Interaction Between Family Violence and Mental Retardation

Heidi L. Strickler

Abstract

Although family violence and mental retardation are both prevalent in today’s society; very little research has been conducted to investigate the relationship between them. Characteristics that make individuals with mental retardation more vulnerable to family violence are discussed in the areas of child, adult, and sexual abuse. Common psychological effects of this trauma are then explored followed by implications for practice. Because family violence and mental retardation are both societal as well as personal issues, intervention and prevention efforts must occur at both a direct service level and a community/macro service level. With such intervention and prevention efforts, persons with mental retardation will receive superior service when dealing with issues related to family violence.

Family violence has plagued society for centuries. Currently, although much research is being conducted in this area, there is a dearth of research in which investigators have examined the relationship between family violence and mental retardation, studies necessitated by the current emphasis on deinstitutionalization and community integration. Individuals with mental retardation are now living with their families of origin, in small group homes that function as a family unit, or on their own in the community. As this trend continues, these individuals will be exposed to the same societal ills as individuals without mental retardation are. Therefore, it is imperative that practitioners working in both the field of family violence and the field of mental retardation become familiar with the perils facing this population.

My purpose in this paper is to review what is known about the relationship between family violence and mental retardation. A case study of an individual with mental retardation from my practice is used to illustrate themes found in the literature. This individual has experienced various forms of abuse as both a child and an adult, which were a central aspect of her treatment. Case study example are set in italics.

Case Study

Jane is a 40-year-old woman with moderate mental retardation. She has Axis I diagnoses of schizophrenia, undifferentiated type, post-traumatic stress disorder, and eating disorder, not otherwise specified. She has an additional Axis II diagnosis of Borderline Personality Disorder. Jane was removed from her family of origin when she was approximately 6 years of age because her neighbors contacted the police with reports of neglect. She was placed in a foster home, where she was burnt with cigarettes and beaten by the other foster children. At age 9 she ran away from this foster home and was placed in another. In this second foster home, she was gang raped repeatedly by her three foster brothers around the time she turned 12. After running away from this home several times, Jane was placed in a third foster home, where, if she made a mistake she was placed in the corner and hit. After running away again, at approximately age 16, Jane was placed in a state school for individuals with mental retardation. At the time of this writing she was served by her area Mental Health and Mental Retardation Center. She lived in an apartment with one female roommate. Jane received individual counseling twice per week, group counseling once per week, and psychiatric medication reviews every 3 months.

Characteristics That Increase Vulnerability to Abuse

Because individuals with mental retardation are often thought of to be child-like, people may won-
nder how they can be abused when they appear to need constant protection. Ironically, the people who believe that these individuals need protection are often the ones who are abusive. Statistics reveal that individuals with mental retardation are exposed to abuse at higher rates than are people within the general population. Individuals with disabilities have been found to be at least 1.5 times more likely than those without disabilities to experience sexual abuse (Sobsey, Randall, & Parilla, 1997). Children with disabilities are 4 to 10 times more likely to experience maltreatment than are children without disabilities (Sobsey et al., 1997). What factors make individuals with mental retardation so vulnerable to family violence?

**Childhood Victimization**

Each year approximately 33 out of every 1,000 children in America are reported to have been abused (Sobsey et al., 1997). Because, as already noted, children with mental retardation are several times more likely than those without mental retardation to experience abuse, it is important to investigate risk factors that may be unique to this population. One possible contributing factor is that as children, they lack certain behaviors that children without mental retardation use to attract attention from parents. Consequently, they are less likely to bond with their parents and are more likely to be targets of abusive behavior (Valentine, 1990).

Another factor that may increase the risk of abuse is that children with mental retardation place more financial and caretaking demands on their parents than do those without mental retardation. These financial and emotional demands may place stress on an already overloaded parent, leading the parent to violently punish the perceived cause of the stress (Valentine, 1990). Other possible links between parenting behavior and the abuse of children with mental retardation include high stress, parental isolation, and unrealistic expectations for a child's performance (West, Richardson, LeConte, Crimi, & Stuart, 1992).

