability Statistics Center (www.dsc.uscf.edu) indicates that about *30 percent of working-age adults who are limited in their ability to work live in poverty.*
- **Lack of control of their personal affairs—**When caregivers, family members or others have power over individuals with disabilities (through controlling their finances, transportation, what they eat or how they bathe, their access to communication, etc.) then the potential for the misuse of power exists. Those who sexually perpetrate against persons with disabilities often take advantage of this imbalance of power. (See *Disabilities 101*. *Guardianship and Conservatorship* and *Disabilities 101. Working with Victims with Mental Illnesses.*)
- **Perceived lack of credibility of people with disabilities when they disclose sexual violence—**Criminal justice system professionals sometimes hesitate to pursue cases in which a victim's credibility can be challenged. Offenders often target persons whom they may perceive as lacking credibility (as mentioned earlier), including those with certain developmental disabilities and mental illnesses. One study noted that 45 percent of female psychiatric outpatient clients reported being sexually abused during childhood.[24] (See *Disabilities 101. Working with Victims with Mental Illnesses.*)
- **Factors regarding perpetrators—**Some research on the victimization of people with disabilities has noted the stress experienced by caregivers and emphasized that attention should be given to providing caregivers the support they need. While caregiver stress is a concern, professionals in the sexual violence field are quick to point out that stress on the part of caregivers does not cause perpetration and certainly never justifies it.

  Alcohol and drug abuse by perpetrators are frequently factors in sexual violence. *"Half of all sexual assault perpetrators are under the influence of alcohol at the time of the assault, with estimates ranging from 30 percent to 75 percent*."[25] It is important to note that alcohol or drug use does not cause sexual violence perpetration, but may reduce the inhibitions of offenders.

FYI—When reviewing the above list with victims, emphasize **it is not a specific disability that creates the risk, but the situation that the person with a disability is in that creates the risk.** Unfortunately, someone with a disability is more likely to be in a situation where they have limited finances/resources, are isolated, have a caregiver who wasn't screened, etc.

FYI—Although increased risk for victimization may exist for some persons with disabilities, the opportunity also exists to increase the protective factors and services that can minimize or eliminate that risk.

What barriers perpetuate the risk of sexual victimization and prevent reporting by victims with disabilities?

Service providers should be aware of related barriers, as listed below, that may perpetuate the risk of sexual victimization and prevent reporting by persons with disabilities.

Examples of Barriers that May Perpetuate Risk and Prevent Reporting

Accessibility for persons with disabilities—for example:

- Reliance on caregiver to access resources/services
- Lack of transportation/lack of access to transportation
- Communication challenges
- Lack of physical accessibility of services

Situational factors—for example:

- Programmatic barriers (lack of needed services, lack of information about available services, negative attitudes of agency staff towards people with disabilities, etc.)
- Financial dependency or reliance on caregiver for access to finances

Fear—for example:

- Fear of perceived consequences (retaliation by offender, loss of caregiver, loss of independence, etc.)
- Fear because of negative past experience
- Fear of not being believed

Educational/socialization factors—for example:

- Manipulated to feel blame
- Lack of knowledge regarding sexuality
- Lack of knowledge regarding rights
- Socialized to be compliant
- History of being protected by others inhibits accessing resources for protection
- Inhibited from being self-directed

How can the risk of sexual victimization for persons with disabilities be reduced?
Individuals should never be blamed or held responsible for their own victimization. As a society, we do not prevent murders by teaching people how to dodge bullets; similarly, we cannot prevent sexual violence by focusing on avoiding offenders. However, increasing protective strategies for at-risk individuals has proven to be one way to help reduce the risk of victimization. Risk reduction is also the responsibility of service providers, as they can proactively identify resources and address obstacles to reporting and accessing services.

See the chart below for examples of actions that both individuals with disabilities and service providers can take to reduce risk and increase access to services.

Strategies to Reduce the Risk of Sexual Victimization for Persons with Disabilities

Examples of protective strategies that at-risk individuals can use (implementation may require the help of service providers):

- Ensure access to communication methods (phone, Internet, etc.) if help would be needed. (See *Sexual Violence 101. Safety Planning.*)
- Maintain access to assistive devices. (See *Disabilities 101. Accommodating Persons with Disabilities.*)
- Minimize financial dependency on one person; include more than one person in financial

arrangements (e.g., assisted living staff and a family member, or a guardian and a service provider).

