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Journal of Disability Policy Studies 2008 19: 86 originally published online 10 June 2008
DOI: 10.1177/1044207308315278

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Journal of Disability Policy Studies
Volume 19 Number 2
September 2008 86-94
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Sexual Assault and Women With Cognitive Disabilities

Codifying Discrimination in the United States

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Criminal sexual assault statutes vary across the 50 U.S. states and the District of Columbia. However, most statutes mandate increased restrictions and penalties for crimes committed against victims with cognitive impairments. Current statutes pertaining to victims with cognitive impairments and the standards and methods typically used by courts to determine victims' capacity to consent are evaluated. The authors analyze these policies and demonstrate that the statutes stem from and perpetuate a legacy of systematic oppression including, but not limited to, the sexual exploitation and deprivation of people with cognitive impairments. They argue that current statutes not only fail to diminish but may also enhance the risk of sexual assault to adults with cognitive disabilities. The authors further argue that these statutes deprive adults with cognitive impairments of their civil liberties. They conclude with recommendations for changes in policy and practice.

Keywords: *civil rights; law/legal issues; sexual assault*

Every U.S. state criminalizes nonconsensual sexual activity. Most states classify these offenses in one of three ways: sexual contact "by force and without consent," sexual contact with a child, or sexual contact with a person who is mentally "defective" or "incapable" (*Sexual Assault Statutes,* 2006). Consent is the central focus of federal and state definitions of sexual assault. Competent adults have the right to consent to or refuse sexual activity, and both rights are protected under law. Children are deemed incapable of giving consent because they lack cognitive, intellectual, and emotional maturity. Like children, adults with cognitive disabilities are deemed incapable of legally consenting in most states (*Sexual Assault Statutes,* 2006).

In this article, we argue that sexual assault statutes generally fail to thwart the sexual abuse of adults with cognitive disabilities. We demonstrate that although the intention of these statutes is to protect, the statutes instead stem from and perpetuate a legacy of systematic oppression that includes the sexual exploitation and deprivation of people with cognitive impairments. There are several stages to our argument. We first examine trends and variability in the current sexual assault statutes in the 50 states as they pertain to victims with cognitive impairments. Second, we illustrate the standards and methods typically used by courts to determine victims' capacity to consent and the presence of mental disabilities, termed mental "defects" in most statutes. We then discuss how the specification for victims with cognitive impairments in sexual assault legislation fails to protect them from unwanted sexual encounters. Rather, the current sexual assault legislation robs victims with cognitive impairments of their civil liberties in two important ways: (a) The legislation justifies the victim's loss of due process rights during trial, and (b) the legislation violates the victim's right to privacy and to self-expression by rendering all sexual activity of people with cognitive impairments illegal. We conclude with policy recommendations that are necessary to address the injustices perpetuated under states' existing policies and practices.

Sexual Assault Statutes in the 50 States

The National Center for Victims of Crime defines sexual assault as an act committed against another who is "unwilling or unable to physically, mentally, or legally consent" (*Sexual Assault Legislation,* 2004). Because sexual crimes are not federal offenses, each state has its own definition, and there is state variability in how victims are defined. Forty-five states specify that individuals with

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so-called mental deficiencies are incapable of legally consenting to a sexual act (*Sexual Assault Statutes,* 2006), and thus these states render all sexual acts involving persons with mental disabilities illegal.

However, the specification for crimes against victims with disabilities varies for the District of Columbia and the five remaining states that do not explicitly criminalize the sexual activity of people with cognitive impairments. Colorado and the District of Columbia do not use the term *mental deficiency* in their sexual assault statutes but instead stipulate that an assault occurs when the perpetrator knows the victim is "incapable of appraising his or her conduct" (*Sexual Assault Legislation,* 2004). The three remaining states, Georgia, Massachusetts, and Missouri, do not afford particular status or heightened scrutiny to sexual assault when the victim has cognitive impairments. Massachusetts defines sexual assault as "sexual intercourse by force and against the victim's will" (*Sexual Assault Statutes,* 2006), regardless of the victim's cognitive abilities.

Although states vary in the level of detail provided in their definitions of mental deficiencies, most states that use the term *mental deficiency* stipulate its legal meaning. A typical example is offered by the Michigan statutory definition of mental deficiency that includes developmental disabilities and mental retardation (*Michigan Sexual Assault Statutes,* 2005). For the purposes of this article, we use the term *cognitive disabilities* or *cognitive impairments* to incorporate intellectual and developmental disabilities, including mental retardation.

Although most states use the term *mental deficiency* to refer to people with cognitive impairments, there is state variability in the classification of offenses when the victim has mental disabilities. Some states consider sexual assaults against victims with cognitive disabilities to be greater offenses with harsher penalties. States also vary in their definitions of rape versus other forms of violence such as sexual assault, battery, abuse, or torture (*Sexual Assault Statutes,* 2006). We employ the term *sexual assault* to encompass any unwanted sexual contact, from unwanted fondling to coerced oral sex and forced sexual intercourse.