Gender also appears to be a risk factor for various types of abuse. In the general population, girls are sexually abused 2.5 times more often than are boys, whereas boys are physically abused 35% more often (Sobsey et al., 1997). Specifically, boys with disabilities experience significantly more physical abuse and neglect, whereas girls experience significantly more sexual abuse (Sobsey et al., 1997). Therefore, depending upon the type of abuse, the child's gender can be considered a risk factor.

**Adult Victimization**

There are several factors, similar to childhood factors, that serve to make adults with mental retardation more likely to be victims of family violence. For the purposes of this paper, three types of adult living arrangements are considered “family.” First, an adult with mental retardation may live with his or her biological, adoptive, or foster family, and any type of relative may perpetrate violence. Second, he or she may live in a small group home wherein the residents interact as a family unit, and violence may be perpetrated by either staff or another resident. Third, an adult with mental retardation may reside in his or her own apartment with a significant other or a roommate, and this relationship may become violent. These living situations are considered because most cases of abuse occur in the living arrangement. In addition, staff and “family” members are the most frequent perpetrators of abuse (Furey & Haber, 1989).

One factor contributing to the likelihood of abuse of adults with mental retardation is the level of cognitive functioning. The incidence of abuse is much higher for adults with mild and moderate mental retardation than for those with severe or profound levels. The higher incidence may be explained by the fact that individuals with mild or moderate mental retardation are more capable of interacting with or reacting to the abuser, thus accelerating the abuse cycle (Zirpoli, Snell, & Loyd, 1987). Those with a higher level of adaptive behavior functioning are also at greater risk. Therefore, contrary to the belief that individuals with severe and profound mental retardation are abused more often because they are less likely to report the abuse, researchers have found that individuals with mild and moderate mental retardation and higher levels of adaptive behavior functioning are at the greatest risk to be in a violent situation (Marchetti & McCartney, 1990).

Finally, in a very comprehensive analysis, Nosek, Howland, and Young (1997) have listed nine factors that place individuals with mental retardation at a greater risk for family violence than are those individuals without mental retardation: (a) an increased dependency on others for long-term care; (b) a denial of human rights, resulting in perceptions of powerlessness by both the victim and the perpetrator; (c) less risk of discovery as perceived...
by the perpetrator; (d) the difficulty some survivors have with getting others to believe their reports; (e) less education about appropriate and inappropriate sexuality; (f) living in social isolation, which increases the risk of being manipulated by others; and (g) having the potential for physical helplessness and vulnerability in public places (Nosek et al., 1997); (h) the values and attitudes held by professionals in the field of disabilities toward integration without considering individual capacities for self-protection, and (i) the lack of economic independence that most individuals with mental retardation face contribute to the risk of adult abuse.

Sexual Victimization

Many of the risk factors for family violence both in childhood and adulthood are carried over into the sexual violence arena. There are, however, certain factors that make individuals with mental retardation more susceptible to sexual violence than to any other form of family violence. Women with mental retardation are at particular risk for this type of victimization, and the greatest threat again comes from caregivers, friends, and acquaintances (Furey, 1994). In fact, Furey estimated that 99% of sexual perpetrators are known by the victim.

Because the majority of perpetrators of sexual violence are known to the individual and are caregivers of some type, the increased dependence upon others that most adults with mental retardation experience is a contributing factor to their risk for sexual violence (Furey, 1994). Corresponding with this dependence is a sense of acquiescence from the individual with mental retardation. Typically, such individuals tend to obey their caregivers rather than challenge them. Persons with mental retardation are frequently educated to believe that they do not have control over what happens to them and that they do not have choices in their lives (Furey, 1994; Murphy, & Razza, 1998). Interestingly, the majority of victims have no communication problems, no hearing or visual impairment, and no mobility problems.

One factor that makes adults with mental retardation afraid to report sexual abuse, especially abuse that occurs in a family setting, is the fear of retribution. This fear is often combined with a fear of becoming homeless and being separated from their family and support network (Furey, 1994; Murphy & Razza, 1998). Therefore, individuals with mental retardation may be more likely to continue to live in an abusive environment than would individuals without mental retardation.

