Sexual Abuse Victim Empowerment Programme: An archival study assessing the relationship between demographics and level of intellectual functioning

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

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Signature Date

ABSTRACT

Sexual abuse of individuals with cognitive deficits appears to be an extremely prevalent problem in contemporary society. Although it appears that many cases go unreported and remain unknown to everyone other than the victim and the perpetrator, reported rates of sexual abuse of children, adolescents and adults with cognitive deficits are high. The objective was to create a demographic profile of people with mental retardation who have been sexually abused whom are part of the Sexual Abuse Victim Empowerment (SAVE) programme in the Western Cape. Group comparisons were made between the different levels of mental retardation in terms of sexual knowledge, competence as witness, adaptive functioning and adaptive functioning age equivalents.

One hundred and forty four complainant's completed case files were used from the archives of Cape Mental Health (CMH) society to collect data. The complainant's chronological ages ranged from 8 to 60 years. Demographic variables were taken from the case files in order to complete a demographic profile and to make the group comparisons between the different levels of mental retardation.

The results showed that the chronological age range of the complainants was very large (8-60 years), however the age range equivalents for adaptive functioning was much smaller (1-19 years). Significant differences were found between the groups of different levels of mental retardation in terms of sexual knowledge, competence as a witness, adaptive functioning and adaptive functioning age equivalents.

The findings suggest that chronological age is not a measure of adaptive functioning as the age equivalent for adaptive functioning is usually much lower than the chronological age. No significant difference for sexual knowledge was found between the group of complainants with differing degrees of mental retardation in terms of ability to consent to sexual intercourse. This suggests that no matter how low the extent of the cognitive deficit is, the person is still unable to consent to sexual intercourse.

OPSOMMING

Die seksuele misbruik van persone met kognitiewe gebreke blyk ‘n problem te wees wat baie voorkom in die hedendaagse samelewing. Alhoewel dit blyk asof baie gevalle onbekend bly vir almal behalwe die slagoffer en die skuldige, is gerapporteerde gevalle van die seksuele misbruik van kinders, adolessente en volwassenes met kognitiewe gebreke tog hoog. Die oogmerk was om ‘n demografiese profiel te skep van mense met verstandelike gestremdhede wie seksueel misbruik was en deel is van die Sexual Abuse Victim Empowerment (SAVE) program in die Wes-Kaap. Groepvergelykings tussen verskillende vlakke van verstandelike gestremdhede in terme van seksuele kennis, bevoegdheid as getuie, aanpassingsfunksionering en die ouderdomsekwivalente van aanpassingsfunksionering is gedoen.

Een honderd vier en veertig klaers se voltooide saaklêers uit die argiewe van die Cape Mental Health (CMH) vereniging is gebruik om data te versamel. Die klaers se kronologiese ouderdomme het gewissel van 8 tot 60 jaar. Demografiese veranderlikes was van die saaklêers gekry ten einde ‘n demografiese profiel te voltooi en om groepsvergelykings te maak ten opsigte van verskillende vlakke van verstandelike gestremdheid.

Die resultate het gewys dat die reikwydte van die kronologiese ouderdomme van die klaers baie groot was (8-60 jaar), maar dat die reikwydte van die ouderdomsekwivalente van aanpassingsfunksionering baie kleiner was (1-19 jaar). Beduidende verskille was gevind tussen die groepe met verskillende vlakke van verstandelike gestremdheid ten opsigte van seksuele kennis, bevoegdheid as getuie, aanpassingsfunksionering en ouderdomsekwivalente van aanpassingsfunksionering.

Die bevindinge suggereer dat kronologiese ouderdom nie ‘n aanduider is van aanpassingsfunksionering nie, siende dat die ouderdomsekwivalente van aanpassingsfunksionering gewoonlik veel laer is as die kronologiese ouderdom. Geen beduidende verskille vir seksuele kennis is gevind tussen groepe klaers met verskillende vlakke verstandelike gestremdheid ten opsigte van hulle vermoë om in te stem tot seksuele omgang nie. Dit suggereer dat ongeag hoe laag die graad van kognitiewe gebrek is, die persoon steeds nie die vermoë het om toe te stem tot seksuele omgang nie.

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1.1 Introduction

The diagnosis of Mental Retardation, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (APA, 2000), is defined as significantly subaverage general intellectual functioning (having an IQ of 70 or less) resulting in, or associated with, concurrent impairment in adaptive behaviour and manifested during the developmental period, before the age of 18. Mental retardation is generally assessed by a combination of formal intelligence tests and observation of adaptive functioning (Burack, Hodapp & Zigler, 1998). The nosology and the criteria for this diagnosis has been commonly accepted, however the use of the term, "Mental Retardation" is a contentious issue. Some of the terms used colloquially include, but are not limited to, cognitive deficit, cognitive handicap and intellectual disability. For the purposes of this document and study the term, "cognitive deficit", will be used to denote the diagnosis of Mental Retardation according to the DMS-IV-TR criteria.

According to Tharinger, Horton and Millea (1990) there is a growing recognition that children, adolescents, and adults with a cognitive deficit are particularly vulnerable to sexual abuse and exploitation and are in need of intervention services. This population is especially vulnerable due to their often life-long dependence on caregivers, relatively powerless position in society, emotional and social insecurities, and lack of education regarding sexuality and sexual abuse. To work effectively with this population, mental health professionals and educators must be alert to what is known about the sexual abuse and exploitation of persons with mental retardation. Furthermore, they need to become educated about the rights of these persons to special legal protection from abuse and neglect and to appropriate and effective mental health interventions. According to Drew, Logan and Hardman (1990) the challenge for mental health professionals and educators is to protect persons with cognitive deficits from sexual abuse and exploitation, to provide appropriate psychotherapeutic interventions when abuse occurs, to respect their right to developmentally appropriate knowledge about sexuality and sexual abuse, and to allow for the fulfilment of their sexuality.

The Sexual Abuse Victim Empowerment programme (SAVE) at Cape Mental Health Society (CMH) offers mental health services to indigent people living in the community in Cape Town with intellectual disabilities and who have been victims of sexual abuse. It is a specialised programme, which offers assistance to those with cognitive deficits to gain redress for the sexual abuse committed against them that would be otherwise impossible for this population to accomplish on their own due to their cognitive handicap. The SAVE programme offers social work services to the complainant and their families to help them through the trauma and to prevent further abuse from occurring. It also offers a psychological evaluation that assesses the level of intellectual and everyday functioning; understanding of sexual matters, and competence to be a witness in a court of law, as well as the need for court preparation.

According to CMH, the project is often hamstrung by the following: a) high costs and demands on the programme; b) the number of staff working at Cape Mental Health is not large so each staff member is overloaded with work; c) the result of the limited number of staff is long waiting lists of complainants waiting to be evaluated in order to be included into the programme; d) since there is a waiting list complainants are only included into the programme if they have a cognitive deficit and if there is a strong likelihood that there will be a court case; e) the population of complainants that the SAVE project deals with are indigent people who are of a low socio-economic background; and f) inconsistent communication about the outcome of trials forming part of the SAVE project. The respective role players in this endeavor face numerous challenges as a result of the difficulties in the adequate dissemination of information regarding trial outcomes. These challenges include, but are not limited to incomplete recordkeeping or case files and psychological consequences such as decreased motivation, increased perceptions of global stress and vulnerability, and lack of closure.

The present study represents an attempt to explore sexual abuse among a triply vulnerable population, a population comprising of people with cognitive deficits, low socio-economic status and survivors of sexual abuse. The study culminated in a thesis that is comprised of five chapters reporting on various aspects of the study. The remainder of this introductory chapter is devoted to a brief overview of the ensuing chapters.

Chapter two entails an overview of the literature pertinent to the aims and objectives of the present study. The aim of this chapter is to locate the study in the extant literature on the sexual abuse among the cognitively handicapped. Furthermore, the literature review is used to provide a rationale for the present study. This chapter provides an overview of the literature available focusing on sexual abuse among those populations where there is, and is not, persons with cognitive deficits.

Chapter three focuses on the methodology used in the present study. This chapter includes a detailed discussion on the design, sampling technique, methods of data collection and analysis.

The fourth chapter reports the finding obtained in the study. The findings of both the quantitative and the qualitative methods of data collection are given to provide a comprehensive picture of the relationship between demographics, level of intellectual functioning, sexual knowledge, competence as a witness and adaptive functioning.

In chapter five the results are discussed. This chapter also looks at how these results compare with the literature in this area, that is, sexual abuse within the population of those with cognitive deficits. Furthermore, conclusions and recommendations are made in the light of the results obtained.

CHAPTER TWO

THE LITERATURE REVIEW

CHAPTER TWO: THE LITERATURE REVIEW

Ryerson (1981) reported that sexual abuse of individuals with cognitive deficits appears to be an extremely prevalent problem in contemporary society and it appears that many cases go unreported and remain unknown to everyone other than the victim and the perpetrator (Pillay & Sargent, 2000). Sobsey and Varnhagen (1990), however, reported that the rates of sexual abuse of children with cognitive deficits and sexual assault of adults with cognitive deficits are high despite the known underreporting of sexual abuse in general.

A large body of literature exists concerning sexual abuse and its consequences covering a number of different populations who have been affected (Romano & Van De Luca, 2001; Rumstein-McKean & Hunsley, 2001; Haj-Yahia & Tamish, 2001). Most of the populations that have been studied have no intellectual disabilities, or the studies did not focus on the link between cognitive deficits and sexual abuse. One of the populations studied are males who have been sexually abused. Despite the increasing awareness of sexual victimization involving males, there remain a number of factors (e.g., stigma of homosexuality, male ethic of self-reliance) that continue to contribute to the underreporting of such cases (Tyler & Cauce, 2002). Mental health professionals and medical staff may also be responsible for the underreporting of male sexual abuse. Mental health professionals are not asking male patients about histories of sexual abuse. The majority of staff questioned in a study rarely inquired about sexual abuse in male patients and staff are generally using ineffective and unsystematic methods of enquiry when they do ask. Two thirds of staff report having had no specific training in assessment/treatment of sexual abuse and a similar number do not feel sufficiently trained to be able to inquire about sexual abuse in male patients (Lab, Feigenbaum & Silva, 2000). Due to varying definitions, sampling differences and methodologies, figures have been estimated from as low as three percent to as high as 31 percent of males who are sexually abused by Peters, Wyatt, and Finklehor (quoted in Lab et al., 2000). Finklehor (1984) concluded that in the general population, probably between 2.5%–8.7% of men have been sexually victimized in childhood. As with women, this rate seems to be higher in clinical samples. Nonetheless, there appears to be growing recognition of male sexual

abuse as a serious problem with potentially numerous debilitating consequences. The clinical and research literature presently contains a number of articles on issues pertaining to males who have experienced sexual abuse during childhood (King, Flisher, Noubary, Reece, Marais & Lombard, 2004; Nolan, O'Flaherty, Turner, Keary, Fitzpatric & Carr, 2002; Romano & Van De Luca, 2001).

A popular population of investigation for sexual abuse is among females. Doucette (1986) found that women with a variety of disabilities, one being mental retardation, are about one and a half times more likely to have been sexually abused as children than non-disabled women. It was stated by Sullivan, Vernon, and Scanlan (1987) that the sexual abuse norms in the general population is 10 percent for males and 25 percent for females, but the numbers of sexual abuse in the disabled population increases for males and females. A review by Finkelhor (quoted in Roberts, O'Connor, Dunn, Golding & The ALSPAC Study Team, 2004) suggested prevalence rates for serious sexual abuse in childhood of between 7 and 36% for females. For the population of female sexual abuse victims, consequences have been studied in large and many of the effects have been identified, such as depression, adjustment problems, and susceptibility to psychopathology, sexual dysfunction later in life and poor adjustment to parenting (Fleming, Mullen, Sibthorpe & Bammer, 1999; Roberts et al., 2004). Female survivors of sexual abuse are said to also experience relationship difficulties, problems in attachment, marital conflict and divorce, secondary traumatization, maternal attitudes and functioning, and the heightened risk for having children who themselves are sexually abused (Rumstein-McKean & Hunsley, 2001). According to King et al. (2004) 1.6% of women aged 15–49 years reported being raped before the age of 15 years in South Africa. Thus the age at greatest risk for women in South Africa is between 12 and 17 years. Balogh et al. (2001) supported the finding that adolescents are at greatest risk of sexual abuse.