- Receive and understand basic information on sexual violence, personal boundaries, personal safety and community resources. (See *Sexual Violence 101. West Virginia Laws on Sexual Assault and Abuse, Sexual Violence 101. Safety Planning* and *Collaboration 101. Creating a Community Resource List.*)
- Require that a caregiver and/or guardian be screened (including a background check with regular evaluations that include input from the consumer and support persons), undergo training on healthy sexuality and develop stress management skills.
- Inform all caregivers and service providers that sexual violence will be reported to law enforcement and then follow through with reporting. (See *Sexual Violence 101. Mandatory Reporting.*)
- Reduce isolation through multiple, unscheduled social connections (family, friends, church, neighbors, social networks, etc.) that occur in person or via the phone or Internet. Also maintain regular conversations with someone other than the caregiver (a doctor, advocate, family member, APS worker, clergy, etc.) to verify personal safety.
- Have an individualized safety plan. (See *Sexual Violence 101. Safety Planning.*)

Examples of ways that organizations can increase access to their services:

- Advertise services in accessible formats in venues utilized by persons with disabilities.
- Provide services at no or low-cost.
- Partner with agencies serving victims with disabilities to provide education about available resources, their rights, sexuality, and healthy sexual relationships versus sexual violence.
- Have the necessary resources available to communicate with victims seeking services, such as a picture board, capacity to hire an interpreter, etc. (See *Disabilities 101. Accommodating Persons with Disabilities.*)
- Identify accessible resources to meet the needs of victims of sexual violence and persons with disabilities (related to safety, housing/safe shelter, green space for service animals, transportation, etc.). (See *Collaboration 101. Creating a Community Resource List.*)
- Ensure the facility is accessible or arrange to provide equivalent services at an alternate site. (See *Disabilities 101. Accommodating Persons with Disabilities,* as well as the *Tools to Increase Access* modules.)
- Train staff to appropriately respond to disclosures from victims with disabilities, provide crisis intervention and safety planning, support victims and quickly connect them with the resources they need. (See *Sexual Violence 101. Crisis Intervention.*)

Examples of ways service providers can work on a systemic level to reduce risk:

- Change policies that limit victims' access to services. (See *Disabilities 101 modules*.)
- Support projects, such as affordable and accessible housing, that increase safe, independent living opportunities for persons with disabilities. (See *Collaboration 101* modules.)
- Encourage policies and practices that will increase the safety of individuals with disabilities, such as screening policies for personal care attendants and guardians. (See *Sexual*

Violence 101. Safety Planning, Disabilities 101. Accommodating Persons with Disabilities, and *Tools to Increase Access. Readiness to Serve Victims with Disabilities: A Review of Intake Practices.*)

- Increase awareness of the risk of sexual victimization to create a supportive social environment that encourages victims to speak out.
- Provide cross-training to all disciplines involved in the service delivery system (including law enforcement officers, medical providers and prosecutors) to ensure that victims with disabilities will be well served at all points of entry into the system.

FYI—The above suggestions can help change the situation, not the disability. However, the risk for victimization can be reduced if local agencies and communities eliminate barriers to accessing services for persons with disabilities, increase protective resources available to persons with disabilities, and support persons with disabilities in taking steps to protect themselves.

Test Your Knowledge
Refer to the pages in this module as indicated to find the answer to each question.

1. One out of how many women and one of how many men in the United States have been victims of an attempted or completed rape in their lifetimes? What are the comparable rates for women and men in West Virginia? Is the risk for sexual victimization lower, equal to or greater for persons with disabilities—nationwide and in West Virginia? *See page B1.3.*
2. What factors increase the risk of sexual victimization for persons with disabilities? *See pages B1.4–B1.6.*
3. What barriers exist that may prevent reporting by sexual violence victims with disabilities? *See pages B1.6–B1.7.*
4. What can be done to challenge the factors contributing to victim-blaming and the vulnerability of persons with disabilities to sexual violence? *See pages B1.8–B1.9.*

Part 2: DISCUSSION

Projected Time for Discussion
2 hours

Purpose and Outcomes

Part 2: Discussion is designed to help participants apply the information presented in *Part 1: Core Knowledge* of this module to their collaborative work with sexual violence victims with disabilities. The discussion could be incorporated into forums such as agency staff or board meetings as well as multi-agency meetings or trainings. Anticipated discussion outcomes include increased understanding of the risk for victimization faced by persons with disabilities, the barriers to reporting victimization, and ways service providers and communities can address those issues.