Table 1 delineates each state's statutory specification related to victims with cognitive impairments. Across all states, there are five general categories of terminology. The table illustrates how most states regard people with cognitive impairments as legally incapable of understanding, resisting, or consenting to sexual activity.

Table 1
Specification of Cognitive Limitations in State Sexual Assault Statutes

Sexual Assault Crimes Punishable by Law	States
Sexual contact with a mentally defective victim	MD, NH
Sexual contact with a victim deemed incapable of consent because of mental defect, disease, retardation, infirmity, or unsoundness of mind	AL, AZ, CA, CT, DE, HI, ID, IL, IN, IA, KS, KY, LA, ME, MN, MT, NY, OK, OR, PA, SD, WV
Sexual contact with a victim who, due to mental defect, is mentally incapable of resisting or understanding the nature and consequences of the act	AK, AR, FL, MI, MS, NJ, NM, NC, ND, OH, RI, SC, TN, TX, UT, VT, VA, WA, WI, WY
Sexual contact with a victim who is mentally incapable of resisting or understanding the nature and consequences of the act	CO, DC, NE, NV
Sexual contact by force and against the will of the victim	GA, MA, MO

Source: *Sexual Assault Statutes in the United States* (2006).

Determination of Capacity to Consent

The cornerstone of criminal sexual assault legislation is whether the victim consented. As noted previously, most states assert that nonconsensual sexual activity can be categorized in one of three ways: (a) sexual contact by force, (b) sexual contact with a child, and (c) sexual contact with a person with mental disabilities (Reed, 1997). In situations where the victim has or is believed to have cognitive disabilities, evidence of the impairment must be presented during trial. If the court determines that the victim was incapable of consenting, the perpetrator could be tried for assaulting a person with mental disabilities (Reed, 1997), which may carry more severe penalties than assault against a nondisabled victim.

State laws generally require that courts determine three factors in assessing a victim's capacity to consent: knowledge of relevant facts, intellectual ability, and voluntariness (Reed, 1997; Stavis, 1991). States also vary in the relative weight they give to each factor. Generally, *knowledge of relevant facts* refers to the victim's awareness of the nature and consequences of sexual activity. Courts can interpret this knowledge of facts narrowly as a basic understanding of the physiological aspects of sexual contact, or they can interpret this knowledge broadly as an awareness of the moral, ethical, and emotional dimensions of sexual contact. Courts are also obligated to evaluate the victim's intellectual ability to comprehend and rationally evaluate the risks and benefits of engaging in sexual activity. In addition, laws mandate an assessment of the victim's voluntariness, or the victim's vulnerability to coercion and level of understanding that she may choose to engage or refrain from sexual activity (Reed, 1997; Stavis, 1991).

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States have generally concurred that consent means knowing, intelligent, and voluntary agreement to engage in sexual activity. However, how each aspect of consent should be measured is contested. Most often, courts evaluate a victim's capacity to consent through either a clinical or a judicial determination of competency. A clinical determination of competency is an evaluation of the victim's intellectual and emotional limitations performed by a clinical professional (e.g., a psychiatrist, psychologist, or physician) who subsequently testifies during the trial. Judicial determinations of competency refer to the judge's assessment of the victim's decision-making capacity based on expert testimony and the sum of the evidence presented during trial (Reed, 1997; Stavis, 1991). However, clinical and judicial competency determinations vary by state and jurisdiction.

Historically, courts have relied on evaluations of general functioning ability to determine an individual's capacity to consent to sexual activity. For example, a person's ability to handle daily living tasks (e.g., prepare meals, hold a job, or read and write) often determined the court's decision of whether the person was capable of knowingly, intellectually, and voluntarily engaging in sexual activity (Reed, 1997). More recently, courts have introduced other evaluation methods such as consideration of the victim's competence to consent in other realms (e.g., medical care). However, IQ and mental age testing remain the most frequently used measure of competence, despite longstanding concerns about the validity and reliability of these tests (Gould, 1981). Continued reliance on these tests exemplifies just one of the several ways in which outdated and overly scrupulous methods are employed in sexual assault trials where the victim has a cognitive impairment.

The Victim on Trial: Persecuting the Disability, Not the Perpetrator

An estimated 68% to 83% of women with developmental disabilities will be sexually assaulted in their lifetimes (Tyiska, 1998) as contrasted with an estimated 18% of lifetime incidence of sexual assault among women generally (Tjaden & Thoennes, 2006). However, sexual assault is notoriously underreported (Petersilia, 2000): An estimated 36% of such crimes were reported in 2004 (*Criminal Victimization, 2004,* 2005). In cases involving victims with disabilities, reporting rates are exceptionally low. Tharinger, Horton, and Millea (1990) found that only 3% of such crimes were reported. Moreover, when victims have cognitive disabilities, this underreporting is compounded by low prosecution and conviction rates. Sobsey and Doe (1991) found that although the perpetrator was known to the victim in 95% of reported sexual abuse cases of people with disabilities, only 22% of the alleged offenders were charged, and approximately 8% of those charged were convicted. In short, the vast majority of sexual assault cases against victims with mental disabilities pass without legal intervention.