Much research has focused on sexual abuse occurring in childhood (Haj-Yahia & Tamish, 2001; Davis & Petretic-Jackson, 2000). Topics studied under this population have been effects, adjustment in later life, outcomes in adulthood, parenting behaviours, psychological well-being, and many more (Fleming et al., 1999; Roberts et al., 2004). Abuse-associated symptom domains reported in the literature include dissociation,

anxiety, sexual dysfunction, sleep disturbance, anger/hostility, substance abuse, revictimization, low self-esteem and self-concept impairment, depression, self-blame, guilt, and helplessness, self-mutilation, suicidality, posttraumatic stress responses, obsessions and compulsions, and somatization (Rosenthal, Feiring & Taska, 2003; Ruggiero, McLeer & Dixon, 2000). The body of literature existing for this population is large and most areas have been researched. In South Africa, rape is the most frequently reported crime against South African children, accounting for one-third of all serious offences against children reported between 1996 and 1998 (King et al., 2004).

The population of adolescents has also been widely researched. A major problem in the adolescent's population is the lack of disclosure of sexual abuse. The main impediments to disclose to a family member were fear of not being believed, shame, and fear of causing trouble to the family. The main impediments for not seeking services were ignorance of the existence/functioning of protective agencies, wish to keep the secret, lack of awareness of being abused, mistrust of adults and professionals, and fear of the consequences of disclosure. When they did disclose to professionals, the teens received very limited support (Crisma, Bascelli, Paci & Romito, 2004). Existing research documenting abuse-related sequelae within the adolescent population has focused primarily on child sexual abuse. Findings have generally demonstrated that adolescents with a sexual abuse history exhibit a wide range of emotional and behavioural problems. Most notably, investigators have consistently found that adolescent survivors of child sexual abuse report greater depression and general psychological distress, more conduct problems and aggression, lower self-esteem, and more substance abuse problems (Meyerson, Long, Miranda & Marx, 2002).

The population of perpetrator has also been studied. Here this population has been broken up into family member or non-family member. It is more common that the perpetrator of the sexual abuse is not a direct family member, however the incidence of intrafamilial sexual abuse is high (Cyr, Wright, McDuff & Perron, 2002). A review of the literature (Furey, 1994) suggests that individuals with a cognitive deficit, in particular mental retardation, may be particularly at risk for abuse by caregivers and acquaintances, rather than strangers. Enquiry has also been made as to what these people are like; questions of psychopathology have been researched. International studies have yielded a

very basic profile of a common perpetrator: abuse perpetrators are employed, have been married, and are older than 30 years of age. It is not clear as to whether this profile will hold locally. In the abuse cohort, as many as 14% have a previous sexual or violent record (Cullen, Smith, Funk & Haaf, 2000; Walsh, MacMillan & Jamieson, 2002). Linked to who the perpetrator is, is where the sexual abuse occurs. According to Kvam (2004) abuse events take place in the victim's home (15.4%), the offender's home (15.4%), in a car/bus (2.9%) or other places, like in a hut, in the woods, on at camp (15.4%).

The majority of research literature available concerning sexual abuse is of people who have no physical or mental disabilities (Kvam, 2004; Sullivan & Knutson, 2000). The above mentioned research was conducted using participants who are physically or mentally healthy, or lacking in disabilities in these areas. There is a limited amount of literature available where research on sexual abuse has been done using participants who have a mental or physical disability. Results from studies among disabled children differ from studies among children in the general population both in terms of magnitude of the problem and in the gender distribution of the victims. A study conducted with deaf children who have been sexually abused concluded that deaf children may have a 2–3 times greater risk of sexual abuse than hearing children (Kvam, 2004). Deaf females aged 18–65 who lost their hearing before the age of 9 reported sexual abuse with contact before the age of 18 years more than twice as often as hearing females, and deaf males more than three times as often as hearing males. The abuse of the deaf children was also more serious. Deaf children are at greater risk of sexual abuse than hearing children. Sullivan et al. (1987) cite several studies suggesting that 54 per cent of deaf boys and 50 per cent of deaf girls are sexually abused as children. Presented norms for sexual abuse in the general population is 10 per cent for boys and 25 per cent for girls, these figures suggest that the rate of sexual abuse is double for girls and five times as high for boys who are deaf. Brookhouser, Sullivan, Scanlan and Grabarino (1986) previously had reported high rates of sexual abuse among hearing-impaired children. The special schools for the deaf represent an extra risk of abuse, regardless of whether the deaf pupils live at home or in boarding schools. Most studies conclude that the risk of sexual abuse is doubled when a child is disabled (Kvam, 2004).

Limited studies have been conducted using mentally disabled people as the participants for sexual abuse research (Ahlgrim-Delzell & Dudley, 2001; Tang & Lee, 1999). It is difficult to know how prevalent abuse is among people with developmental disabilities because of the limited number of studies and the underreporting of abuse to proper authorities. It is estimated that only 20% of abusive incidents are reported. Abuse investigations are likely to be handled internally without referrals to the proper authorities. Also, complainants with mental disabilities can be persuaded more readily or easily by the perpetrator not to disclose abusive incidents (Ahlgrim-Delzell & Dudley, 2001; Sullivan & Knutson, 2000). Studies have been done using those who have mild mental retardation. Sexual abuse victimization is a pervasive problem among individuals with mental retardation and its prevalence may be higher than the estimated prevalence within the general population (Verdugo & Bermejo, 1997). 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 (Tang & Lee, 1999; Hersen, McGonigle & Lubetsky, 1989). Individual risk factors that increase the vulnerability to sexual victimization among the mentally disabled include their impoverished sexual knowledge, a lack of sex education, lifelong physical and emotional dependence on adults, impaired verbal and social abilities, and a lack of knowledge on sexual abuse preventive skills (Tharinger et al., 1990). People with mental retardation are often sexually stigmatized and perceived as asexual, sexually incompetent, or possessing uncontrollable libido and perverted sexual habits. This makes them a target for sexual abuse as they do not have knowledge regarding sexual matters and they are not viewed as sexual beings, so it is easily kept secret by the perpetrators and the individuals with mental retardation (Tang & Lee, 1999).

An intervention programme called the Sexual Abuse Victim Empowerment (SAVE) programme has been established for people with cognitive deficits to gain redress for the sexual crimes committed against them. It is difficult for those with cognitive deficits to report sexual crimes. The recognition of sexual crimes against this population is made more difficult by the tendency to avoid seeing people with cognitive

deficits as sexual. It is very rare for sexual abuse cases involving complainants with cognitive deficits to go to court, and for the complainant to appear, especially as sole witness against the accused, which is frequently required in sexual abuse cases. This is one of the reasons why the SAVE programme was developed in 1990 at Cape Mental Health Society (CMH). It was also developed due to requests from the South African Police Services (SAPS) and the Regional Court personnel for assistance. CMH is a non-profit, non-governmental agency, which offers a comprehensive mental health service to indigent people living in the community in Cape Town.

The rate of sexual assault in South Africa is very high. Estimates of the prevalence of sexual violence range from one in three to one in five women having been raped in South Africa (Human Right Commission). In response to the requests for the SAVE programme, a psycho legal service was established to assist complainants with cognitive deficits in sexual cases. As the costs of this programme and the demands on it are high, complainants are included in the programme only if there is a strong likelihood that there will be a court case. In all cases of alleged sexual abuse reported to CMH, social work services are made available to help the families to prevent further sexual abuse from occurring and to assist the client over the trauma. Once included in the programme, the complainant and the family are given support before and during the court case. This includes court preparation. In addition, a psychological evaluation is conducted and the psychologist is available to act as expert witness in the court case.

The programme has been in operation for approximately five years. There has been a steady increase in the utilisation of the programme by the South African Police Services and the Department of Justice. Currently about 45 complainants are assessed per year within the programme, and there is a six-month waiting list. This represents a considerable increase in professional time allocated to it by CMH over the years. Due to this, there has been an increase in attention to such cases in the justice system since the implementation of the programme. Investigating officers frequently inform CMH that without an assessment, cases cannot be taken further, and prosecutors have informed CMH that the availability of expert evidence has increased the number of cases going to trail.

The psychological evaluation in the psycho-legal programme assesses the following areas:

- Level of intellectual functioning
- Adaptive functioning
- Level of understanding of sexuality
- Ability to consent to sexual activity
- Competence as a witness

Below follows a brief exposition of how these areas are assessed.

The level of intellectual functioning is assessed by using a South African scale, the Individual Scale for General Scholastic Aptitude (ISGSA), at CMH. According to Robinson (1998), the ISGSA is an adjusted, modernised and standardised version of the Individual Scale of the National Bureau for Education and Social Research. The concept "general scholastic aptitude" is used in the new name; as the scale is mainly used to evaluate general scholastic aptitudes with a view to predict future scholastic performance. The ISGSA is intended for South African children between the ages of 4 to 16 and 11 months whose mother tongue is either English, Afrikaans or Xhosa. The aim of the ISGSA is to evaluate a testee's general scholastic aptitude within a short application time. It may be used as a screening tool for those who progress slowly at school due to a mental disability (Robinson, 1998). The test is also user-friendly and does not have stringent discontinue rules that help to reduce the testee's anxiety. However, it is only an aid and cannot be used without other information and evidence to diagnose a testee as cognitively deficient. With age scales an intelligence quotient is determined that expresses the ratio between a testee's mental age and chronological age (Robinson, 1998). The testee's performance is compared to the age performances of children at different ages. The test can be administered to those who are environmentally advantaged as well as environmentally disadvantaged. Each group is compared to a norm group of the same type as to not underestimate the testee's potential. For this test, a general scholastic aptitude score (SA) and a test age is produced. For the reasons mentioned above, CMH administers this instrument to assess their clients intellectual functioning. It

is best suited for the type population that CMH works with, being that their clients have mental disabilities.

Another individual test for measuring intellectual functioning that is used in South Africa is the Junior South African Individual Scales (JSAIS). This test was developed as there was a need for an instrument suitable for preschool children. The age range covered by the JSAIS includes 3 years to 7 years 11 months. The aim of this instrument is to establish the general intellectual level of the testee as well as to evaluate the child's relatively strong and weak points in some significant facets of intelligence (Madge, 1981). Another aim of this instrument is that some of the tests within the battery enable the tester to evaluate certain non-cognitive behaviours including concentration, perseverance, willingness to work, hyperactivity, impulsiveness and distractibility (Madge, 1981).

Following from the JSAIS comes the Senior South African Individual Scale – Revised (SSAIS-R). The SSAIS-R has been standardised for South African pupils between the ages of 7 years and 16 years 11 months with English or Afrikaans as their mother tongue. The SSAIS-R is used to obtain a differential picture of certain cognitive abilities. Firstly the level of general intelligence is determined, used to predict scholastic achievement. Secondly relative strengths and weaknesses in certain important facets of intelligence are evaluated to obtain diagnostic and prognostic information (Van Eeden, 1991). The two primary mental abilities measured by the tests of the SSAIS-R are a verbal and a non-verbal factor.

The JSAIS and SSAIS_R are long tests to administer to a child and as a result clerical errors may occur. If a tester does not take extra care, clerical errors can occur which may result in a profile which reflects a distorted picture of the child's true abilities (Madge, 1981). In addition, neither of these tests has been standardized recently enough for appropriate use with the population under study. For these reasons, and for the age group it tests, CMH uses the ISGSA to assess the intellectual functioning of complainants or service users.

Adaptive functioning refers to how effectively individuals cope with ordinary life demands and how capable they are of living independently and abiding by community standards. According to the DSM-IV-TR definition (Mash & Wolfe, 2002), persons with

mild mental retardation constitute the largest group of persons with this disorder. As a group, children with mild mental retardation show small delays in development and typically develop social and communication skills in the preschool years, perhaps with modest delays in expressive language. With appropriate supports, individuals with mild mental retardation can usually live successfully in the community, either independently or under supervised settings. Louw and Edwards (2000) stated that persons with moderate mental retardation constitute approximately 10 percent of those with mental retardation. Individuals at this level of impairment are more adaptively impaired. Communication is usually handicapped as communication may be done through single words and gestures, that similar to the average two year old; however at adulthood communication is better. For daily living skills, people with moderate mental retardation usually require supportive assistance. With regard to socialisation skills, people with moderate mental retardation have difficulties in recognising social conventions, such as appropriate dress or humour. Sadock & Sadock (2003) stated that people with severe mental retardation constitute approximately three percent of persons with mental retardation. Individuals at this level of impairment have poor adaptive skills. Communication skills are largely handicapped for persons with severe mental retardation as they tend to communicate in three word phrases. In terms of daily living skills, people with severe mental retardation may be able to perform simple tasks in closely supervised settings. People with severe mental retardation are unable to live successfully in the community independently; they do need to live in a group home or with their families so as to provide them with assistance and care.