Although these risk factors may be similar to those found in the population at large, there is a group of factors pertaining only to individuals with mental retardation, including beliefs that these individuals are or should be asexual beings, have repressive rules about sexuality, have been sexually abused as a child, been punished for masturbation, have had contact with the opposite sex monitored or forbidden, and have been forbidden to discuss sexuality (Furey & Niesen, 1994). Although the general population has certain taboos about sexuality and may feel uncomfortable discussing such topics, there is a virtual blanket of silence about sexuality in the interactions individuals with mental retardation have with family members, staff members, teachers, etc. Accurate information about sexuality is not available from peers, and frequently the opportunity for such discussion does not exist (Furey & Niesen, 1994). Finally, these individuals, particularly those functioning in the mild to moderate range, often experience social isolation. They do not quite fit in with people who do not have mental retardation nor those with more severe levels of mental retardation (Tharinger, Horton, & Millea, 1990). Consequently, they exert great effort trying to “fit in” with persons who do not have mental retardation. These attempts increase their sexual vulnerability, particularly with significant others who may be functioning at a higher intellectual level (Finucane, 1998; Tharinger et al., 1990).

Individuals with mental retardation are at significant risk for sexual victimization by someone with whom they live, are dependent upon, or with whom they are friends. Sobsey and Doe (1991) reported that 16.8% of the perpetrators of sexual abuse were natural family members, 15.2% were acquaintances, 9.2% were generic service providers (e.g., babysitters), 8.2% were strangers, 3.8% were dates, and 2.2% were step-family members. These investigators also found that women with disabilities are 1.5 times more likely to have been sexually abused as children than are women without disabilities. In fact, upon admission to a psychiatric institute, approximately 81% of women reported a history of physical or sexual abuse prior to admission.

Psychological Sequelae of Abuse in Individuals With Mental Retardation

Despite the amount of literature devoted to reasons why individuals with mental retardation are at greater risk for family violence, there is a notice-
able dearth of literature about the psychological consequences of this abuse. This lack may be due to several reasons. First, because family violence is often difficult to assess in individuals with mental retardation, it is difficult to evaluate its consequences (Tomasulo, Keller, & Pfadt, 1995). Second, there is a belief among many professionals that individuals with mental retardation are not suitable for counseling. This belief is erroneous with regard to individuals with mild and moderate retardation because there are case reports demonstrating the effectiveness of psychotherapy with such individuals (Finucane, 1998; Murphy & Razza, 1998; Tomasulo et al., 1995). Third, the majority of shelters for battered women and children are ill-equipped to deal with individuals who have mental retardation, and, therefore, these individuals are excluded from research on treatment and psychological effects that come from the clinical experience of shelter workers (Tomasulo et al., 1995). A final explanation is related to the misdiagnosis of postrauma symptoms as psychiatric or behavioral disorders (Crane, Henson, Colliver, & MacLean, 1988).

**Psychological Sequelae of Childhood Abuse**

Children who are abused by their caregivers suffer many social, cognitive, and psychological consequences just like children without mental retardation. When children are continually abused, they develop less productive intellectual skills, fewer social cognitive competencies, and display lower levels of intelligence than do children who are not abused (Barahal, Waterman, & Martin, 1981). This finding demonstrates another interaction between family violence and mental retardation. Although children with mental retardation are more likely to experience family violence than those without mental retardation, family violence might also lead to mental retardation and developmental delays (Barahal et al., 1981). In addition, a child with a mild developmental delay may become more socially and cognitively deprived as a result of abuse and, therefore, exhibit an even lower level of behavioral and intellectual functioning (Barahal et al., 1981). Another factor differentiating children who are and are not abused is locus of control. Children who are abused tend to exhibit a highly external locus of control, whereas children who are not abused tend to have a balance between an internal and external locus of control (Barahal et al., 1981).

A final difference between children who are and are not abused exists in the realm of social functioning, which Zirpoli et al. (1987) found to be an area in which individuals with mental retardation are especially lacking in skills. Children who are abused are often less able to comprehend social role concepts, exhibit more difficulty understanding subtle and complex relationships between people, and are more egocentric and insensitive to socioemotional contexts than are nonabused children (Barahal et al., 1981). Zirpoli et al. noted that these deficits are frequently extensively apparent in children and adults with mental retardation. Further such individuals often have difficulty with complex and abstract social interactions, commonly lacking the ability to negotiate social role options in various situations. These difficulties can be exacerbated by family violence, as will be shown in the case study example.