The phenomenon of the victim knowing her perpetrator and the lack of legal intervention is not unique to adults with disabilities. Generally, perpetrators are acquaintances and intimates, they are frequently people who victims trust, and legal charges are not always successfully brought against perpetrators (Frazier & Haney, 1996; Tjaden & Thoennes, 2006). However, these problems are more pronounced for adults with disabilities because, in part, of their marginalized, disenfranchised status in society. The increased likelihood that a woman with intellectual disabilities will be attacked by an acquaintance is related to her typical reliance on others for care, support, and financial assistance (Andrews & Veronen, 1993; Beck-Masey, 1999; Carlson, 1997; Sobsey & Doe, 1991).

These patterns of underreporting and inadequate response by criminal justice suggest that the current legal system does not facilitate victims' reporting of sexual assault or perpetrators' accountability. The prospect of conviction of assault charges when victims have cognitive impairments is particularly grim. Indeed, we found that the statutory specification intended to protect victims with cognitive impairments appears to contribute to the low rates of reporting and conviction among this population of victims. By considering victims with mental disabilities to be a special class deserving unique treatment, the statutory specification justifies the victim's loss of due process rights during trial.

Interpreting Rather Than Hearing the Victim

Most states' sexual assault legislation pertaining to adults with cognitive disabilities fundamentally transforms the objective of the trial from assessing if the assault occurred to determining the victim's capacity to consent. This central point of contention during the trial gives professionals the right to surmise the victim's thoughts, motivations, and actions before and during the assault. This focus turns trials involving victims with mental impairments into an exhaustive evaluation of the victim's capabilities: The prosecution argues that victims were not intelligent enough to consent, and the defense argues that victims were not impaired enough to invalidate their consent. Either way, the central consideration of the trial unfairly rests on the victim, and not on the perpetrator.

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A standard course of court proceedings has emerged when victims have cognitive disabilities. First, a psychologist testifies about the generic aspects of the victim's impairment, such as relevant medical, psychological, physical, and social issues. Next, a professional qualified to evaluate the victim presents testimony about the victim's mental age, language skills, and concrete thinking ability. Third, after the judge and jury are presented with this information about what life is like for the accuser and her purported credibility, most victims with mild or moderate cognitive impairments are asked to testify about their victimization (Denno, 1997; Rogers, 1999). After these three phases of the trial, the "attributes of the victim's impairment are fresh in the jurors' minds . . . understanding how the victim thinks and acts will allow jurors to focus on the content of the victim's testimony and the issue of consent" (Rogers, 1999, p. 3). Moreover, the attention paid to the individual's impairment and abilities predisposes jurors and judges to view the victim's testimony through a discriminatory, differential lens that would never be used to evaluate the testimony of nondisabled victims.

Furthermore, with supposedly impartial declarations about the victim's reliability, professionals lawfully preempt the victim's own story of being sexually assaulted. However, the research literature, extending back to Goddard's use of IQ testing on the Kallikaks (Smith, 1985), is rife with examples of professional abuse of diagnostic prerogative (Gould, 1981; Razack, 1994) and the limited validity and reliability of such expert judgments in supposedly unbiased testing situations (Denno, 1997). Biklen and Schein (2001) argued that professionals' testimonies regarding the victim's capacities distracts the judge and juror from the crime and unnecessarily centers the trial on the victim's impairments.

> The only contextually relevant issues at hand are whether the person can communicate in a manner to be understood (i.e., if necessary, with communication aids such as translators) and acknowledge the requirement to tell the truth. In this sense, mental retardation need not [be] raised as an issue. (p. 443)

For the most part, people with cognitive disabilities are just as able to present a truthful account of their experiences as are nondisabled people (Valenti-Hein & Schwartz, 1993). Although mental disabilities may be associated with intentional memory deficits, cognitive impairments do not affect the type of memory necessary for providing a reliable testimony during trial. When individuals testify to events they witnessed or experienced, they rely on their incidental or "automatic" memory to retrieve the information, a process that is no more difficult for people with cognitive impairments than it is for nondisabled people (Henry & Gudjonsson, 1999).