Adaptive functioning is assessed at CMH using an instrument called the Vineland Adaptive Behaviour Scales. The Vineland Adaptive Behaviour Scales are a revision of the Vineland Maturity Scale. According to Foxcroft and Roodt (2001), the scales assess personal and social sufficiency of individuals from birth to adulthood. They do not require the direct administration of tasks to an individual, but instead require a respondent who is familiar with the individual's abilities and general behaviour. This is what makes the Vineland Adaptive Behaviour Scales instrument so well suited to be used at CMH as the complainant does not have to take part in the test. A parent or guardian can complete the test on behalf of the complainant. Many of the complainants who make use of the

SAVE programme at CMH have a cognitive deficit that is so severe that the complainant cannot communicate, thus the parent or guardian completing it on the complainants behalf. The scales measure adaptive behaviour in four domains: Communication, Daily Living Skills, Socialisation and Motor skills (Foxcroft & Roodt, 2001).

The last three areas are assessed through interviews. A very basic level of understanding is required of the mechanics of sexual intercourse and its implications in order for the complainant to be found able to consent. Assessment of competence as witness demands as much on the supportive facilities in court as it does on the abilities of the complainant. In Cape Town there is awareness in the courts of the special needs of these complainants, which would otherwise not be found in a less supportive context. Once the assessment is completed, the psychologist submits the report to the investigating officer or prosecutor, and is available to act as an expert witness in court.

Assessing people with a cognitive deficit to determine if they will be competent to act as a witness is challenging, as people with cognitive deficits rarely appear as witnesses in court (Cooke & Davies, 2001). This is especially challenging when the person with a cognitive deficit is the victim of sexual abuse and/or are the sole witness against the accused (Kebbell & Hatton, 1999). Historically, justice systems and particularly the criminal justice system, have regarded people with a cognitive deficit as unreliable witnesses. It has been believed that their memory systems are inherently defective, and therefore, it has been assumed that they are susceptible to suggestion and lack the skills to accurately report the events that took place (Perlman, Ericson, Esses & Isaacs, 1994). Recalling information, in other words remembering, can often be difficult for people with a cognitive deficit because they tend to take longer to encode, understand and store information than their peers in the general population (Bull, 1995). This influences the reliability of a witness with a cognitive deficit to be able to give an accurate and consistent account of the alleged rape. As a consequence, people with a cognitive deficit may have incomplete free recall abilities (Milne & Bull, 1999).

CMH also offers the service of court preparation for those complainants who are able to act as a competent witness. Some guidelines were given by B.J. Dickman (Personal communication, May 25, 2005), a psychologist working at CMH, in providing the service of court preparation to clients:

It is commonly understood that for everyone appearing in court, it is anxiety provoking. Accordingly, for vulnerable witnesses such as children and people with a cognitive deficit, familiarity with the setting and procedure can make the difference between competence and incompetence in court as a witness. Liaison with the prosecutor/s is essential. The aim should be to run the court preparation sessions in the weeks just prior to the due date of the trail. There are a number of steps to follow when conducting court preparation. Firstly it is essential to familiarise the complainant with physical setting of the court room – this includes explaining where the complainant will sit when giving the evidence, where the prosecutor will stand, where the defence attorney will stand, and where the magistrate will be. Next it is important to make sure that the complainant meets the prosecutor handling the case ahead of time. The role of each lawyer needs to be explained simply. For example, the prosecutor will help the complainant tell her/his story and the defence attorney will help the accused tell his/her story. The magistrate will listen to both and decide, following rules, the fate of the accused. Next it is essential to emphasise the importance of truth telling but in a non-offensive manner. Leading on from this, it must be emphasised that the complainant has the right to ask for a question to be repeated or rephrased. It is important to understand the question being asked so the complainant can answer truthfully without guessing the answer due to a lack of understanding. Also make sure the complainant understands that it is acceptable not to know an answer to a question. It is fine to respond with "I do not know". Finally, it may be helpful for the complainant to know that she/he can use their words in describing the account of what had happened.

At CMH court preparation usually comprises a single visit to the court and a couple of sessions discussing the process of the trail. More work may be required with particular complainants. If the complainant is unable to act as a competent witness, an intermediary is arranged to testify on behalf of the complainant, this usually done by an expert witness, namely one of the psychologists at CMH.

The present study aimed to provide a demographic profile of the complainants making use of the services rendered by the SAVE programme. The study also endeavoured to discover whether there are significant differences in the complainant's sexual knowledge, competency as a witness and their adaptive functioning. The

differences will be sought between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe cognitive deficit.

The present study attempted to answer the following questions:

1. What is the demographic profile of the complainants?
2. Are there significant differences in sexual knowledge between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:
    a) body part vocabulary
    b) conception
    c) contraception
    d) sexually transmitted diseases
    e) overall sexual comprehension
    f) ability to consent to sexual intercourse
3. Are there significant differences in competence as witness between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:
    a) understanding the purpose of court proceedings
    b) ability to provide consistent account of the alleged rape
    c) whether court preparation is needed
    d) ability to answer clarifying questions
    e) whether an intermediary is needed
4. Are there significant differences in adaptive functioning between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:
    a) communication skills
    b) daily living skills
    c) socialization skills
5. Are there significant differences in adaptive functioning age equivalents between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:
    a) communication skills age equivalent

b) daily living skills age equivalent

c) socialization skills age equivalent

CHAPTER THREE

METHODOLOGY

CHAPTER THREE:

METHODOLOGY

3.1 Aims

- The study aimed to provide a demographic profile of the complainants or service users of the SAVE project
- The study aimed to test whether there were significant differences in sexual knowledge between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of
    - body part vocabulary
    - conception, contraception
    - sexually transmitted diseases
    - overall sexual comprehension, and
    - ability to consent to sexual intercourse
- The study aimed to test whether there were significant differences with regard to competence as witness between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of
    - understanding the purpose of court proceedings
    - ability to provide a consistent account of the alleged rape
    - whether court preparation is needed, ability to answer clarifying questions, and
    - whether an intermediary is needed
- The study aimed to test whether there were significant differences in adaptive functioning between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of

  - communication skills
  - daily living skills
  - socialization skills
- the study aimed to test whether there were significant differences in adaptive functioning age equivalents between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of age equivalents for
  - communication test-age
  - daily living test-age,
  - socialization test-age

3.2 Research Questions

The present study attempted to answer the following questions:

6. What is the demographic profile of the complainants?
7. Are there significant differences in sexual knowledge between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:
   a) body part vocabulary
   b) conception
   c) contraception
   d) sexually transmitted diseases
   e) overall sexual comprehension
   f) ability to consent to sexual intercourse
8. Are there significant differences in competence as witness between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:
   a) understanding the purpose of court proceedings

b) ability to provide consistent account of the alleged rape
c) whether court preparation is needed
d) ability to answer clarifying questions
e) whether an intermediary is needed

9. Are there significant differences in adaptive functioning between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:
    a) communication skills
    b) daily living skills
    c) socialization skills
10. Are there significant differences in adaptive functioning age equivalents between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:
    a) communication skills age equivalent
    d) daily living skills age equivalent
    e) socialization skills age equivalent

3.3 Design

The present study incorporated an archival survey design. The study was restricted in terms of access to complainants registered with CMH. After many meetings with the staff at CMH it was concluded that due to the fact that the population under study is a triple vulnerable population, as the complainants 1) have mental retardation; 2) are sexually abused and 3) may have another psychiatric diagnosis, the researcher was allowed no access what so ever to the complainants. It was decided that the researcher may only have access to the complainant's case files and the staff members working at CMH.

The design of the present study followed that of an archival research design. According to McBurney (1998) the term “archival research” refers to research conducted using data that the researcher had no part in collecting. Archival data are those that are present in existing records. The term “archives” refers to both the records being used and the places where the records are housed. The archives that were used in the study were in the form of case files that were housed at CMH. There are several advantages inherent to archival research. Goodwin (1995) states the most obvious one is that the amount of information available since the late twentieth century is virtually unlimited and the possibilities are only restricted by the creativity of the researcher. A second strength is that archival research can converge with the results of laboratory research, therefore increasing external validity. A third advantage is that archival information is nonreactive, because the information already exists; collecting information eliminates the possibility of subject reactivity (Goodwin, 1998). There are however disadvantages to using archival research as the design. According to Goodwin (2003) the fact that archival data already exists can create problems for the researcher. Despite the vast amount of information available, some information vital to a researcher may be missing or the available data may be unrepresentative. Another problem with archival research is that of experimenter bias (Goodwin, 1998). In archival research, this can take the form of selecting only those records that supports one’s hypothesis or interpreting the content in a way that is bias by a researcher’s expectations. This however should not have affected the study as a sampling strategy had been chosen to counteract the possibility of choosing records that fits the expectations of the researcher. The information required from the case files and court records is of such a nature that bias from the researcher is minimized.

3.4 Population

The population under study is that of those indigent adults living in the Cape Town community. This is a triply vulnerable population in that they have the following characteristics (The first two forming the defining characteristics):

1. According to the ISGSA test, have been diagnosed as having a level of cognitive functioning below 70 (i.e. cognitively deficient).
2. Have been sexually abused.
3. May also have a comorbid diagnosis.

There is another criterion important to complainants being included into the SAVE programme being that there has to be a strong likelihood that their case will go to trail.

3.5 Sampling Frame

This is a triple vulnerable population so in order to protect this population and given the infancy relationship between researcher and CMH, the following was agreed upon:

1. Researcher will be given access to the completed case files held at CMH.
2. Researcher will under no circumstances be allowed access to clients in person.

The sampling frame was composed of the register of closed cases seen in the SAVE programme. As mentioned before, the inclusion criteria for being included in the SAVE programme are: 1) sexual abuse had to take place; 2) complainant has to be diagnosed with mental retardation; and 3) complainants are included in the programme only if there

is a strong likelihood that there will be a court case. This study therefore made use of the closed case reports seen at CMH as a sampling frame.

3.6 Sample

This study made use of non-probability sampling since not every element eligible for inclusion in a study has an equal chance of being selected (Dooley, 1995). The study specifically employed purposive sampling where the researcher looked for specific characteristics e.g. IQ score below 70, sexual abuse history etc. Although this type of sampling might pose limitations on external validity or generalizability, it helps to procure a sample that is representative of the stated population and ensures that the researcher is able to answer the questions posed. Given the stated infancy of research into this area for this population, the more conservative approach to sampling here is warranted (Babbie & Mouton, 2002). The final sample consisted of 145 completed case files.

3.7 Procedure

The data collection process employed took place over four days. The research team consisting of the primary researcher and an assistant, met for four consecutive days at CMH. A private room was allocated at CMH for the four days that was required to complete the data capturing process. The researcher and the research assistant were shown where all the completed case files were stored and thus given the access to use the completed case files to gather the relevant information. A quiet and private environment was established for the research team to do their work with out experiencing any interruptions.

First all the completed case files were collected. A tentative reading of the first few case files was done in order to complete a code sheet for capturing the demographic variables and other variables relevant to the study. The relevant variables were sourced out and decided upon by the researcher and the research assistant as well as the codes for each variable in order to capture the maximum amount of relevant data and so no information would be left out (See Appendix A). For every variable an operational definition was drawn up to establish what is and what is not included under each variable and its relevant codes. A data capturing sheet was drawn up on the computer once the variables were decided on.

Once the variables were punched into the computer along with the relevant codes for each variable, the data capturing began. The researcher read out the relevant variable and its code to the research assistant. To prevent for any errors in the data capturing process, each code that was read to the research assistant, the research assistant would check the case file to see if the correct code was being put into the data base. Therefore there was a double check to ensure that were no errors in capturing the data. The researcher also checked what the research assistant typed into the computer to see if the correct information was being loaded. The cured data set was checked for accuracy by rechecking ten percent of the captured data against the original protocols.

3.8 Instruments

3.8.1. Case Files

The principal characteristic of case files is that they examine individual instances, or cases, of some phenomenon (McBurney, 1998). For the purposes of this study, the case files housed at CMH contained details of each individual complainant as well as their personal case material for going to trial.