Refer to the learning objectives at the beginning of this module for specific outcomes for this

module.

Preparation

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator for the discussion as well as a note taker.
- Participants and the facilitator should review the power and control wheels in *Abuse of People with Developmental Disabilities by a Caregiver,*[26] included at the end of this module.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, blank attendance sheet, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

1. **Invite participants to identify the discussion ground rules to promote open communication.** Utilize the following principles: *(10 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the various topics. There are no right or wrong answers, only different perspectives.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among participants and ultimately may shut down dialogue.
- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.

2.a. **Utilizing the list of barriers to reporting in *Part 1: Core Knowledge*, review each item and ask each participant to identify if it would be a barrier for a victim with a disability seeking services from their specific agency.** (For example, if a victim with a physical disability had a caregiver who was the offender and the victim contacted your agency for help, would you have the capacity to fully serve her?[27] What if she lacked transportation? What if she needed an interpreter?) Identify whether each barrier is a result of the disability (which cannot be changed) or the lack of accessible services. *(15 minutes)*

2.b. **As a group, brainstorm possible ways to overcome any identified barriers.** *(Up to 30 minutes)*

3.a. Make sure each participant has a copy of *Abuse of People with Developmental Disabilities by a Caregiver.* These power and control wheels address various types of intimidation and abuse that a victim of sexual violence may experience. **As a group, review each of the eight categories on the wheels and identify where victims with developmental disabilities who are experiencing that type of mistreatment by their caregivers could easily access services in your community.** Then expand your assessment to include victims with various types of disabilities (physical, sensory and cognitive).

Be realistic in your assessment. For example, under intimidation, if the victim has a pet and her caregiver is abusing the pet, is there emergency housing that would allow the victim either to bring her pet or is there somewhere to board the pet? Would the lack of a "pet-friendly" living environment or lack of finances to board a pet be barriers that might cause someone in your community to remain in an abusive situation? Under financial abuse, if a person with a cognitive disability was living in a group home and a staff person was stealing her money, is there a place she could report the theft and would be believed, or would she have to endure the misconduct just to have a place to live?

3.b. **Create a list of barriers that need to be addressed in your community and possible strategies for engaging additional partners** to assist in addressing those barriers. *(up to 1.25 hours)*

FYI—If you work with clients with developmental disabilities who are experiencing or are at risk for abuse perpetrated by their caregivers, the power and control wheels provided in *Abuse of People with Developmental Disabilities by a Caregiver* might be useful tools for explaining the dynamics of abuse to them and/or their non-offending support persons. One suggestion is that you first discuss with clients what they can expect in a healthy, nonviolent relationship with their caregivers, using the wheel that says "nonviolent" on the outer rim. Then you can compare that wheel with the other wheel that discusses tactics used against victims by abusive caregivers (the wheel that says "violence" on the outer rim) and ask clients to identify tactics their caregivers may already be using. Next, you, the clients and their support persons can discuss options for responding to the abuse and do safety planning. Keep in mind your responsibilities regarding mandatory reporting of abuse. (See *Sexual Violence 101. Mandatory Reporting.*)

The Wisconsin Coalition Against Domestic Violence also offers an *Abuse in Later Life Power and Control Wheel* that may be helpful if you are working with older clients—see http://www.ncall.us/resources.html.

4. **Closing.** Ask each participant to write down how the information gained from this discussion will promote change in their agency's policies, practices or training programs and their next steps in the process of initiating that change. Then facilitate a large group discussion on this topic. *(15 minutes)*

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[1]P. Tjaden & N. Thoennes, Prevalence, incidence and consequences of violence against women survey: Findings from the National Violence against Women Survey (National Institute of Justice and Centers for Disease Control

& Prevention, 1998), http://www.ncjrs.gov/pdffiles/172837.pdf. For the full report, published in 2000, go to http://www.ncjrs.gov/pdffiles1/nuj/183781.pdf or http://www.ojp.usdoj.gov/nij/pubs-sum/183781.htm. Note that all online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[2]Paragraph from West Virginia Bureau for Public Health, Health Statistics Center, 2008 Behavioral Risk Factor Surveillance System (BRFSS) survey (2008),

[3]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, the term "victims" is primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" generally are used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[4]For an overview of their more comprehensive research, see N. Groth & H.J. Birnbaum, Men who rape: *The psychology of the offender* (Da Capo Press, 2001).