Reed (1997) and Denno (1997) similarly warn that clinical competence assessments are overly reliant on IQ and mental age testing. Although mental capabilities fluctuate with education, age, fatigue, and life experience, test scores are fixed, unlike individual functioning. Moreover, continued reliance on IQ and mental age testing lags behind professional recommendations for a comprehensive evaluation of functioning in competence determinations (American Association of Mental Retardation, 2002). Reed asserted that IQ testing infantilizes people with cognitive limitations, despite the fact that they are adults in their sexual functioning.

Denno (1997) recommended that in sexual assault cases involving victims with cognitive impairments, courts should evaluate the situational context of the sexual assault and not the impairment. She argued that the same questioning standards should be applied to all victims because the experience of being assaulted is equally traumatizing and the courage to testify equally difficult for all assault victims to muster, regardless of their cognitive abilities.

Most sexual assault laws allow nondisabled professionals, lay witnesses, jurors, judges, and lawyers to reduce the victim's experience to a tragedy told in a storyteller's words rather than empowering adults with disabilities to tell their own stories. These court proceedings, in which adults with disabilities do not speak for themselves, limit victims' opportunities to reestablish a sense of control and safety in their lives. Although the evidence is limited, the victim can benefit from the experience of participating in the apprehension and conviction of the perpetrator (Frazier & Haney, 1996). By preventing victims from fully participating in the trial, this same process fails to treat women with impairments as people who were violated and who experience violation as nondisabled women do. Instead, these victims are exclusively seen as defective or pitiable: a posture that further victimizes them (Razack, 1998).

Forgiving the Rape Shield Law in the Name of Defect

The lobbying efforts of feminist advocates resulted in the institution of rape shield laws that prohibit defense attorneys from presenting victims' sexual histories during trials (*Sexual Assault Legislation,* 2004). Prior to enactment of these laws, alleged rapists could defend themselves during trials by portraying their victims as promiscuous or sexually active. However, today most states stipulate that evidence about victims' sexual histories can be considered only if it is materially

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relevant (*Rape Shield Statutes,* 2003). In cases where victims have cognitive impairments, rape shield laws are supplanted by the central focus of determining capacity to consent: Consequently, victims with cognitive limitations routinely have their sexual histories introduced into their accusers' trials (Rogers, 1999). Defense attorneys have successfully argued that evidence of a victim's past sexual conduct helps prove that the victim was aware of the "nature and consequences" of sexual activity.

Thus, victims with mental disabilities are denied the privacy rights guaranteed to nondisabled victims. Instead, women with cognitive impairments are often forced to expose the most intimate details about their lives to courtrooms full of strangers, and frequently not even in their own words but through those of a professional. A trend of expert witnesses relating details about the accuser's sexuality was evident in cases that involved victims with cognitive disabilities and in which the rape shield laws were dismissed (Denno, 1997; Razack, 1994). Often, the sexuality of victims with cognitive impairments is depicted as deviant and aggressive.

The 1989 Glen Ridge, New Jersey, case illustrates how the sexual assault law overrode the rape shield law. In this case, a young woman with a developmental delay was lured into a neighborhood basement after school by a gang of young men who sexually assaulted her with a baseball bat, a stick, and a broom (Block, 2000; Lefkowitz, 1997). Both prosecution and defense attorneys set the young woman's impairment as the focal point of the trial (Block, 2000; Lefkowitz, 1997). The defense argued that because of her impairments, she "craved the embracing . . . craved the euphoria because her brain functioned in that way . . . her feeling for sex and her drive—her genitals' signals—are greater than normal" (as cited in Biklen & Schein, 2001, p. 438). Similarly, the prosecution argued that the woman's impairments made her so eager to please that she was incapable of resisting the rape. One of her own attorneys stated, "This is not something that could have been done or would have been done to a girlfriend of one of the defendants. Normal human beings wouldn't tolerate such acts of cruelty, humiliation, and degradation" (as cited in Biklen & Schein, 2001, p. 439).

Glen Ridge catalyzed advocacy efforts that ultimately amended the rape shield law in New Jersey as it pertained to victims with disabilities. However, several months after the Glen Ridge trial, in North Carolina five young men repeatedly raped a young woman with cognitive disabilities. Forcibly inserting a broom handle, pipe, and candle into her vagina while videotaping the incident, they promised her a date if she endured the treatment and pledged not to report (Ayres, 1993). Similar to the Glen Ridge case, this assault reflects beliefs that are pervasive in our society, including the stereotype that women with cognitive disabilities are hypersexual.

When such stereotypes are presented in the media as part of the legal process, paired with the low rate of prosecution of raping women with mental disabilities, then adults with disabilities are likely put at greater risk of assault by sexual predators aware of both the stereotypes and the ease of escaping legal consequences. Thus, every time a woman with mental disabilities is prohibited from participating freely in the legal process (i.e., prohibited from telling her own story) and every time stereotypes of women with mental disabilities are used as legal tools by prosecutors and defense attorneys, such actions likely increases the risk of sexual assault that accrues to women with disabilities.