The complainant's case files were used for gathering information. All the required information regarding the complainants demographics are stored in the case files, as well as the means of information distribution. The advantage of using the case files is that the needed information has already been documented in them (McBurney, 1998). Another advantage to using the complainant's case files in this instance is to protect the complainants as they are a vulnerable population. By having no contact with the complainants, this will not expose them to any further perceived external stress. The disadvantage of using the complainant's case files may be that some of the required information may be missing (Goodwin, 1998). The complainant's case files did not consistently contain information regarding the complainant's ethnicity and socioeconomic status, therefore this information had to be left out of the study. This criticism was addressed by only including case files that were accurate and complete. A total of four cases had to be rejected since the full assessment battery was not administered.

3.9 Data Analysis

Due to the nature of the study the researcher employed descriptive statistics and inferential statistics for the purposes of data analysis.

3.9.1. Descriptive statistics

The task for the researcher was to determine what the demographic profile of the complainants look like. In order do complete this, the researcher made use of descriptive statistics using frequency distributions. Descriptive statistics are statistical procedures that summarise and/or describe the characteristics of a sample. A frequency is the number of participants who fall into each category. The frequencies are organised into frequency

distributions which show the frequency in each category. This is the most relevant statistical procedure to use for determining a profile of the complainants. A profile would consist of the frequencies of each variable under study. This will allow the researcher to describe this particular population with regard to, for example the number of males and females, the age range as well as the average age of the complainants at the time of investigation, IQ scores and the complainants relationship to the perpetrator as well as the informant. Using descriptive statistics will allow the researcher to provide an overall summary of what the population looks like and where the averages lie in each variable.

3.9.2. Inferential statistics

In order to answer the research questions that hypothesized differences between varying levels of cognitive deficit, analysis of variance (ANOVA) was used. ANOVA is one of the most flexible statistical tools available for the evaluation of data and can be used to analyse several independent variables (Shavelson, 1981). ANOVA compares the variability of the means against a standard based on the variability of the scores within each group. ANOVA's compare the variability between groups with the variability within groups. If the means are more variable than expected, the researcher concludes that the independent variable had an effect (Kaplan, 1987). This statistical tool is relevant to answering this question as there are more than two groups or independent variables with level of intellectual functioning or cognitive deficit as the grouping variable e.g. groups consisting of participants with mild, moderate and severe cognitive deficits. ANOVAs were used to test the hypothesized differences in sexual knowledge, competence as a witness, and adaptive functioning for significance. The results of these analyses have been tabulated and are presented in the ensuing chapter.

CHAPTER FOUR

RESULTS

CHAPTER FOUR: RESULTS

This chapter contains the results of statistical analyses that attempted to test the hypotheses stated in chapter three. The chapter is organized in such a manner that it follows a listing of the research questions or hypotheses stated in the preceding chapter. Each hypothesis will be restated and followed by description of the statistical analysis employed to test that hypothesis, and a summary of the results.

4.1 Research question 1

The first research question attempted to ascertain the demographic profile of the complainants making use of the services rendered in the SAVE programme. The demographic profile of the complainants was compiled by means of descriptive statistics, in particular frequency distributions of various demographic variables included in the study. The results of these distributions are summarized in Table 4.1 to Table 4.19. Below follows a brief exposition of the results summarized in each of the nineteen tables. Table 4.1 reflects the gender distribution of the sample, the complainants in the SAVE programme.

Table 4.1

Frequency Table for Gender (N=144)

Variable	*f*	%	Cumulative %
Gender			
Female	134	93.7	93.7
Male	9	6.3	100

As evident in Table 4.1, the sample was comprised of 134 female participants (93.7%) and 9 male participants (6.3%). Table 4.2 summarises the age distribution of the complainants in the SAVE programme.

Table 4.2

Frequency Table for Age (N=144)

Variable	*f*	%	Cumulative %
Age range			
8-11	5	3.5	3.5
12-22	98	68.2	71.5
23-31	28	19.6	91.0
32-60	13	9.1	100

As shown in Table 4.2, the minimum age of the complainants is 8 years and the maximum age is 60 years. Thus the total age range is between 8 years and 60 years. For the age range of 8 to 11 years, there were a total of 5 complainants within that age range with a percentage of 3.5%. For the largest group there were a total of 98 complainants (68.2%) within the age range of 12 to 22 years. There were a total of 28 complainants within the age range of 23 to 31 years, thus having a percentage of 19.6% of the sample. For the age range of 32 to 60 years there was a total of 13 complainants (9.1%). Table 4.3 shows whom referred the complainant to the SAVE programme and the distribution of each referee within the sample.

Table 4.3

Frequency Table for Referred by (N=144)

Variable	*f*	%	Cumulative %
Referred by			
Sexual offences court	63	43.8	43.8
CMH	38	26.4	70.1
SAPS	41	28.5	98.6
Rape crisis and Child and family welfare	2	1.4	100

As seen in Table 4.3, the sexual offences court referred 63 complainants (43.8%) from the sample to the SAVE programme. Cape Mental Health referred 38 complainants (26.4%) from the sample to the SAVE programme. It can be seen that 41 complainants from the sample were referred to the SAVE programme by the South African Police Services, thus referring a total of 28.5% of the sample. Rape crisis together with child and family welfare referred 2 complainants to the SAVE programme giving them a referral percentage of 1.4% of the sample. Table 4.4 shows who the informants were, on behalf and the complainants, who informed the staff from the SAVE programme what had occurred during the alleged rape.

Table 4.4

Frequency Table for Informant (N=144)

Variable	*f*	%	Cumulative %
Informant			
Unknown	1	0.7	0.7
Parent	87	60.4	61.1
Sibling	17	11.8	72.9
Extended family member	20	13.9	86.8
Guardian	17	11.8	98.6
Other	1	0.7	99.3
Self	1	0.7	100

Table 4.4 shows the distribution of informants among the sample. There was one complainant assisted by an informant in the SAVE programme whom was not recorded which gives the category of unknown informant a percentage of 0.7%. A parent of the complainant acted as an informant for 87 complainants (60.4%) for the SAVE programme, making a parent as the informant the largest group. A sibling to the complainant informed the SAVE programme of 17 complainants (11.8%) alleged rape. An extended family member of the complainant acted as informant for 20 complainants to the SAVE programme, thus assisting 13.9% of the complainants within the sample. Of the sample, 17 complainants (11.8%) were assisted by their guardian who acted as

informant. For the category of other relation to the complainant, one complainant was assisted from the sample with a percentage of 0.7% of the sample. There was one complainant (0.7%) who acted as informant for him/her self from the sample. Table 4.5 shows what the relationship of the complainant to the perpetrator was and the distribution of each relation among the sample.

Table 4.5

Frequency Table for Relationship to the perpetrator (N=144)

Variable	*f*	%	Cumulative %
Relationship to the perpetrator			
Unknown	28	19.4	19.4
Nuclear family member	8	5.6	25.0
Extended family member	2	1.4	26.4
Friend	30	20.8	47.2
Care giver	6	4.2	51.4
Acquaintance	39	27.1	78.5
Step relative	7	4.9	83.3
Neighbour	21	14.6	97.9
Landlord	1	0.7	98.6
Pastor	2	1,4	100

As evident in Table 4.5, an unknown person to the complainant allegedly raped 28 complainants (19.4%) within the sample. A nuclear family member of the complainant allegedly raped 8 complainants, adding to 5.6% of the sample. Of the sample, 30 complainants (20.8%) were allegedly raped by a person classified as being a friend of the complainant. A caregiver of the complainant allegedly raped 6 complainants (4.2%). A person classified as an acquaintance to the complainant allegedly raped 39 complainants (27.1%) of the SAVE programme, making it the largest group. The category of step relative also included a live in boyfriend or girlfriend of one of the complainant's parents. This category of person allegedly raped 7 complainants (4.9%). Of the sample, 21 complainants were allegedly raped by their neighbour, adding to a percentage of 14.6% of the sample.

The landlord of where the complainant lived allegedly raped 1 complainant (0.7%). A pastor of the church to which the complainant belonged to allegedly raped 2 complainants (1.4%). Table 4.6 illustrates the number and percentage of how many complainants within the sample function within the given communication skills domains, this being either mild; moderate; severe; borderline mild to moderate; borderline moderate to severe cognitive deficit; as well as borderline and average.

Table 4.6

Frequency Table for Communication skills domain (N=144)

Variable	*f*	%	Cumulative %
Communication skills domain			
Mild	6	4.2	4.2
Moderate	33	22.8	28.1
Severe	80	55.6	85.6
Borderline mild to moderate	7	4.9	90.6
Borderline moderate to severe	10	6.9	97.8
Borderline	1	0.7	98.6
Average	2	1.4	100

As seen in Table 4.6, complainants functioning at a mild level of a cognitive deficit in the communication skills domain, 6 complainants (4.2%) communicate at this level. For the complainants who are able to communicate only at a moderate level of cognitive deficit, 33 complainants (22.8%) communication skills falls into this category. Most complainants within the sample can only communicate at the level of severe cognitive deficit, this being 80 complainants with a percentage of 55.6% of the sample. Communicating at a level of borderline between mild to moderate cognitive deficit, 7 complainants (4.9%) communicate at this level. Communicating at a level of borderline between moderate to severe cognitive deficit, 10 complainants (6.9%) communicate at this level. Functioning at a level of borderline cognitive deficit means functioning at a level between average cognitive functioning to mild cognitive deficit. Functioning at this level is 1 complainant with a percentage of 0.7% of the sample. Communicating at an average level of cognitive functioning were 2 complainants with a total percentage of

1.4% of the sample. Table 4.7 shows the results of the age range distribution for communication skills among the complainants of sample.

Table 4.7

Frequency Table for Communication age equivalent (N=144)

Variable	*f*	%	Cumulative %
Communication age equivalent range			
1- 2	17	12.6	12.6
3- 4	60	42.0	57.0
5	20	14.0	71.7
6	18	12.6	85.2
7	9	6.3	91.9
8	7	4.9	97.0
9	3	2.1	99.3
14	1	.7	100

Table 4.7 shows that for the age range from 1 to 2 years there are 17 complainants who communicate at this age level, this being 12.6% of the sample. Most complainants, 60 complainants, communicate at the age level of between 3 to 4 years, making this group 42% of the sample. There are 20 complainants (14%) whose communication skills age equivalent is 5 years of age. Having the communication skills of a person of 6 years of age is 18 complainants. This group makes up 12.6% of the sample. For the age of 7 years there are 9 complainants (6.3%) who communicate at this age level. There are 7 complainants (4.9%) who communicate at the age level of 8 years. There are 3 complainants (2.1%) who communicate at the age level of 9 years. There is 1 complainant who has the communication skills of a person who is 14 years old, this complainant being 0.7% of the sample. Table 4.8 shows the number and percentage of complainants who function at the given daily living skills domains, this being either mild; moderate; severe; borderline mild to moderate; borderline moderate to severe cognitive deficit; as well as borderline and average.

Table 4.8

Frequency Table for Daily living skills domain (N=144)

Variable	*f*	%	Cumulative %
Daily living skills domain			
Mild	20	13.9	14.4
Moderate	31	21.5	36.7
Severe	62	43.1	81.3
Borderline mild to moderate	8	5.6	87.1
Borderline moderate to severe	7	4.9	92.1
Borderline	7	4.9	97.1
Average	4	2.8	100

As evident in Table 4.8, there are 20 complainants (13.9%) who fall into the category of mild cognitive deficit for daily living skills. Functioning at a moderate level of cognitive deficit in the domain of daily living skills, there are 31 complainants (21.5%) functioning at this level. Most complainants fall into the severe domain of cognitive deficit in their daily living skills. A total of 62 complainants (43.1%) fall into the severe domain. For the domain of borderline between mild and moderate cognitive deficit, 8 complainants (5.6%) function in their daily living skills at this level. For the domain of borderline between moderate and severe cognitive deficit, 7 complainants (4.9%) function in their daily living skills at this level. For the domain of borderline cognitive deficit, 7 complainants (4.9%) function in their daily living skills at this level. Functioning at an average level in daily living skills, 4 complainants (2.8%) fall into this category. Table 4.9 shows the results of the age range distribution for daily living skills among the complainants.