Jane's intellectual functioning was compromised through family violence. She went from having a diagnosis of borderline intelligence on her first intelligence test to having mild retardation on her second, and finally to having moderate mental retardation on her adult intelligence test. This example is congruent with the negative effect that violence can have on intellectual development. Jane displayed several social deficits as a child and carried these deficits through adulthood. She viewed things in the extreme and as totally beyond her control. When she lost a job, she attributed this to unfavorable conditions rather than her frequent absences or aggressive outbursts. In interpersonal relationships, Jane had severe difficulty with boundary issues and could not negotiate the differences between acquaintance, friend, and best friend.

**Psychological Sequelae of Sexual Abuse**

Because sexual abuse can occur at any age, I now combine some of the effects of childhood abuse discussed earlier with adult sexual abuse. Psychological effects of such abuse of individuals with mental retardation are important to investigate in a family violence setting because almost 50% of individuals with mental retardation who are interviewed report incestuous relationships and 70% to 90% report being sexually abused prior to their 18th birthday (Stromsness, 1993). In interviews, the majority of individuals with mental retardation revealed that the abuse “upset them a lot.” Some of the women, however, were ambivalent and reported that they were confused by the love combined with abuse. Others noted confusion because they felt the abuse was educational (Stromsness, 1993).
As noted earlier, there are some similarities between women with and without mental retardation with regard to their experiences of sexual abuse. Both groups of women typically respond to sexual victimization in one of two ways. They either withdraw from family and peers or they act out in self-destructive ways (Cruz, Price-Williams, & Andron, 1988). In addition, both groups report more negative self-concepts, suicidal ideation, and difficulty forming and maintaining interpersonal relationships (Cruz et al., 1988). In fact, the primary difference between the two groups is that women with mental retardation often exhibit an increased difficulty in discriminating between safe and potentially abusive situations (Cruz et al., 1988). In one comprehensive study on sexual abuse of persons with disabilities, Sobsey and Doe (1991) found that uncategorized emotional distress was expressed by 63% of the victims; withdrawal was reported by 26.5%; and aggression, noncompliance, behavioral disturbances, and inappropriate sexual behavior was reported by 24.7%.

Despite the similarities to women without mental retardation, women with the disorder who have been sexually abused face additional problems when they exhibit either withdrawal or acting out behavior. Because of their diagnosis of mental retardation, these individuals are more likely to be committed to state hospitals for such behaviors (Craine Henson, Colliver, & MacLean, 1988). State hospitals to date have been notorious for not exploring the possibility of sexual abuse. This disclosure was the first one of its type to be recorded. Upon listening to the disclosure, the therapist noted that what had been diagnosed as psychotic symptoms, such as people trying to get into her body through her stomach, were really posttraumatic stress symptoms. Jane was sexually abused in her second foster placement by her foster brothers. Typical of individuals who have been sexually abused, Jane presented as an adult with very low self-esteem and a persistent abandonment fear because of her perception that she was a worthless unlikable person. Jane reported being confused about the abuse because, although it hurt, she also felt loved by the boys. As an adult, she had difficulty discriminating safety in potentially sexual situations. She tended to misinterpret accidental touches and had been suspended from work for punching a man who accidentally bumped into her. She reported that she believed the man was going to touch her inappropriately. In addition to her negative self-concept and confusion about social situations, Jane was also an excellent example of misdiagnosis.

Jane had three state psychiatric hospitalizations and several local psychiatric hospitalizations. She was diagnosed as having schizophrenia, undifferentiated type at each of these hospitalizations. After a year of individual counseling, Jane revealed to her therapist her history of abuse. This disclosure was the first one of its type to be recorded. Upon listening to the disclosure, the therapist noted that what had been diagnosed as psychotic symptoms, such as people trying to get into her body through her stomach, were really posttraumatic stress symptoms. Following consultation with the psychiatrist, Jane was given the diagnosis of posttraumatic stress disorder and her medication was modified.