These cases highlight how women with cognitive disabilities are simultaneously characterized as sexually threatening, sexually vulnerable, and wholly deviant in order to satisfy statutory demands for the determination of victims' consent capacities. In particular, the Glen Ridge case highlights the system's distaste for, and discomfort with, the sexuality of women with disabilities. Numerous states legally define *mental deficiency* as conditions that render one "incapable of resisting" sexual acts. For example, Vermont defines *incapacity* as the inability to decline consent to sexual activity due to "mental illness or mental retardation" (*Sexual Assault Statutes,* 2006).

Sexual assault advocates often cite U.S. society's discomfort with human sexuality as a significant barrier to acknowledging and effectively addressing sexual violence, including legal prosecution. To the extent that it is difficult to openly discuss sexuality in public discourse, sexual violence becomes that much more challenging to address. In the case of sexual violence against women with mental disabilities, society's discomfort with sexuality becomes intertwined with discriminatory attitudes and the stereotypes held about women with cognitive impairments.

Focusing on the victim rather than on the perpetrator, the sexual assault legislation of 45 states magnifies impairment and reifies the supposedly exotic nature of victims. This exploitation both grows from and perpetuates collective beliefs about the deviant and aggressive sexuality of women with disabilities. Through legislation masked as protection, these unfounded, yet ingrained, images of women with disabilities serve to mandate and control their supposedly degenerate sexual behaviors. In fact, the focus on the victim instead of on the perpetrator not only disempowers these women but may also put

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women with mental disabilities at elevated risk of sexual violence. In their failure to prevent abuse or successfully prosecute sexual assault crimes against people with cognitive impairments, the statutes serve only a discriminatory role: They render any consensual sexual activity involving a person with cognitive impairments unlawful.

The Illegality of Sexuality

Controlling one's own life is a central value and defining feature of U.S. citizenship (Stavis, 1991). However, a common assumption stands at the core of the sexual assault legislation of 45 states: People with cognitive impairments are incapable of making choices. Because they are legally incapable of consenting, all sexual activity involving people with cognitive impairments is criminalized.

We argue that sexual assault legislation diminishes the civil and constitutional rights of people with cognitive impairments. Stemming from a historical tradition of criminalizing the sexuality of people with mental disabilities, today's legislation is a more subtle mechanism for preventing people with cognitive impairments from making choices that nondisabled people regard as their exclusive and private prerogative.

The Historical Construction of Disability and Sexuality

In the early 20th century, notions about the heritability of impairment were widely promulgated, and eugenicists embraced this alleged relation as a foundation for social control programs that ultimately included marriage restrictions and coercive sterilization both in the United States (Trent, 1994) and in Nazi Germany (Kühl, 1994). Eugenicists championed society's responsibility to protect itself from a proliferation of people with cognitive limitations, and they asserted that preventing procreation by people with disabilities would systematically eliminate mental impairments (Block, 2000; Trent, 1994). Such population control measures were supported by a 1927 Supreme Court decision that upheld states' rights to coercively sterilize women with mental disabilities (Block, 2000; Trent, 1994).

After World War II, in the face of evidence of the Holocaust's horrors, public support for compulsory sterilization programs dissolved and some state legislatures tightened sterilization restrictions (Kühl, 1994). The sexual revolution and the disability rights movement that emerged in the 1960s and 1970s raised consciousness among the nondisabled that people with cognitive impairments have biological, emotional, and legal rights to engage in intimate relationships. As advocacy grew, some sexual education programs were initiated for adults with developmental disabilities (Kempton & Kahn, 1991).

Although sterilization regulations—the most extreme method of controlling reproduction—have narrowed, many women with cognitive limitations continue to be denied parental rights for their children (Parish, 2002). A mother's cognitive impairments are sometimes sufficient evidence of parental ineptitude. However, it is more common for courts to apply stricter competency standards on mothers with cognitive limitations than those applied on nondisabled parents. These laws are upheld despite evidence that mothers with cognitive impairments are significantly less likely than people in the general population to abuse or neglect their children (Parish, 2002). Motivated by discriminatory assumptions and patronizing attitudes rather than by sound evidence, mothers with cognitive impairments routinely have their custody terminated despite policies necessitating proof of parental wrongdoing (Parish, 2002).

Despite the civil rights advances of people with disabilities, entrenched oppression of women with cognitive impairments is rooted in archaic and pseudoscientific theories about their supposed perversity, sexual deviance, and hypersexuality. Current practices that terminate parental rights solely based on mothers' mental disabilities further illustrate societal beliefs that women with disabilities are ill equipped to raise their children. Many of the governmentally enforced policies that segregated people with cognitive disabilities from the so-called normal population—at one time by institutions and prisons but more recently by group homes and special schools—were originally created to limit their reproduction (Trent, 1994).