Table 4.9

Frequency Table for Daily living age equivalent (N=144)

Variable	*f*	%	Cumulative %
Daily living age equivalent range			
1- 2	9	6.7	6.7
3- 4	33	23.8	32.1
5	22	15.4	48.5
6	25	17.5	67.2
7	16	11.2	79.1
8	10	7.0	86.6
9- 10	9	6.3	93.3
11- 13	7	4.9	98.5
15	1	0.7	99.3
19	1	0.7	100

As seen in Table 4.9, there are 9 complainants (6.7%) whose daily living skills are at the age equivalent of between 1 to 2 years of age. Most complainants have the daily living skills of an average 3 to 4 year old. This group is made up of 33 complainants and it is 23.8% of the sample. There are 22 complainants (15.4%) whose daily living skills are equivalent to that of an average 5 years old. For the complainants who perform daily living tasks equivalent to that of an average 6 year old, there are 25 complainants (17.5%). Performing daily living tasks at the age equivalent of 7 years old, there are 16 complainants (11.2%) functioning in daily living skills at this level. There are 10 complainants (7%) whose daily living skills are at the age equivalent of 8 years of age. Performing at an age equivalent of 9 to 10 years in daily living tasks, there are 9 complainants (6.3%). There are 7 complainants (4.9%) performing daily living tasks at the age equivalent of between 11 to 12 years of age. Functioning at an age equivalent of 15 years in daily living skills, there is 1 complainant (0.7%). There is 1 complainant (0.7%) who performs daily living tasks at the age equivalent of 19 years. Table 4.10 displays the results of complainants who socialise at the given levels of cognitive

functioning, this being either mild; moderate; severe; borderline mild to moderate; borderline moderate to severe cognitive deficit; as well as borderline and average.

Table 4.10

Frequency Table for Socialisation skills domain (N=144)

Variable	*f*	%	Cumulative %
Socialisation skills domain			
Mild	14	9.7	10.1
Moderate	38	26.4	37.4
Severe	49	34.0	72.2
Borderline mild to moderate	16	11.1	84.2
Borderline moderate to severe	17	11.8	96.4
Borderline	3	2.1	98.6
Average	2	1.4	100

As evident in Table 4.10, there are 14 complainants (9.7%) who socialise at the level of mild cognitive deficit. The ability to socialise at a moderate level of cognitive deficit, 38 complainants (26.4%) socialise at this level. Most complainants socialise at a severe level of cognitive deficit, this being 49 complainants and 34.0% of the sample. Socialising at the level of borderline between mild and moderate cognitive deficit, 16 complainants (11.1%) socialise at this level. For the domain of borderline moderate to severe cognitive deficit, functioning at this level in socialisation skills is 17 complainants (11.8%). Socialising at a borderline level of cognitive deficit is 3 complainants (2.1%). Functioning at an average cognitive level in socialisation skills are 2 complainants with a percentage of 1,4% of the sample. Table 4.11 shows the age range equivalents of which the complainants are able to socialise at as well as the age range distribution among the sample.

Table 4.11

Frequency Table for Socialisation age equivalent (N=144)

Variable	*f*	%	Cumulative %
Socialisation age equivalent range			
1- 3	31	24.4	24.4
4	50	35.0	61.5
5	23	16.1	78.5
6	17	11.9	91.1
7- 9	10	7.0	98.5
12- 13	2	1.4	100

As seen in Table 4.11, there are 31 complainants (24.4%) who socialise at the age equivalent of between 1 to 3 years. Most complainants socialise at the age equivalent of 4 years of age. In this group there are 50 complainants (35%). Socialising at an age equivalent of 5 years there are 23 complainants (16.1%). There are 17 complainants (11.9%) who socialise at the age equivalent of 6 years old. Socialising at an age equivalent of between 7 to 9 years there are 10 complainants (7%). There are 2 complainants who socialise at the age equivalent of between 12 to 13 years; these 2 complainants form 1.4% of the sample. Table 4.12 shows the distribution of complainants whose adaptive behaviour falls into the given domains, this being either mild; moderate; severe; borderline mild to moderate; borderline moderate to severe cognitive deficit and borderline.

Table 4.12

Frequency Table for Adaptive behaviour composite score (N=144)

Variable	*f*	%	Cumulative %
Adaptive behaviour composite score			
Mild	9	6.3	6.6
Moderate	41	28.5	36.5
Severe	70	48.6	87.6
Borderline mild to moderate	7	4.9	92.7
Borderline moderate to severe	7	4.9	97.8
Borderline	3	2.1	100

As evident in Table 4.12, the overall adaptive behaviour of 9 complainants (6.3%) falls into the mild level of cognitive deficit. There are 41 complainants whose adaptive behaviour falls into the moderate level of cognitive deficit totalling to 28.5% of the sample. Most complainants' adaptive behaviour falls into the category of severe cognitive deficit, in this group there being 70 complainants (48.6%). For borderline between mild and moderate and between moderate to severe, there are 7 complainants in each domain respectively making each domain 4.9% of the sample. The adaptive behaviour of 3 complainants (2.1%) falls into the borderline level of cognitive deficit. Table 4.13 shows the results of the complainants ISGSA scores as well as their distribution across the sample.

Table 4.13

Frequency Table for ISGSA (N=144)

Variable	*f*	%	Cumulative %
ISGSA			
Test not administered	7	4.9	4.9
Mild	32	22.2	27.5
Moderate	41	28.5	56.3
Severe	28	19.4	76.1
Borderline mild to moderate	18	12.5	88.7
Borderline moderate to severe	10	6.9	95.8
Borderline	4	2.8	98.6
Average	2	1.4	100

As seen in Table 4.13, the test was not administered to 7 complainants as the complainants were unable to complete the ISGSA, this formed 4.9% of the sample. Functioning at a mild level of cognitive deficit are 32 complainants (22.2%), as depicted by the ISGSA scores. Most complainants function at a moderate level of cognitive deficit. An ISGSA score of moderate cognitive deficit was given to 41 complainants, making this group of complainants 28.5% of the sample. There are 28 complainants (19.4%) who have an ISGSA score of severe cognitive deficit. For the diagnosis of borderline between mild and moderate cognitive deficit there are 18 complainants (12.5%). There are 10 complainants (6.9%) with a diagnosis of borderline between moderate and severe cognitive deficit from the test scores of the ISGSA. There are 2 complainants who function at an average level of cognitive functioning as depicted from the ISGSA scores; they form 1.4% of the sample. Table 4.14 presents the results of how many complainants claimed rape had occurred or who claimed no rape had occurred (raped being defined as vaginal penetration).

Table 4.14

Frequency Table for Rape (N=144)

Variable	*f*	%	Cumulative %
Rape			
Yes	135	93.8	93.8
No	9	6.3	100

As seen in Table 4.14, of the sample consisting of 144 complainants, 135 complainants (93.8%) claimed that they were raped. For 9 complainants (6.3%) there was no claim made that rape had occurred. Table 4.15 shows the results of how many complainants claimed they had or had not been sodomised.

Table 4.15

Frequency Table for Sodomy (N=144)

Variable	*f*	%	Cumulative %
Sodomy			
Yes	17	11.8	11.8
No	127	88.2	100

As evident in Table 4.15, 17 complainants (11.8%) claimed that sodomy did occur. Most complainants claimed that sodomy did not occur, this being 127 complainants and adding to 88.2% of the sample. Table 4.16 presents the amount of complainants who claimed that oral sex occurred and who claimed that oral sex did not occur.

Table 4.16

Frequency Table for Oral sex (N=144)

Variable	*f*	%	Cumulative %
Oral sex			
Yes	2	1.4	1.4
No	142	98.6	100

Looking at Table 4.16, most complainants claimed that oral sex did not occur. This group of complainants amounted to 142 complainants with a percentage of 98.6% of the sample. It was claimed for 2 complainants (1.4%) that oral sex did occur. Table 4.17 displays the results of how many complaints claimed that masturbation occurred and those who claimed that it did not occur.

Table 4.17

Frequency Table for Masturbation (N=144)

Variable	*f*	%	Cumulative %
Masturbation			
Yes	8	5.6	5.6
No	136	94.6	100

As seen in Table 4.17, masturbation was claimed to have had occurred by 8 complainants (5,6%). Most complainants claimed that no masturbation occurred. This group amounted to 136 complainants and 94.6% of the sample. Table 4.18 shows the results of the number of perpetrators claimed by the complainant and their distribution among the sample.

Table 4.18

Frequency Table for Number of perpetrators (N=144)

Variable	*f*	%	Cumulative %
Number of perpetrators			
1	126	86.1	86.1
2	13	9.0	95.1
3	5	3.5	98.1
5	1	0.7	99.3
7	1	0.7	100

As evident in Table 4.18, most complainants claimed there was one perpetrator present during the alleged rape. For this group there are 126 complainants (86.1%). For 13 complainants (9%) it was claimed that there were two perpetrators present during the alleged rape. It was claimed by 5 complainants (3.5%) that there were three perpetrators. It was claimed by 1 complainant (0.7%) that there were five perpetrators. Of the sample 1 complainant (0.7%) claimed to have seven perpetrators present during the alleged rape. Table 4.19 shows the given proximities from where the complainant lives to where the alleged rape occurred.

Table 4.19

Frequency Table for Proximity (N=144)

Variable	*f*	%	Cumulative %
Proximity			
In home/nearby	41	28.5	28.9
Neighbourhood	45	31.3	60.6
Distant	56	39.4	100

As seen in Table 4.19, 41 complainants (28.5%) claimed that the rape occurred inside or nearby (nearby being in the same street) the complainants home. The alleged

rape occurred in the neighbourhood of the complainants' home for 45 complainants (31.3%). Most of the alleged rapes occurred outside the neighbourhood of the complainants' home or distant from the complainants' home. For this group there were 56 complainants and it was 39.4% of the sample.

4.2 Research question 2

The second research question determined whether there are significant differences in sexual knowledge between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:

a) body part vocabulary
b) conception
c) contraception
d) sexually transmitted diseases
e) overall sexual comprehension
f) ability to consent to sexual intercourse

The hypothesized differences (stated in questions 2a – 2f) in the complainants' sexual knowledge were tested by means of analysis of variance (ANOVA), in particular one-way ANOVA. The following dependent variables were used in the study: body part vocabulary; conception; contraception; sexually transmitted diseases; overall sexual comprehension and ability to consent to sexual intercourse. The results of the variances are summarized in Table 4.20 below.

Table 4.20

Differences in sexual knowledge between complainants with Mild mental retardation (N= 32), Moderate mental retardation (N=41), Severe mental retardation (N= 28), Borderline mild to moderate mental retardation (N= 18), and Borderline moderate to severe mental retardation (N= 10)

Variable and source	SS	MS	F	Sig
Body parts				
Between groups	7.14	1.78	11.494	.000**
Within groups	19.25	.16		
Conception				
Between groups	5.30	1.33	7.499	.000**
Within groups	21.91	.18		
Contraception				
Between groups	3.04	.76	5.483	.000**
Within groups	17.07	.14		
Sexually transmitted diseases				
Between groups	5.34	1.34	8.622	.000**
Within groups	19.21	.16		
Sexual comprehension				
Between groups	36.72	9.18	5.490	.000**
Within groups	207.34	1.67		
Sexual consent				
Between groups	4.26	1.07	.826	.511
Within groups	159.94	1.29		

*** p < .01*

From Table 4.20 it becomes evident that significant differences in sexual knowledge were found in terms of body part vocabulary, conception, contraception, sexually transmitted diseases and overall sexual comprehension at alpha level less than .001 between the varying levels of cognitive deficit stipulated in the research question. Thus the probability that these findings are erroneous is less than 99.9 %.

Body part vocabulary, as anticipated there was an inverse correlation between body part vocabulary and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly lower body part vocabularies.

Knowledge of conception in terms of how the groups compared, as anticipated, there was an inverse correlation between knowledge of conception and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly less knowledge of conception.

Knowledge of contraception in terms of how the groups compared, as anticipated, there was an inverse correlation between knowledge of contraception and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly less knowledge of contraception.

Knowledge of sexually transmitted diseases in terms of how the groups compared, as anticipated, there was an inverse correlation between knowledge of sexually transmitted diseases and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly less knowledge of sexually transmitted diseases.

Overall sexual comprehension in terms of how the groups compared, as anticipated, there was an inverse correlation between sexual comprehension and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly lower sexual comprehension.

It can also be seen from Table 4.20 that there were no significant differences in sexual knowledge in terms of ability to consent to sexual intercourse found between the varying levels of cognitive deficit stipulated in the research question.

4.3 Research question 3

The third research question tested for significant differences in competence as witness between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:

a) competence as a witness
b) understanding the purpose of court proceedings
c) ability to provide consistent account of the alleged rape
d) whether court preparation is needed
e) ability to answer clarifying questions
f) whether an intermediary is needed

The hypothesised differences (stated in questions 3a - 3e) in the complainants' competency in acting as a witness were tested by means of analysis of variance (ANOVA), in particular one-way ANOVA. The following dependent variables were used in the study: understanding of court proceedings; ability to provide a consistent account of the alleged rape; whether court preparation is needed; ability to answer clarifying questions and whether an intermediary is needed. The results of the variances are summarized in Table 4.21 below.