**Psychological Sequelae of Adult Abuse**

Despite frightening statistics indicating that domestic violence reports have increased by 117% from 1983 to 1991, and that each year at least 572,032 women are violently assaulted by someone they know, relatively little is known about domestic
violence as it relates to mental retardation (National Clearinghouse for the Defense of Battered Women, 1995). Individuals with mental retardation who have been abused in a domestic violence setting often present with confusion, low self-esteem, and have a difficult time communicating their experience (Murphy et al., 1998). As a result of the abuse, these individuals frequently display excessive obedience and compliance that contribute to an increased sense of helplessness and vulnerability. Because abuse of persons with mental retardation is extremely likely to be perpetrated by someone the individual knows, these persons often have an extremely difficult time developing trust (Murphy & Razza, 1998). Noted psychological effects of adult violence in persons with mental retardation have been identified as low self-esteem, dependency, inadequate coping skills, and impaired decision-making abilities (Murphy et al., 1998).

Further psychological effects may be extrapolated from domestic violence practice with members of other minority groups. Social isolation and extreme obedience have been identified as effects of domestic violence for many culturally diverse groups (e.g., Brownell & Congress, 1998). These factors are also often seen in persons with mental retardation. Somatic complaints have also been identified as a prevalent result of domestic violence in culturally diverse families. Such complaints include trauma responses (such as hypervigilance and jumpiness), anxiety reactions (such as trembling and heart palpitations), or psychiatric manifestations (such as suicidal ideation) (Yoshihama, 1998). Another common theme in domestic violence to culturally diverse individuals is that, typically, the abused person attempts to endure the situation and does not consider separation as a viable option. These beliefs are frequently supported by friends and relatives (Lee & Au, 1998). Women in this situation frequently hold internalized values and beliefs about perseverance and submission to men as being part of what is necessary to be a “good” woman (Lee & Au, 1998).

Despite the limited information on the effects of adult domestic violence on persons with mental retardation, the minority status allotted to persons with mental retardation allows for comparison to other cultural minorities. Just as with other cultures, persons with mental retardation tend to display excessive obedience and compliance, low self-esteem, and an internalized belief in enduring the situation (Murphy & Razza, 1998). In addition, because persons with mental retardation, particularly at the mild or moderate level, wish to be perceived as “normal,” they may endure a situation or not explore options in order to try to fit in with what they believe is mainstream society (Finucane, 1998). I have not included a case study presentation for the psychological effects of adult domestic violence because Jane has not experienced this type of violence.

**Implications for Practice**

Despite a lack of literature on the topic of family violence and its relationship to mental retardation, practitioners in a variety of areas must be informed about this topic. Specifically, service providers in psychiatric facilities, medical facilities, schools, and child and adult protective services need to be cognizant of issues of family violence for individuals with mental retardation. In addition, practitioners in the domestic/family violence field must be aware of and knowledgeable about issues regarding mental retardation, and service providers in the mental retardation field must be attentive to and well-informed about family violence issues.

**Direct-Practice Implications**

Direct-practice implications involve interventions for individuals with mental retardation who are at risk for or have suffered from family violence. Direct-service practitioners must be conscious of the increased risk factors for family violence among individuals with mental retardation. They need to educate children and adults with mental retardation about issues related to sexuality, abuse, and neglect. In addition, practitioners must ensure that they consider more than intelligence when determining an individual’s ability to consent to participate in various acts. An intimate knowledge of the client’s individual abilities is necessary to understand behavioral, psychological, and cognitive sequelae of abuse (Parker & Abramson, 1995). To ensure that posttraumatic stress is not misdiagnosed, direct-service providers must also be knowledgeable of the differential diagnosis of psychiatric and behavioral problems in individuals with mental retardation who have been abused (Craine et al., 1998).

Once professionals are erudite about these broader areas, a look into the individual’s specific situation can begin. Prior to starting an intervention, professionals working with individuals with
mental retardation who have been abused should provide a comprehensive assessment that includes exploration into the person's levels of dependency and overcompliance, assertiveness, self-esteem, and any history of abuse. A skills evaluation of such areas as problem-solving abilities, communication skills, and the ability to discover alternative solutions and explanations for abusive events should also be conducted (Carlson, 1997). Following the completion of the assessment, the professional can develop an individualized treatment plan for intervention. Typically, such interventions aim to improve self-esteem, increase independence, and enhance coping skills, problem-solving skills, and communication skills (Carson, 1997). Although these are the most common areas in which intervention is needed, other treatment areas may be added or omitted, depending upon the individual's needs. In addition to enhancing these skills, professionals should have an important, yet practical goal of treatment in which they address the development of self-protection skills and a safety plan (Carlson, 1997). Through safety planning, persons with mental retardation who have been abused can begin to re-establish feelings of safety in their surroundings as well as better protect themselves in the future.