Although involuntary sterilization is unlawful in most states today, lawmakers have not entirely rejected the eugenic theories that motivated institutional segregation, marriage restrictions, and coercive sterilization. Overtly or not, U.S. sexual assault statutes criminalize the sexual activity of people with disabilities. Rendering the consent of individuals with disabilities meaningless, the laws usher eugenics in through the back door.

A More Difficult Test to Pass

A majority of U.S. states' sexual assault legislation requires attorneys to establish whether victims with cognitive impairments are capable of knowingly, intellectually, and voluntarily engaging in sexual activity. However, this same assessment is not typically employed when nondisabled victims bring their assault cases to trial. Scrutinizing victims with cognitive impairments and their understanding of sexual activity effectively

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holds them to a "higher consent standard" than that which is imposed on nondisabled victims (Denno, 1997).

How people with cognitive impairments are probed for their understanding of sex, often relying on their histories of sexual activity, far exceeds what any nondisabled person would be expected to endure or publicly disclose. When nondisabled people engage in unsafe sex, their behavior is considered private acts, not criminal activities (Kaeser, 1992). People with cognitive limitations are held to a higher standard of understanding and defending their behavior than are the nondisabled, who are not required to prove they carefully weighed the physiological, emotional, or moral aspects of their sexual activities.

This discrimination is clearly evident when the line of questioning reserved for victims with cognitive impairments is applied to nondisabled victims. For example, the American Prosecutors Research Institute (Rogers, 1999) suggested a line of questions for prosecutors to ask victims with cognitive impairments to establish a victim's ability to consent, including, "How do babies get inside a woman?" and "Why does the pill prevent a woman from getting pregnant?" (Rogers, 1999, p. 2). Nondisabled victims, of course, do not have to submit to such questioning.

Even more worrisome is how the sexual knowledge of people with cognitive impairments is evaluated, especially considering that there is only a slim possibility that the victim participated in adequate sexual education (Cheng & Udry, 2003). Current sexual education programs geared for adolescents and adults with cognitive limitations emerged from concerns about their increased vulnerability to abuse, not from efforts to build their capacity for informed consent (McCarthy, 2002). Entrenched in the language of violence and victimization, sexual education for people with cognitive impairments delivers messages about sexuality that run counter to human physiological and emotional needs to seek intimacy (McCarthy, 2002). This misguided focus trains students to avoid rather than understand their sexuality, thereby leaving them unprepared to testify on their comprehension of the mechanics of sexual activity. These policies and practices essentially create revolving doors of discrimination in which individuals with cognitive impairments are punished for not grasping information they were never given. Therefore, improved sexual education for people with cognitive impairments represents just one of several necessary interventions to address the problematic intersection of sexuality and disability in laws, policies, and services.

Policy and Practice Recommendations

Successfully combating the omnipresent discrimination against people with intellectual impairments in the United States will require effective advocacy to eliminate sexual assault laws that reify the deviance of women with intellectual disabilities. Beyond lobbying to remove the "mentally deficient" specification in existing sexual assault statutes, several feasible policy and practice measures can be employed to (a) prevent the sexual abuse of people with cognitive impairments, (b) ensure that such cases are justly tried, and (c) reframe the legal and social systems' approach to disability and sexuality. The following changes are necessary.

Improvement in Sexual Education for People With Cognitive Impairments

Many current sexual education programs for people with cognitive impairments conflate issues of consensual and nonconsensual sexual activity, which inevitably leads students to mentally entangle actions that constitute violence with those that constitute love (McCarthy, 2002). Therefore, sexual education programs for people with cognitive impairments should be reframed to present sexual activity as a natural, positive, and healthy demonstration of affection that requires consent from both participants. In addition to teaching physiology, sexual education should focus on skills for building and maintaining supportive relationships. Similarly, it is imperative for sexual education programs to foster self-esteem and self-worth in students with cognitive impairments (McCarthy, 2002).

Sexual Assault Prevention for Individuals With Cognitive Limitations

The same risk prevention focal areas for all women apply to people with cognitive impairments: reducing the individual's susceptibility for assault, and increasing security in the social and physical environments (Andrews & Veronen, 1993). Individual risk prevention should involve an evaluation of the person with cognitive impairments for characteristics that may increase her vulnerability to assault. Common traits associated with cognitive disabilities and risk for abuse include overcompliance, low self-esteem, and internalized self-devaluation. Professional assessment of these characteristics should be folded into individual safety plans and the formulation of person-specific problem-solving techniques (Carlson, 1997).

In addition, social and environmental changes are imperative. In residential facilities, disability advocates must seek improved staff training, tightened security, increased surveillance, and mandatory reviews for resident safety. Community efforts to prevent assault should inform and equip caregivers to respond to the sexual concerns of care recipients with cognitive limitations

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(Andrews & Veronen, 1993). On a societal level, a concerted effort will be required to dissolve stereotypes concerning the sexuality and powerlessness of people with cognitive impairments if reductions in sexual violence against victims with disabilities are to be realized.

