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KNOWLEDGE ON SEXUAL ABUSE AND SELF-PROTECTION SKILLS: A STUDY ON FEMALE CHINESE ADOLESCENTS WITH MILD MENTAL RETARDATION

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ABSTRACT

Objective: This study aimed to examine the level of sexual abuse knowledge and self-protection skills in a sample of female Chinese adolescents with mild mental retardation. It was hypothesized that the participants would exhibit impoverished knowledge on sexual abuse and related self-protection strategies.

Method: A total of 77 female Chinese adolescents aged from 11 to 15 years old who met the inclusion criterion of the study were recruited from four special schools for mental retardation. The Chinese versions of the Personal Safety Questionnaire and the "What If" Situation Test (Wurtele, 1990) were administered orally to the participants during individual interviews.

Results: Participants were more able to accurately recognize inappropriate than appropriate touches and sexual requests, and possessed limited information about sexual abuse. They were also inadequate in protecting themselves against sexual abuse, and had the most difficulty in reporting the sexually abusive incident and characteristics of the offender. Regression analyses also showed that their sexual abuse knowledge was the best predictor for self-protection skills.

Conclusion: The present findings provided strong cross-cultural support to previous Western studies that found females with mild mental retardation of high risk to sexual abuse and in need of specially designed prevention program to enhance their competency against sexual victimization and exploitation. With modification and refinement, measurement scales used in the Western general population could be extended to Chinese adolescents with mental retardation. Suggestions on the design of the sexual abuse prevention programs, limitations of the present study, and recommendations for future studies were also discussed. © 1999 Elsevier Science Ltd

Key Words—Sexual abuse, Chinese sexual abuse.

INTRODUCTION

SEXUAL ABUSE VICTIMIZATION is a pervasive problem among individuals with mental retardation (Beail & Warden, 1995; Brown, Stein, & Turk, 1995; Elvik, Berkowitz, Nicholas, Lipman, & Inkelis, 1990; Hames, 1996; Tharinger, Horton, & Millea, 1990; Turk & Brown, 1993), and its prevalence may be higher than the estimated prevalence within the general population (Baker & Duncan, 1985; Ludlow, 1991). Sexual abuse of these individuals often occurs repeatedly and over protracted periods of time in a variety of settings, including institutions, community residential facilities, and other service settings; and involves caregivers and other providers, family members, peers with mental retardation, and other acquaintances (Beail & Warden, 1995; Furey, 1994; Mansell, Sobsey, & Calder, 1992; Sobsey, 1994; Turk & Brown, 1993).

Individual risk factors that increase these people's vulnerability to sexual victimization include

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their impoverished sexual knowledge (Brantlinger, 1985; Edmonson, 1988; McCabe, 1993), a lack of sex education (Fenwick, 1994; Ludlow, 1991), lifelong physical and emotional dependence on adults (Furey, 1994; O'Day, 1983), impaired verbal and social abilities (Singer, 1996; Sobsey, 1994), and a lack of knowledge on sexual abuse preventive skills (Haseltine & Miltenberger, 1990; Watson, 1984). The ecological models, on the other hand, argue that cultural, community, and family responses to mental retardation also increase the risk for sexual abuse (Belsky, 1980; Bronfenbrenner, 1977; Garbarino & Stocking, 1980). With the social stigma and low status ascribed to them, individuals with mental retardation are often denied of their rights to sexual expression and opportunities to social interaction, and are fostered to comply and depend on their caregivers and institution staff (Sobsey, 1994; Sundram & Stavis, 1994). The misconceptions about the asexuality of these people may also result in a failure of the community, service providers, and caregivers to recognize the potential risk of sexual abuse and exploitation, to detect such incidents when they occur, or to protect and assist the victims (Hames, 1996; Mansell et al., 1992; Sobsey, 1994; Tharinger et al., 1990).

Among the identified risk markers, inadequate sexual knowledge remains the most salient factor regarding sexual victimization of individuals with mental retardation. Studies have shown that these people's level of sexual knowledge is generally lower than those without mental retardation (Hall & Morris, 1976; McCabe, 1993; Watson & Rogers, 1980). While they may know the gross anatomical differences between sexes, these people often have vague ideas about the internal organs and possess either inadequate or distorted information concerning conception, contraception, venereal disease, homosexuality, and sterilization. Their limited sexual knowledge is mainly due to their inadequate verbal or communicative skills to ask people about sexual matters, a lack of reading ability to use books and magazines as sources of information, and deprived opportunities for sex education in segregated special schools or institutions.

Despite evidences to the contrary, people with mental retardation are often sexually stigmatized and perceived as either asexual, sexually incompetent, or possessing uncontrollable libido and perverted sexual habits (Abramson, Parker, & Weisberg, 1988; Burt, 1973; Ludlow, 1991). In the past decades, segregation, institutionalization, and surgical sterilization or castration have variously been proposed to restrict sexual expression of these people. Staff of institutions for mental retardation have routinely discouraged all forms of sexual expression by their residents, even masturbation in private, to avoid scandal or reputation damage (Hames, 1996; Sundram & Stavis, 1994). Even parents of offsprings with mental retardation may refuse to believe that their offsprings have sexual needs and feelings and reject attempts at providing sex education in the mistaken belief that ignorance will prevent sexual activity, sexual education will jeopardize their innocence, or sexual information will overstimulate their concern with sex (Abramson et al., 1988; Alcorn, 1974; Watson & Rogers, 1980). A few parents may accept their offsprings' need for sex education, but often transfer this responsibility for training to the professionals.

Adequate large-scale sex education programs for people with mental retardation are generally lacking (Ludlow, 1991; McCabe, 1993; Tharinger et al., 1990). A majority of these programs have preplanned or group curriculum sequences adopting from those provided for normal school children, and have not taken into account the varying needs and (dis)abilities of individuals with mental retardation (Edmonson, 1988; Ford, 1987; O'Day, 1983). These programs have focused mainly upon cleanliness, morality, and good health habits; and are geared toward teaching inhibition rather than reducing anxiety and increasing appropriate heterosexual behaviors. Moreover, this type of sexuality curriculum often fails to address real-life problems confronted by these people, such as the high incidences of sexually transmitted diseases, sexual abuse and exploitation, and unwanted pregnancy; and provides little or no information on how to protect themselves against these problems (Ludlow, 1991; Tharinger et al., 1990). Many researchers have pointed out that this population needs sexual abuse prevention programs that address competency enhancement against sexually abusive circumstances (Haseltine & Miltenberger, 1990; Sobsey, 1994; Sundram

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