Table 4.21

Differences in competence as witness between complainants with Mild mental retardation (N= 32), Moderate mental retardation (N=41), Severe mental retardation (N= 28), Borderline mild to moderate mental retardation (N= 18), and Borderline moderate to severe mental retardation (N= 10)

Variable and source	SS	MS	F	Sig
Competence				
Between groups	5.40	1.35	8.106	.000**
Within groups	20.48	.17		
Purpose of court proceedings				
Between groups	10.89	2.72	15.908	.000**
Within groups	21.04	.17		
Court preparation				
Between groups	4.38	1.09	6.290	.000**
Within groups	21.58	.17		
Consistent account				
Between groups	3.18	.80	4.842	.001**
Within groups	20.37	.16		
Clarifying questions				
Between groups	6.81	1.70	9.783	.000**
Within groups	21.41	.17		
Intermediary needed				
Between groups	2.77	.69	2.922	.024*
Within groups	29.39	.24		

** $p<.05$. * * $p < .01$.*

From Table 4.21 it becomes evident that significant differences in competence as witness were found in terms of understanding of court proceedings; ability to provide a consistent account of the alleged rape; whether court preparation is needed and the ability to answer clarifying questions at alpha level less than .001 between the varying levels of cognitive deficit stipulated in the research question. Thus the probability that these findings are erroneous is less than 99.9%.

Competence as witness in terms of how the groups compared, as anticipated, there was an inverse correlation between competence as witness and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly lower abilities to act as a competent witness.

Understanding the purpose of court proceedings in terms of how the groups compared, as anticipated, there was an inverse correlation between understanding the purpose of court proceedings and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly less understanding of the purpose of court proceedings.

Needing court preparation in terms of how the groups compared, there was an inverse correlation between needing court preparation and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly less need for court preparation.

Ability to give a consistent account of the alleged rape in terms of how the groups compared, as anticipated, there was an inverse correlation between ability to give a consistent account of the alleged rape and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly less ability to give a consistent account of the alleged rape.

Ability to answer clarifying questions in terms of how the groups compared, as anticipated, there was an inverse correlation between ability to answer clarifying questions and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly less ability to answer clarifying questions.

It can also be seen from Table 21 that there were significant differences in terms of needing an intermediary at alpha level less than .05 between the varying levels of cognitive deficit stipulated in the research question. Thus the probability that these findings are erroneous is less than 95%.

Needing an intermediary in terms of how the groups compared, there was an inverse correlation between needing an intermediary and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly less need for an intermediary.

4.4 *Research question 4*

The fourth research question determined whether there are significant differences in adaptive functioning between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:

a) communication skills
b) daily living skills
c) socialization skills
d) overall adaptive functioning

The hypothesised differences (stated in questions 4a – 4d) in the complainants' adaptive functioning was tested by means of analysis of variance (ANOVA), in particular one-way ANOVA. The following dependent variables were used in the study: communication skills; daily living skills; socialisation skills and overall adaptive functioning. The results of the variances are summarized in Table 4.22 below.

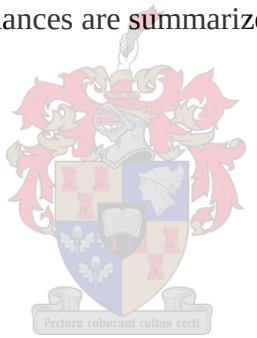


Table 4.22

Differences in adaptive functioning between complainants with Mild mental retardation (N= 32), Moderate mental retardation (N=41), Severe mental retardation (N= 28), Borderline mild to moderate mental retardation (N= 18), and Borderline moderate to severe mental retardation (N= 10).

Variable and source	SS	MS	F	Sig
Communication skills domain				
Between groups	3.12	.78	.996	.413
Within groups	94.08	.78		
Daily Living skills domain				
Between groups	5.21	1.30	.749	.561
Within groups	208.79	1.74		
Socialisation skills domain				
Between groups	20.08	5.02	3.758	.006**
Within groups	160.28	1.34		
Overall Adaptive Functioning				
Between groups	5.64	1.41	1.644	.168
Within groups	102.10	.858		

* * $p < .01$

From Table 4.22 it becomes evident that a significant in difference adaptive functioning was found in terms of socialisation skills at alpha level less than .01 between the varying levels of cognitive deficit stipulated in the research question. Thus the probability that these findings are erroneous is less than 99%.

Socialisation skills in terms of how the groups compared, as anticipated, there was an inverse correlation between socialization skills and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly lower socialisation skills.

It can also be seen from Table 4.22 that there were no significant differences in adaptive functioning in terms of communication skills, daily living skills and overall adaptive functioning found between the varying levels of cognitive deficit stipulated in the research question.

4.5 Research question 5

The fifth research question tested whether there are significant differences in adaptive functioning age equivalents between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:

a) communication skills age equivalent
b) daily living skills age equivalent
c) socialization skills age equivalent

The hypothesised differences (stated in questions 5a – 5c) in the complainants' adaptive functioning was tested by means of analysis of variance (ANOVA), in particular one-way ANOVA. The following dependent variables were used in the study: communication skills age equivalent; daily living skills age equivalent and socialisation skills age equivalent. The results of the variances are summarized in Table 4.23 below.

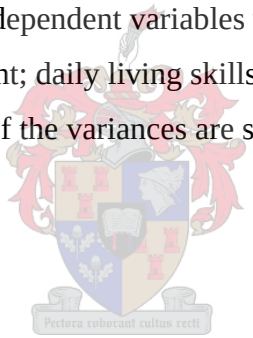


Table 4.23

Differences in adaptive functioning age equivalents between complainants with Mild mental retardation (N= 32), Moderate mental retardation (N=41), Severe mental retardation (N= 28), Borderline mild to moderate mental retardation (N= 18), and Borderline moderate to severe mental retardation (N= 10).

Variable and source	SS	MS	F	Sig
Communication age equivalent				
Between groups	219.99	55.00	41.430	.000**
Within groups	155.32	1.33		
Daily Living age equivalent				
Between groups	328.70	82.18	19.348	.000**
Within groups	492.68	4.25		
Socialisation age equivalent				
Between groups	137.61	34.40	19.41	.000**
Within groups	207.38	1.77		

** p < .01*

From Table 4.23 it becomes evident that significant differences in adaptive functioning age equivalents were found in terms of communication skills age equivalent; daily living skills age equivalent and socialisation skills age equivalent at alpha level less than .001 between the varying levels of cognitive deficit stipulated in the research question. Thus the probability that these findings are erroneous is less than 99.9%.

Communication skills age equivalent in terms of how the groups compared, as anticipated, there was an inverse correlation between communication skills age equivalent and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly lower communication skills age equivalents.

Daily living skills age equivalents in terms of how the groups compared, as anticipated, there was an inverse correlation between daily living skills age equivalents and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly lower daily living skills age equivalents.

Socialisation skills age equivalents in terms of how the groups compared, as anticipated, there was an inverse correlation between socialisation skills age equivalents

and degree of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly lower socialisation skills age equivalents.

CHAPTER FIVE

DISCUSSION OF THE RESULTS

CHAPTER FIVE: DISCUSSION OF THE RESULTS

This chapter includes a discussion of the results presented in the previous chapter, chapter four. The aim is to discuss the results from the statistical analyses, to make inferences thereof and to determine whether or not these findings concur with previous research. The chapter is organised in such a manner that it follows a listing of the research questions or hypotheses stated in the preceding chapter. Each hypothesis will be restated and followed by a discussion of the results from the statistical analysis employed to test that hypothesis.

5.1 Research question 1

The first research question attempted to compile the demographic profile of the complainants making use of the services rendered in the SAVE programme. The demographic profile of the complainants was compiled by means of descriptive statistics, in particular frequency distributions, of various demographic variables included in the study.

5.1.1 Gender: The sample was consisted of 144 complainants registered as clients of the SAVE programme. From the results it can be seen that there are 134 female participants (93.7%) and 9 male participants (6.3%). This shows that the majority of the sample comprised of female participants. This gender distribution trend concurs with statistics stated in other research on sexual abuse (Sullivan *et al*., 1987; Tyler & Cauce, 2002). Sullivan *et al*. (1987) pointed out that the sexual abuse norms in the general population is 10 percent for males and 25 percent for females, but that the numbers of sexual abuse in the disabled population increases for both males and females. As can be seen from these findings, sexual abuse patterns of the general population is replicated in the population of people with cognitive deficit. In other words, there is a higher prevalence for females being sexually abused. An important point to remember is that male victims of sexual abuse tend to underreport despite the increasing awareness of sexual victimization involving males (Tyler & Cauce, 2002). Tyler and Cauce (2002) further highlight that a number of factors, for example, stigma of homosexuality, male

ethic of self-reliance contribute to the underreporting of such cases. This could be a factor that shows why a lower number of male participants were included in the sample.

5.1.2 Age: The age range of the sample begins with the minimum age of the complainants being 8 years and the maximum age being 60 years. Thus the distribution of ages ranges between 8 years and 60 years that constitutes a relatively large range. The range of ages could be a function of the parameters for the target sample being defined as a diagnostic group, i.e. people with cognitive deficit, rather than a developmental cohort. Thus the large diversity of age was not controlled for, as the diagnosis was the primary inclusion criterion rather than the age of the complainant. The decision not to control for chronological age, was three fold: First, the study aimed to compile a general profile, and to control for age would have been premature and prevented the overall picture of the distribution. Second, theoretically the study aimed to differentiate between developmental age/ test age equivalents since chronological age has often been a confound in the treatment of people with cognitive deficit in the legal system where misappraisals occur since it is based on chronological age rather than developmental age. Third, the sample was considered homogenous in terms of all participants being victims of sexual abuse and having been diagnosed with cognitive deficit. To further refine the purposive sampling to include age parameters might have resulted in a sample that was severely limited in its representativeness of the general population. Below follows a post-hoc stratification of the chronological age cohorts.

For the age range of 8 to 11 years, there were a total of five complainants within that age range with a percentage of 3.5%. For the largest group there were a total of 98 complainants (68.2%) within the age range of 12 to 22 years. There were a total of 28 complainants within the age range of 23 to 31 years, thus having a percentage of 19.6% of the sample. For the age range of 32 to 60 years there was a total of 13 complainants (9.1%). As can be seen from the results, the age group of 12 to 22 years seems to be at the greatest risk of sexual abuse, as this age group has the largest number of victims in from the sample of the present study. It also seems from the present study that adolescents with a cognitive deficit are at a higher risk of being sexually violated. The smallest number of complainants fell into the age range of 8 to 11 years.

According to King et al. (2004) 1.6% of women aged 15–49 years reported being raped before the age of 15 years in South Africa. Thus the age at greatest risk for women in South Africa is between 12 and 17 years. These findings are similar to the results of the present study as adolescents were at greatest risk for sexual abuse. Similarly, Balogh *et al.* (2001) and Tang and Lee (1999) concur with the finding that adolescents were at greatest risk of sexual abuse. Romano *et al*. (2001) had contradicting results stating, overall, the literature seems consistent in suggesting that most sexual abuse experiences begin between the ages of 7 and 10 years. However, in the present sample one cannot be sure that the abuse incident for which service users were currently participating in the SAVE project, was the initial abuse incident. Thus the apparent difference here is that Romano *et al*. (2001) is identifying age at onset that is not within the scope of the present study. Case files often indicated when there had been previous incidents, but this was done inconsistently and to enhance the ability of the client with cognitive deficit to be a competent witness, the intervention is to focus on the incident for which a trial is set. This helps to reduce confusion between events and precluded the researcher in the present study to make any inferences and assertions about the age of initial sexual abuse experiences.

Findings from a review of retrospective studies appear to indicate that the average age of abuse onset is slightly older for males than for females. One such study Hunter (quoted in Romano et al., 2001) found the average age of onset to be 8.1 years for male children and 7.1 years for female children. However, these findings did not reach statistical significance. A further, possible reason for the apparent contradictory results may be due to the fact that the Romano et al. (2001) study was a review paper of the literature. In such meta-evaluations, the aggregates obtained tend to be severely influenced by outliers and often do not reflect trends in special populations. An important aspect to remember here is that the range in adaptive age was considerably smaller than the range for chronological age. The distribution for adaptive ages will be discussed later in this chapter. It is imperative to note at this stage that the sample was more homogenous in terms of adaptive age than chronological age. The adaptive age range is more constricted and tends to be more consistent with the age ranges studied in the literature.