[5]Tjaden & Thoennes.

[6]Age-adjusted rates are used in this report to "account for variations in age and risk of victimization among those with and without disabilities." M. Rand & E. Harrell, Crime against people with disabilities (Bureau of Justice Statistics Special Report, Office of Justice Programs, U.S. Department of Justice, 2009), 2, http://bjs.ojp.usdoj.gov/. For more explanation, see the report.

[7]See Rand & Harrell.

[8]D. Valenti-Heim & L. Schwartz, *The sexual abuse interview for those with developmental disabilities* (1995).

[9]West Virginia Bureau for Public Health, Health Statistics Center.

[10]www.census.gov.

[11]M. Rand, Criminal victimization 2008, *Bureau of Justice Statistics Bulletin* (2009), http://bjsdata.ojp.gov/content/pub/pdf/cv08.pdf.

[12]D. Kilpatrick, C. Edmonds & A. Seymour, *Rape in America: A report to the nation* (Arlington, VA: National Crime Victims Center, 1992).

[13]D. Kilpatrick & B. Saunders, *National survey of adolescents in the United States* (Ann Arbor, MI: Inter-University Consortium for Political and Social Research, 1995), http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/02833.

[14]D. Kilpatrick, *Rape and sexual assault* (National Violence Against Women Prevention Research Center, 2000).

[15]D. Valenti-Heim & L. Schwartz, *The sexual abuse interview for those with developmental disabilities* (Santa Barbara, CA: James Stanfield Company, 1995).

[16]D. Sobsey & C. Vamhagen, *Sexual abuse, assault and exploitation of people with disabilities: A study of victims* (Ottawa: Health and Welfare Canada, 1988).

[17]M. Mandel, *A survey on the prevalence of sexual assault among people with disabilities in the Tucson area* (unpublished raw data) (Tucson, AZ: Southern Arizona Center Against Sexual Assault, 2005). As cited in Office for Victims of Crime, Promising practices in serving victims with disabilities (Washington, D.C.: Office of Justice Programs, U.S. Department of Justice) http://www.ovc.gov/publications/infores/ServingVictimsWithDisabilities_bulletin/crime.html.

[18]M. Ticoll, *Violence and people with disabilities: A review of the literature* (Ontario: L'Institut Roeher, National Clearinghouse on Family Violence, Family Violence Prevention Unit, Health Canada, 1994), http://www.phac-aspc.gc.ca/ncfv-cnivf/publications/fvdisabliterature-eng.php; and Day One: The Sexual Assault and Trauma Resource Center, Rhode Island Coalition Against Domestic Violence and PAL: An Advocacy Organization for Families and People with Disabilities, *Is your agency prepared to ACT? Conversation modules to explore the intersection of violence and disability* (Advocacy Collaboration Training Initiative, 2004).

[19]D. Sobsey, Sexual offenses and disabled victims: Research and practical implications, *Visa Vis,* 6(4) (1988).

[20]I. Johnson & R. Sigler, Forced sexual intercourse among intimates, *Journal of Interpersonal Violence,* 15(1) (2000).

[21]M. Young, M. Nosek, C. Howland, G. Chanpong & D. Rintala, Prevalence of abuse of women with physical disabilities, *Archives of Physical Medicine and Rehabilitation,* 78 (suppl) (1997), s34-s38.

[22]L. Stimpson & M. Best, *Courage above all: Sexual assault against women with disabilities* (Toronto: DisAbled Women's Network, 1991).

[23]Statistics Canada, Centre for Justice Statistics, 1994, as cited in Harm's Way: The many faces of violence and abuse against persons with disabilities (Ontario: L'Institut Roeher, 1995).

[24]K. Muenzenmaier, I. Meyer, E. Struening & J. Ferber, Childhood abuse and neglect among women outpatients with chronic mental illness, *Hospital Community Psychiatry,* 44(7) (1993), 666-670.

[25]A. Abbey, Alcohol and sexual violence perpetration (National Online Resource Center on Violence Against Women 2008), www.vawnet.org.

[26]Used with permission from Wisconsin Coalition Against Domestic Violence, available through http://www.ncall.us/resources.html #NCALLPUBS.

[27]Although males and females are both victims of sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims/clients are often referred to as female.