Finally, therapeutic intervention, such as processing the abuse through role-plays and other experiential exercises, can be used with individuals who have mental retardation. Cognitive–behavioral therapy is also helpful in assisting the individual with correcting thinking errors regarding abusive experiences as well as learning and planning safer methods of behaving in various situations. These goals can be accomplished by utilizing an interactive behavioral model that has been shown to work with individuals who have mental retardation specifically in relationship counseling, mental health counseling, sexuality education and counseling, and advocacy training (Tomasulo et al., 1995). Regardless of the method of intervention, practitioners must take care to utilize repetition and may need to assume a more directive stance than one would if working with a person who does not have mental retardation. When this special care is taken, psychotherapy is indeed possible with individuals who have mental retardation (Carlson, 1997). (For a summary of the direct-practice intervention process, see Table 1.)

Jane participated in individual psychotherapy that was a combination of psychodynamic and cognitive behavioral techniques. Individual psychotherapy occurred twice weekly for 30 to 45 minutes and was reinforced by daily phone calls. During individual psychotherapy the focus was on identifying and coping with feelings related to the abuse as well as everyday life. Individual sessions also were focused on utilizing cognitive behavioral techniques to improve Jane's self-esteem and combat irrational thinking patterns. The daily phone calls served as a reminder that someone valued Jane and reinforced topics discussed in therapy sessions. In addition, individual sessions also served to monitor Jane's psychiatric symptoms and response to psychotropic medications. It was through the establishment of empathy and a trusting therapeutic relationship that the abuse was disclosed and worked through.

Jane also participated in two psychoeducational groups. The first was a relaxation group in which relaxation techniques, such as progressive relaxation, deep breathing, and guided imagery, were taught. This group provided a setting for Jane to learn techniques and receive feedback about when and where each technique would be appropriate for use. Jane graduated from this group and has been able to successfully utilize the relaxation techniques to combat stressful situations and trauma-related flashbacks. Jane also participated in a food issues group where emotional connections to food were explored. Jane was able to reveal that she alternated between self-starvation and bingeing in an effort to control her emotions because she was frightened by their intensity. This pattern of disordered eating began after her experience with sexual abuse. Jane also developed insight into how her current eating habits were affected by her perceptions of interpersonal stress, being controlled and danger.

Macro Implications

In order for family violence toward persons with mental retardation to be ameliorated, intervention at societal, interagency, and agency levels needs to occur. An important agency intervention includes developing agency policy that requires practitioners to be trained in the areas of family violence, sexuality, and mental retardation. Currently, such training is lacking in protective services, mental health/mental retardation services, and domestic violence services (Buchele-Ash, Turnbull, & Mitchell, 1995). Community domestic violence services should, at the very least, institute training policies on individuals with mental retardation and develop a policy to ensure the coordination of services for such individuals. Person-
### Table 1 Direct-Practice Intervention Process