Merging the Advocacy Efforts of Disability and Sexual Assault Advocacy Groups

Sexual assault advocacy efforts are largely based on second-wave feminist efforts to end sexual violence against all women. The sexual assault movement has made significant strides in addressing the problem of sexual violence against women. However, given the ongoing prevalence of sexual violence, especially against women with disabilities, more work is needed.

Unfortunately, women with cognitive impairments have generally been excluded from prominent feminist writings, advocacy groups, and discourse. McCarthy (2002) posited that women with mental impairments have been "severed from the sisterhood" (p. 93) and are often disregarded because characteristics of their impairments run counter to the images of women that feminists promote: strong, smart, and powerful. Advocacy efforts must fully and meaningfully include women with cognitive limitations. Victims with impairments should be able to seek support from disability advocates as well as from organizers for the judicial rights of nondisabled victims of sexual assault. Although a collaborative effort between disability and victims' rights advocacy groups has not yet been established (Nosek, Foley, Hughes, & Howland, 2001), building a unified voice for all victims of sexual assault should be an important priority.

Specifically, people working for sexual assault organizations that provide prevention programs and postassault services should be trained to work effectively with adults with mental disabilities. Likewise, disability advocates and workers should be trained in sexual violence prevention and response. At the community level, interagency collaboration between disability and sexual assault services is needed. Such collaboration may include having staff members on the boards of the other agencies, holding assault support groups in disability organizations, and having disability advocates staff crisis services at sexual assault organizations. Such interagency collaboration could make both service systems more responsive and effective in meeting the needs of victims with disabilities.

Conclusion

All but three states single out victims with cognitive impairments in their sexual assault statutes. In doing so, they minimize the violent act and dehumanize and further disempower victims. The states whose sexual assault statutes qualify offenses based on victims' cognitive abilities establish an unwarranted hierarchy of crime.

Myriad issues contribute to the increased vulnerability of women with mental disabilities being victimized, including social isolation, increased dependency on others, less education, and internalized devaluation (Nosek et al., 2001). Most of these issues stem from the stigma and discrimination that accompany intellectual disabilities in U.S. society (Andrews & Veronen, 1993; Beck-Masey, 1999; Block, 2000; Carlson, 1997). State sexual assault laws fail to situate the problem within a larger framework of interlocking systems of oppression (Razack, 1994) and instead reduce sexual assault cases to a problem of individual deficits.

Sexual assault legislation fails all victims to some extent. For example, some states still require perpetrators to use a weapon or inflict serious physical harm before assaults are charged as rape. Others stipulate that only vaginal intercourse is considered rape or that husbands cannot rape their wives (*Sexual Assault Statutes,* 2006). Nondisabled and disabled victims alike struggle to gain credibility in court. Yet victims with cognitive impairments must also navigate the confounding effects of multilayered discrimination to establish their credibility, including proving the normality of their sexuality.

Sexual assault against women with disabilities is despicable and endemic. However, states' sexual assault legislation fails to address the problem. Instead, existing legislation exacerbates the trauma by forcing victims to assume a mantle of deviance in order to prosecute the crimes against them. To satisfy the system's focus on capacity to consent, victims are turned into a different, and lesser, kind of human being. If states prosecuted sexual assault offenders based solely on the National Center for Victims of Crime standards, any person who refuses to consent to a sexual act is, by definition, a victim of assault. In short, the presence of a disability is irrelevant. Statutory specifications do not provide further protection for people with mental disabilities but, rather, prolong a shameful history of segregation and social control of people with intellectual impairments.

References

American Association of Mental Retardation. (2002). *Mental retardation: Definition, classification, and systems of support.* Washington, DC: Author.

Andrews, A. B., & Veronen, L. (1993). Sexual assault and people with disabilities. *Journal of Social Work and Human Sexuality, 8,* 137–159.

Ayres, B. D. (1993, May 30). Rape, retardation, and a town aghast. *New York Times*. Retrieved December 11, 2006, from http://query.nytimes.com

Downloaded from dps.sagepub.com at Serials Records, University of Minnesota Libraries on October 12, 2011

Beck-Masey, D. (1999). Sanctioned war: Women, violence, and disabilities. *Sexuality and Disability, 17,* 269–276.

Biklen, D., & Schein, P. L. (2001). Public and professional constructions of mental retardation: Glen Ridge and the missing narrative of disability rights. *Mental Retardation, 39,* 436–451.

Block, P. (2000). Sexuality, fertility, and danger: Twentieth-century images of women with cognitive disabilities. *Sexuality and Disability, 18,* 239–254.

Carlson, B. E. (1997). Mental retardation and domestic violence: An ecological approach to intervention. *Social Work, 42,* 79–89.