5.1.3 Referral sources: Part of creating a demographic profile of the complainants involves who referred the complainants to the SAVE programme. From the results it can be seen that the sexual offences court referred 63 complainants (43.8%) from the sample to the SAVE programme. Cape Mental Health referred 38 complainants (26.4%) from the sample to the SAVE programme. There were 41 complainants from the sample who were referred to the SAVE programme by the South African Police Services, thus referring a total of 28.5% of the sample. Rape crisis together with Child and Family Welfare referred 2 complainants to the SAVE programme giving them a referral percentage of 1.4% of the sample.

5.1.4 Informants: An essential person in the demographic profile is the person who acted as an informant on behalf of the complainants to account for what had occurred during the alleged rape. There was one complainant assisted by an informant whom requested not to be named. Thus 0.7% of the informants were unknown. A parent of the complainant acted as an informant for 87 complainants (60.4%) for the SAVE programme, making a parent as the informant the largest group. A sibling of the complainant informed the SAVE programme of 17 complainants (11.8%) alleged rape. An extended family member of the complainant acted as informant for 20 complainants to the SAVE programme, thus assisting 13.9% of the complainants within the sample. Of the sample, 17 complainants (11.8%) were assisted by their guardian who acted as informant. For the category of other relation to the complainant, one complainant was assisted from the sample with a percentage of 0.7% of the sample. There was one complainant (0.7%) who acted as informant for him/her self from the sample. The sexual offences court referred most complainants to the programme. This may be the case as the most complainants disclosed the account of the alleged rape to a parent, who then in turn acted as the informant. On the complainant disclosing the alleged rape to the parent, or any other informant, the general reaction is to take the matter the police. Once the matter has been taken to the police, a case is made and sent to the sexual offences court where the case is legally dealt with. The sexual offences courts in the Western Cape know of the SAVE programme and refer many complainants to it for help, support and intervention for the court case.

5.1.5 Relationship to perpetrator: Relationship to the perpetrator was also investigated. The results look as follows; 28 complainants (19.4%) were an allegedly raped by a person unknown to the complainant. A nuclear family member was the alleged perpetrator in eight cases, accounting for 5.6% of the variance. Of the sample, 30 complainants (20.8%) were allegedly raped by a person classified as a friend of the complainant. Caregivers accounted for six cases (4.2%) of alleged rape of complainants. A person classified as an acquaintance, i.e. someone known to the client through a family member or friend, accounted for 39(27.1%) instances of rape making it the largest group. Step relatives also included a live-in boyfriend or girlfriend of one of the complainant's parents. This category accounted for seven (4.9%) of the alleged rapes. Of the sample, 21 complainants were allegedly raped by a neighbour, accounting for 14.6% of the sexual abuse offenses in the sample. Landlords of the complainants were responsible for one (0.7%) of the alleged rapes. A religious leader e.g. pastor, accounted for two (1.4%) of the alleged rapes. It can thus be said that of the sample consisting of 144 complainants, 28 complainants (19.4%) where allegedly raped by a person who was unknown to the complainant. The majority of complainants (80.6%) were allegedly raped by a person that was known to or was somehow related to the complainants. So it can be said that most of the perpetrators of this sample were someone known to the complainant. Of the known perpetrator group, 15 complainants (10.5%) were allegedly raped by family member and 99 complainants (68.8%) were allegedly raped by a non- family member, but who was known by the complainant. It can thus be deduced from the known perpetrator group that the largest subgroup was made up of non- family members. This finding concurs with Kvam's (2004) finding that disabled people are more often abused by an offender from the family or the circle of acquaintances. In addition children with disabilities are subject to the added risk constituted by caregivers that provided special care to the disabled. This means that people with a disability are more likely to be sexually abused by a person known to the victim. A review of the literature (see Furey, 1994) suggests that individuals with a cognitive deficit, in particular mental retardation, may be particularly at risk for abuse by caregivers and acquaintances, rather than strangers that is illustrated by the findings of the present study. Crisma *et al*. (2004) also concluded that it more likely for

the perpetrator of sexual abuse to be a person who is known to the victim, for example, the perpetrator may be a parent, caregiver or a friend. Cyr *et al*. (2002) conducted a study on perpetrators of sexual abuse. The population was broken up into family member or non-family member. They stated that it is more common that the perpetrator of the sexual abuse is not a direct family member, however the incidence of intrafamilial sexual abuse is high as well as sexual abuse committed by a person known to the victim. These findings seem to correlate with the present studies findings. The incidence of direct family members being the perpetrator seems so be more prevalent in the other studies however. This may be so as the samples were smaller than the sample of the present study.

5.1.6 Adaptive age: As mentioned before, adaptive age was an important variable in the present study. Adaptive age was operationalized as comprising three domains: communication skills, social skills and daily living skills as measured by the Vinelands Maturity Scale. Below follows a discussion of the variability of the sample in terms of the three domains, as well as an overall adaptive functioning score.

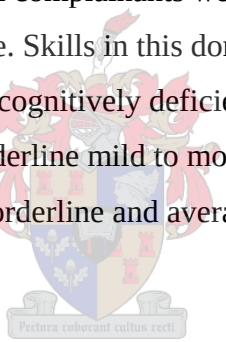
5.1.6.1 Communication skills: In the communication domain complainants were assessed to determine at which level their communication skills were. Skills in this domain were categorised in terms of the degree to which their skills were cognitively deficient. The categories were as follows: mild; moderate; severe; borderline mild to moderate; borderline moderate to severe cognitive deficit; as well as borderline and average. The results are discussed below:

Six complainants (4.2%) functioned at a mild level of a cognitive deficit in the communication skills domain. 33 complainants (22.8%) functioned at a moderate level of a cognitive deficit in the communication skills domain. Most complainants within the sample, 80 complainants (55.6%), were estimated to have communication skills commensurate with severe cognitive deficit. Seven complainants (4.9%) were estimated to have communication skills commensurate with a borderline level between mild to moderate cognitive deficit. Ten complainants (6.9%) possessed communication skills at a level of borderline between moderate to severe cognitive deficit. One complainant (0.7%)

possessed communication skills at the level of borderline cognitive deficit, i.e. between average cognitive functioning to mild cognitive deficit. Two complainants (1.4%) demonstrated communication skills an average level of cognitive functioning.

As can be seen from the results, most complainants possessed communication skills that were at the severe level of cognitive deficit. This in turn means that 55.6% of the complainant's possess communication skills that are limited and very basic. The second largest group of complainants (22.8%) have communication skills at to the level of moderate cognitive deficit. This group of complainants also have a limited and basic communication pattern, but not as limited and basic as those who fall into the severe level of cognitive deficit in terms of communication skills. This means that the sample generally tends to function in terms of communication skills at a low level. This also means that the complainants' ability in general daily communication is severely limited.

In the communication domain complainants were assessed to determine at which level their communication skills were. Skills in this domain were categorised in terms of the degree to which their skills were cognitively deficient. The categories were as follows: mild; moderate; severe; borderline mild to moderate; borderline moderate to severe cognitive deficit; as well as borderline and average. The results are discussed below:



5.1.6.2 Age equivalent for Communication skills: The age range equivalents for communication skills were calculated and ranged from 1 year to 14 years of age. As mentioned before, the range for age equivalents (14 years) is far more constricted than the range for chronological age (52 years). This illustrates that the skills in the communication domain for this sample is not commensurate with chronological age. The age equivalent provides a more accurate and appropriate estimate of the communicative abilities of persons with cognitive deficit that is important in their ability to negotiate sexual experiences. For example, a person with a cognitive deficit may have a chronological age of 35, but have the age equivalent of 9.7 years for communication skills.

The results for the communication age range equivalents are as follows; for the age range from 1 to 2 years (12.6%) there are 17 complainants who communicate at this

age level. Most complainants, 60 complainants, communicate at the age level of between 3 to 4 years, making this group 42% of the sample. There are 20 complainants (14%) whose communication skills age equivalent is 5 years of age. Eighteen complainants (12.6%) have communication skills equivalent to a 6-year old. Nine complainants (6.3%) have communication skills equivalent to a 7-year old. Seven complainants (4.9%) communicate at the equivalent of an eight year old. Three complainants (2.1%) communicate at the equivalent of a 9-year old. There was one complainant (0.7%) who has the communication skills of a person who was 14 years old.

It becomes evident that the age range equivalent for the majority (42%) of the sample was between the ages of 3 to 4 years. The second largest group consisted of 14% of the sample with communication skills equivalent to that of a 5-year old. The next largest group (12.6% of the sample) possessed communication skills equivalent to that of a 6-year old. Adding these groups together, 68.6% of the sample communicates at an age equivalent of between 3 to 6 years of age, making up more than half of the sample. This means that more than half of the sample has the communication skills that are equivalent to those in early childhood.

Children in early childhood use short, simple sentences to convey messages that usually consist mainly of a noun and a verb, for instance “give biscuit”. However the closer the communication skills are to that of a 6 year old, the more complex the sentences become. The average age range equivalent being between 3 to 6 years of age can explain for the reason that most of the complainants communication skills are at a severe level of cognitive deficit, as their communication skills are shown to be very basic and limited. Thus the results of the age range equivalent and the severity of the cognitive deficit at which the majority of the complainants communicate at seem to correlate with each other.

5.1.6.3 Daily living skills: The level at which the complainants function in terms of their daily living skills was assessed. Daily living skills form part of what the complainant is able to do on his/her own in term of normal daily functioning. This means for example being able to dress oneself, perform personal hygiene and eat and drink with out assistance. There daily living functioning was assessed in terms of

whether the complainants function at a level of either mild; moderate; severe; borderline mild to moderate; borderline moderate to severe cognitive deficit; as well as borderline and average intellectual functioning. The results of these findings are discussed below:

Twenty complainants (13.9%) have daily living skills that fall into the category of mild cognitive deficit. 31 complainants (21.5%) have daily living skills that fall into the category of moderate level of cognitive deficit. Most complainants, 62 (43.1%), have daily living skills that fall into the category of severe cognitive deficit. Eight complainants (5.6%) have daily living skills that are on the borderline between mild and moderate cognitive deficit. Seven complainants (4.9%) have daily living skills that are on the borderline between moderate and severe cognitive deficit. Seven complainants (4.9%) have daily living skills that fall into the category of borderline intellectual functioning. Four complainants have daily living skills that fall into the category of average intellectual functioning.

From the results it can be seen that the largest group of complainants (43.1%) possess daily living skills that are at a level of severe cognitive deficit. This group forms just under half of the sample. This means that just under half of the sample has very poor daily living skills in terms of functioning on his/her own independently. The second-largest group of complainants (21.5%) possess daily living skills that are at a level of moderate cognitive deficit. This group of complainants have poor daily living skills but are not as limited in daily living skills as the group that functions at a level of severe cognitive deficit. The third-largest group (13.9%) possess daily living skills that are at a level of mild cognitive deficit. This means that a small number of complainants from the sample can perform basic daily living skills independently.

5.1.6.4 Age equivalents for Daily living skills: The age range equivalents for daily living skills ranged from 1 to 19 years of age. As mentioned before, the range for age equivalents (19 years) is far more constricted than the range for chronological age (52 years). This illustrates that the skills in the daily living domain for this sample is not commensurate with chronological age. The age equivalent provides a more accurate and appropriate estimate of the extent to which persons with cognitive deficit can perform daily living skills independently. For people with a normal level of general cognitive

functioning one can predict to a certain degree the level of functioning in the daily living domain from chronological age. This however does not apply to people with cognitive deficits.

The results for the daily living age range equivalents are as follows: Nine complainants (6.7%) have daily living skills at the age equivalent of between 1 to 2 years of age. Most complainants (33/23.8% of the sample) have the daily living skills of a 3 to 4 year old. Twenty-two complainants (15.4%) have the daily living skills equivalent to that of an average 5-year old. Twenty-five complainants (17.5%) have the daily living skills equivalent to that of an average 6-year old. Performing daily living tasks at the age equivalent of 7 years old, there are 16 complainants (11.2%). There are 10 complainants (7%) whose daily living skills are at the age equivalent of a 8-year old. Performing at an age equivalent of 9 to 10 years in daily living tasks, there are 9 complainants (6.3%). There are 7 complainants (4.9%) performing daily living tasks at the age equivalent of between 11 to 12 years of age. Functioning at an age equivalent of 15 years in daily living skills, there is 1 complainant (0.7%). There is one complainant (0.7%) who performs daily living tasks at the age equivalent of 19 years.