<table>
<thead>
<tr>
<th>Intervention process</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
<td>Interview with family members, client, and staff to determine any history of abuse, past behavioral problems, current behavior problems, strengths, and weaknesses. Psychometric testing to determine psychopathology, IQ, adaptive behavioral functioning, family functioning etc. (i.e., Hudson's, 1992, Generalized Contentment Scale, etc.). These measures may need to have the wording revised so that the individual understands what is being asked.</td>
</tr>
<tr>
<td><strong>Psychoeducation</strong></td>
<td>Safety planning with the individual; teach the individual about common responses to abuse and give concrete examples that are similar to what the individual has experienced.</td>
</tr>
<tr>
<td><strong>Psychodynamic intervention</strong></td>
<td>Use a modified form of traditional “talk” therapy to assist the individual with processing his/her experience with abuse. Ensure that the “talk” therapy is concrete, repetitious, and conducted in a manner with which the individual feels comfortable.</td>
</tr>
<tr>
<td><strong>Cognitive-behavioral intervention</strong></td>
<td>Use established curricula that have been developed for this population to teach and enhance relaxation, social skills, emotion management, relationships, etc. Frequently used curriculum include “Positively” (Kerr, 1997) for emotion management, “Old Me, New Me” (Lupin, 1996) for relaxation, “Circles I, II, &amp; III” (Champagne &amp; Walker-Hirsh, 1993, 1987, and 1988) and “Being With People” (Downer, 1990) for relationships, and various games for social skills. These materials are available through the James Stanfield Company and PCI Educational Publishing.</td>
</tr>
<tr>
<td><strong>Psychopharmacology</strong></td>
<td>After a thorough assessment, it may become apparent that there is a concurrent psychiatric disturbance. Common psychiatric sequelae include mood disturbances, anxiety disorders, and posttraumatic stress disorder. A psychiatrist familiar with persons with mental retardation should be consulted to develop an accurate psychopharmacological treatment plan if necessary.</td>
</tr>
<tr>
<td><strong>Evaluation</strong></td>
<td>Interview family, client, and staff to determine whether they have noticed changes in client’s behavior and emotional state. Use the same psychometric testing as before to determine whether there has been a significant improvement in symptoms as seen in posttest scores.</td>
</tr>
<tr>
<td><strong>Termination</strong></td>
<td>Discuss termination issues with client. Discuss ways client, family, and staff can continue to reinforce progress. Review safety plan with client and ensure that client understands how to access protective and therapeutic services should the need arise.</td>
</tr>
</tbody>
</table>

At community mental health/mental retardation centers should be trained on how family violence may affect their clients and appropriate methods of dealing with such problems should they arise (Carlson, 1997). Once such cross-training occurs, staff at both mental retardation centers and at domestic/family violence agencies will be better equipped to deal with the varying problems of the unique individuals they serve.

In addition to a lack of training, existing domestic violence services are often inaccessible, inappropriate, or unavailable to persons with mental...
Family violence

H. L. Strickler

Conclusions

By virtue of having mental retardation, individuals are placed at a greater than normal risk for child abuse, domestic violence, and sexual abuse. Psychological consequences of abuse are strikingly similar to those suffered by individuals without mental retardation; however, individuals with mental retardation are frequently misdiagnosed with psychiatric or behavioral conditions because abuse issues are not explored. Although sex education is becoming increasingly available to individuals served by mental health and mental retardation centers, abuse prevention and intervention services remain underdeveloped and underutilized. The majority of individuals who are abused have mild or moderate retardation and good verbal skills. They are, therefore, suitable candidates for psychotherapeutic intervention. Such intervention can be successful, as demonstrated by the example of Jane, as reported in this paper, if the therapist is knowledgeable about both mental retardation and the effects of abuse. Further research must be done in the area of mental retardation and family violence in order to determine how social service professionals can better serve this population.

Table 2 Macro Intervention Strategies

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocacy</td>
<td>Provide a consumer advocate familiar with both mental retardation and family violence to assist in medical and legal interviews. Develop community education programs that depict the plight of family violence to include its effects on persons with mental retardation.</td>
</tr>
<tr>
<td>Policy</td>
<td>Enact legislation that provides funding to agencies that address both mental retardation and family violence. Enact agency policies that require cross-training in family violence and mental retardation. Strictly enforce the current reporting policies for abuse of persons with mental retardation.</td>
</tr>
<tr>
<td>Services</td>
<td>Develop accessible, available, and affordable family violence service centers for persons with mental retardation. Develop transportation, legal services, therapeutic services, housing services, and medical services that are appropriate for persons with mental retardation who have been affected by family violence.</td>
</tr>
<tr>
<td>Community involvement</td>
<td>Educate employers, teachers, church leaders, and civic leaders about the warning signs of family violence and available resources. Be specific about these factors in relation to mental retardation. Include agencies that serve persons with mental retardation in community movements that focus on family violence.</td>
</tr>
</tbody>
</table>
References


Family violence


Received 2/18/00, first decision 6/12/00, accepted 2/16/01.

Editor in charge: Marty Wyngaarden Krauss

Author:
Heidi L. Strickler, MSSW, University of Texas Medical Branch, The University of Texas at Arlington, 701 S. Nedderman Dr., Arlington, TX 76019. Address correspondence to the author at 2201 Ramada Dr., Waco, TX 76712. (E-mail: heidi_strickler@hotmail.com)