Cheng, M. M., & Udry, J. R. (2003). How much do mentally disabled adolescents know about sex and birth control? *Adolescent and Family Health, 3,* 28–38.

Criminal Victimization, 2004. (2005, September). Washington, DC: U.S. Department of Justice. Retrieved December 11, 2006, from http://www.rainn.org/docs/statistics/ncvs_2005.pdf

Denno, D. (1997). Sexuality, rape, and mental retardation. *University of Illinois Law Review, 2,* 315–395.

Frazier, P. A., & Haney, B. (1996). Sexual assault cases in the legal system: Police, prosecutor, and victim perspectives. *Law and Human Behavior, 20,* 607–628.

Gould, S. J. (1981). *The mismeasure of man*. New York: Norton.

Henry, L., & Gudjonsson, G. (1999). Eyewitness memory and suggestibility in children with mental retardation. *American Journal on Mental Retardation, 104,* 491–508.

Kaeser, F. (1992). Can people with severe mental retardation consent to mutual sex? *Sexuality and Disability, 10,* 33–42.

Kempton, W., & Kahn, E. (1991). Sexuality and people with intellectual disabilities: A historical perspective. *Sexuality and Disability, 9,* 93–111.

Kühl, S. (1994). *The Nazi connection: Eugenics, American racism, and German National Socialism*. New York: Oxford University Press.

Lefkowitz, B. (1997). *Our guys: The Glen Ridge rape and the secret life of the perfect suburb*. Berkeley: University of California Press.

McCarthy, M. (2002). Sexuality. In P. N. Walsh & T. Heller (Eds.), *Health of women with intellectual disabilities* (pp. 90–102). Oxford, UK: Blackwell.

Michigan Sexual Assault Statutes. (2005, January 5). Okemos, MI: Resource Center on Domestic and Sexual Violence. Retrieved December 11, 2006, from http://www.mcadsv.org/mrcdsv/law/Sexual%20Assault.pdf

Nosek, M., Foley, C., Hughes, R., & Howland, C. (2001). Vulnerabilities for abuse among women with disabilities. *Sexuality and Disability, 19,* 177–189.

Parish, S. (2002). Parenting. In P. N. Walsh & T. Heller (Eds.), *Health of women with intellectual disabilities* (pp. 103–120). Oxford, UK: Blackwell.

Petersilia, J. (2000). Invisible victims: Violence against persons with developmental disabilities. *Human Rights, 27,* 9–13.

Rape Shield Statutes. (2003, May 1). Alexandria, VA: National District Attorney's Association. Retrieved July 15, 2006, from http://www.ndaa-apri.org/pdf/sexual_assault_statutes.pdf

Razack, S. (1994). From consent to responsibility, from pity to respect. *Law and Social Inquiry, 19,* 891–922.

Razack, S. H. (1998). *Looking White people in the eye*. Toronto, Canada: University of Toronto Press.

Reed, E. (1997). Criminal law and the capacity of mentally retarded persons to consent to sexual activity. *Virginia Law Review, 83,* 799–827.

Rogers, L. (1999, November). Successful prosecution when the sexual assault victim is mentally impaired. *Update Newsletter* [National District Attorneys Association], *12*(11), 1-5.

Sexual Assault Legislation. (2004). Retrieved November 16, 2005, from the National Center for Victims of Crime Web site, http://www.ncvc.org/ncvc

Sexual Assault Statutes in the United States. (2006). Portland, OR: National Crime Victim Law Institute. Retrieved July 15, 2006, from http://law.lclark.edu/org/ncvli/clpps.html

Smith, J. D. (1985). *Minds made feeble: The myth and legend of the Kallikak family*. Rockville, MD: Aspen.

Sobsey, D., & Doe, T. (1991). Patterns of sexual abuse and assault. *Sexuality and Disability, 9,* 243–259.

Stavis, P. (1991). Harmonizing the right to sexual expression and the right to protection from harm for persons with mental disability. *Sexuality and Disability, 9,* 131–141.

Tharinger, D., Horton, C. B., & Millea, S. (1990). Sexual abuse and exploitation of children and adults with mental retardation and other handicaps. *Child Abuse and Neglect, 14,* 301–312.

Tjaden, P., & Thoennes, N. (2006). *Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey*. Washington, DC: National Institute of Justice.

Trent, J. (1994). *Inventing the feeble mind: A history of mental retardation in the United States*. Berkeley: University of California Press.

Tyiska, C. G. (1998, September). *Working with victims of crime with disabilities*. Washington, DC: U.S. Department of Justice, Office of Justice Programs. Retrieved December 11, 2006, from http://www.ojp.usdoj.gov/ovc/publications/factshts/disable.htm

Valenti-Hein, D., & Schwartz, L. (1993). Witness competency in people with mental retardation: Implications for prosecution for sexual abuse. *Sexuality and Disability, 11,* 287–294.

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