As can be seen from the results, the largest group of complainants, 23.8% of the sample, can execute daily living tasks at an age equivalent of a 3 to 4 year old. The second-largest group of complainants, forming 17.5% of the sample, function in daily living skills at an age equivalent of 6 years. The next largest group of complainants (15.4%) function in daily living skills at an age equivalent of 5 years. Adding the age equivalents of these three groups, it can be seen that 56.7% of the sample can execute daily living skills equivalent to that of a 3- to 6-year old. This means that this group of complainants have the same daily living skills of a child in early childhood. The daily living skills of this group is very poor and assistance with most skills will be needed. At this age equivalent level the complainants will not be able to perform daily living skills independently or on their own, assistance from a care giver will be required. However at the age of 6 years, one's daily living skills are better in terms of functioning more independently than a 3-year old. This correlates well with the level at which the majority of the complainants function at. The group functioning at a severe level of cognitive deficit in performing daily living skills comprises 43.1% of the sample. 29.4% of sample

possess daily living skills that are equivalent to that of a 7- to 13-year old. The daily living skills of this group of complainants range between that of children in middle childhood and early adolescence. This group of complainant's daily living skills are to a degree more refined. This group of complainants have more independence in terms of performing daily living skills; they can perform many daily living tasks independently but under the supervision of a caregiver or parent. This correlates with the findings of the amount of complainants (21.5%) that function at a moderate level of cognitive deficit in terms of daily living skills.

5.1.6.5 Social skills domain: The socialisation skills of the complainants were assessed and categorized as mild; moderate; severe; borderline mild to moderate; borderline moderate to severe cognitive deficit; as well as borderline and average intellectual functioning. The results are discussed below:

Fourteen complainants (9.7%) possess social skills at the level of mild cognitive deficit. 38 complainants (26.4%) possess social skills at the level of moderate cognitive deficit. Most complainants (34.0% of the sample) possess social skills at the level of severe cognitive deficit. Sixteen complainants (11.1%) possess social skills at the borderline between mild and moderate cognitive deficit. 17 complainants (11.8%) possess social skills at the borderline between moderate and severe cognitive deficit. Three complainants (2.1%) possess social skills at the level of borderline intellectual functioning. Two complainants (1.4%) possess social skills at the level of average intellectual functioning.

For the socialisation skills domain, again the largest group (34%) functions in socialisation skills at a level of severe cognitive deficit. This means that this group of complainants can socialise with others at a very basic level despite their limited understanding of normal socialisation processes between people. The second-largest group of complainants, forming 26.4% of the sample, possess socialisation skills commensurate with moderate cognitive deficit. This group of complainants have a basic understanding of the normal process of socialisation between people, however there skills are limited and basic.

5.1.6.6 Age equivalents for Social skills: The age range equivalents for social living skills ranged from 1 to 13 years of age. As mentioned before, the range for age equivalents (13 years) is far more constricted than the range for chronological age (52 years). This illustrates that the skills in the social skills domain for this sample is not commensurate with chronological age. The age equivalent provides a more accurate and appropriate estimate of the extent to which persons with cognitive deficit can understand social processes and engage socially with other people. This too shows that a person cannot predict the age equivalent for which a person with a cognitive deficit is supposed to socialise at. The chronological age is not a good indicator of the age equivalent of the persons ability to understand social processes and interaction between people. This seriously impedes their ability to negotiate sexual encounters, especially since sexual innuendo and "reading between the lines" often accompany sexualized social interactions. Thus it seems that chronological age for people with cognitive deficit is only a good predictor of physical aging and maturing of the body.

The results for the socialisation age equivalents are as follows: there are 31 complainants (24.4%) who socialise at the age equivalent of between 1 to 3 years. Most complainants(35%) socialise at the age equivalent of 4 years of age. Socialising at an age equivalent of 5 years, there are 23 complainants (16.1%). There are 17 complainants (11.9%) who socialise at the age equivalent of 6 years old. Socialising at an age equivalent of between 7 to 9 years there are 10 complainants (7%). There are 2 complainants who socialise at the age equivalent of between 12 to 13 years; these 2 complainants form 1.4% of the sample.

As can be seen from the results, the largest group of complainants, forming 35% of the sample, have the socialisation skills at an age equivalent of 4 years. Socialising at an age equivalent to that of children in early childhood, this ranging from 4 to 6 years of age is 63% of the complainants from the sample. More than half of the sample socialise at this level. At this age socialisation skills are only being learned so there skills are basic and limited. The second largest group of complainants comprises of 24.4% of the sample. This group has the socialisation skills at an age equivalent of between 1 to 3 years. These complainants socialise at the same level as an infant. This group of complainants have very poor socialisation skills. This age equivalent corresponds with those complainants

whose socialisation skills were estimated to be at the lower end of severe cognitive deficit. The 63% of complainants who function at an age equivalent of early childhood can account for the large number of complainants functioning at the severe and moderate level of cognitive deficit. 9.7% of the sample possess socialisation skills estimated at a mild level of cognitive deficit that corresponds to approximately 7% of complainants who have social skills age equivalents between 7- to 9-year old. This group has a better understanding of the rules and norms of the socialisation process, as children at the ages of 7 to 9 are at a school going level where they have learnt to conform to the norms and standards that society has set out. This group will have an understanding of the socialisation process with limitations.

5.1.6.7 Adaptive functioning: The overall adaptive functioning was tested to determine at what level the complainants function at, this being either mild; moderate; severe; borderline mild to moderate; borderline moderate to severe cognitive deficit and borderline. The results were as follows: Nine complainants (6.3%) were estimated to have an overall adaptive functioning at the level of mild cognitive deficit. Forty-one complainants (28.5%) were estimated to have an overall adaptive functioning at the level of moderate cognitive deficit. The majority of complainants (48.6%) were estimated to have an overall adaptive functioning at the level of severe cognitive deficit. Seven complainants (4.9%) were estimated to have an overall adaptive functioning at the borderline between mild and moderate, and between moderate and severe cognitive deficit respectively. Three complainants (2.1%) were estimated to have an overall adaptive functioning at the level of borderline intellectual functioning.

As can be seen from the results, the largest group of complainants, forming 48.6% of the sample, function at a level of severe cognitive deficit in terms of overall adaptive functioning. This concurs with the results of the separate domains of adaptive functioning that were assessed, this being communication skills, daily living skills and socialisation skills, as each domain had their largest group of complainants functioning at a level of severe cognitive deficit respectively. This means that the overall adaptive skills of most of the complainants are very poor. The second largest group of complainant (28.5%) have the overall adaptive skills at a level of moderate cognitive deficit. This too concurs with

the individual results of the adaptive functioning skills domains. This means that this group of complainants function better in overall adaptive skills than the severe group, however there overall adaptive behaviour is limited. The third largest group of complainants (6.3%) have the overall adaptive skills at a level of mild cognitive deficit. This concurs with the individual results of daily living skills but not for communication skills and socialisation skills. For communication skills and for socialisation skills, the third largest group of complainants function at a level of borderline moderate to severe cognitive deficit.

5.1.7. Intellectual Functioning: The level of cognitive functioning was estimated using the scores obtained on the ISGSA. Seven complainants (4.9%) were unable to establish a baseline score on the ISGSA and the test subsequently discontinued. The results are discussed below:

Thirty-two complainants (22.2%) were estimated to have a general level of cognitive functioning at the level of mild cognitive deficit. The majority (28.5%) of the complainants were estimated to have a general level of cognitive functioning at the level of moderate cognitive deficit. Twenty-eight complainants (19.4%) were estimated to have a general level of cognitive functioning at the level of severe cognitive deficit. Eighteen complainants (12.5%) were estimated to have a general level of cognitive functioning at the borderline between mild and moderate cognitive deficit. Ten complainants (6.9%) were estimated to have a general level of cognitive functioning at the borderline between moderate and severe cognitive deficit. Two complainants (1.4%) were estimated to have an average level of intellectual or cognitive functioning.

As can be seen from the results, most complainants (28.5%) function at a moderate level of cognitive deficit. A moderate level of cognitive deficit means having an IQ score that ranges between 35 to 55 scaled IQ points. The person with a moderate cognitive deficit will have limited cognitive development in mental and physical skills. The second-largest group of complainants (22.8%) function at a mild level of cognitive deficit. A mild level of cognitive deficit means having an IQ score that ranges between 50 to 70. The third-largest group of complainants (19.4%) function at a severe level of cognitive deficit. A severe level of cognitive deficit means having an IQ score that ranges

between 20 to 40. The order of level of cognitive deficit from the largest to the smallest groups of complainants is as follows: moderate cognitive deficit (28.5%), mild cognitive deficit (22.8%) and severe cognitive deficit (19.4%).

The variation in level of cognitive functioning/ deficit for the sample differs from the stated distribution/ incidence of cognitive deficit in the general population (Louw, 2000; Mash & Wolfe, 2002; Sadock & Sadock, 2003). Persons with mild mental retardation constitute the largest group of persons with this disorder, followed by moderate and a small percentage in the severe category (APA, 2000). Louw (2000) stated that persons with moderate mental retardation constitute approximately 10 percent of those with mental retardation whilst Sadock & Sadock (2003) stated that people with severe mental retardation constitute approximately three percent of persons with mental retardation. Thus it would seem that the sample in the present study does not represent or reflect the same distribution described in the general population. This might be attributed to different tests used to assess the level of cognitive functioning in the various studies. However, there is usually agreement between the scales typically used to assess intellectual functioning. A second hypothesis is that fewer people with mild cognitive deficits report sexual abuse with positive responses. In other words, people with mild level of cognitive deficit might appear "normal" and more capable of consenting to sexual contact whereas people with moderate levels of cognitive deficit appear more obviously disabled. This in turn results in a more prompt response to their claims of sexual assault by caregivers and reporting authorities e.g. police.

5.1.8. Cognitive deficit and Adaptive functioning: The extent of the deficit in intellectual functioning, when estimated by the ISGSA (IQ- test) is categorized in the same taxonomy as the deficit in adaptive functioning, estimated by the Vinelands Maturity Scale. The distribution for the degree of cognitive deficit found in the sample in terms of intellectual functioning was as follows: mild cognitive deficit (22.8%); moderate cognitive deficit (28.5%), and severe cognitive deficit (19.4%). The distribution for the degree of cognitive deficit found in the sample in terms of adaptive functioning was as follows: mild cognitive deficit (6.3%); moderate cognitive deficit (28.5%), and severe cognitive deficit (48.6%).

It becomes evident that the estimates of deficits provided by measures of intellectual functioning vary from that provided by measures of adaptive functioning. Measures of intellectual functioning are useful since it helps to inform the diagnostic process by providing an IQ score that has to fall below 70 points as a criterion for making the diagnosis of Cognitive Deficit. Measures of adaptive functioning, however, provide a more three dimensional picture of the person with cognitive deficit, as estimated by an IQ score, in terms of overall adaptive functioning, but also adaptive domains discussed earlier. Thus the apparent contradiction in the estimates of cognitive deficit is more a function of the extent o which measures are more dimensional and nuanced. In other words, the deficit estimate provided by adaptive functioning gives a more accurate description of what the person is capable of whereas the IQ score merely indicates gross functions and overall diagnosic status.

5.1.9. Nature of sexual crime: Sexual rimes reported by participants I nthis sample included rape, sodomy, oral sex, and masturbation. The majority of the sample (93.8%) indicated that they had been raped. This incidence matches the gender distribution of the sample with 93.7% being female participants. The definition of rape legally only makes provision for the crime being perpetrated on women by men. Thus male on male crimes of forced, non-consensual penetration are categorized as sodomy. One male participant reported being raped by a female caregiver where he was forced to perform sexual intercourse while being held down. The definition of rape needs to be widened to enable more such cases to be reported, as well as appropriate advocacy and education to destigmatize the report of female on male forced sexual intercourse. See Tyler and Cauce, (2002) for a review of factors that contribute to the underreporting of sexual crimes by male victims.

Sodomy was reported by 11.8% of the complainants regardless of gender. Male participants reported the higher incidence of sodomy (6.3%). 5.5% of female participants were sodomised. Female participants reported sodomy occurring in addition to rape, and in a few cases occurring independently of any other sexual crime. Only two complainants (1.4%) reported being forced to perform oral sex or having oral sex performed on them. Masturbation was reported by 5.6% of the complainants. The extant literature focuses on

rape and does not generally report on the incidence of other sexual crimes, such as masturbation and oral sex.

5.1.10. Number of perpetrators: The majority of complainants (86.1%) reported being assailed by a single perpetrator. Two perpetrators were present for 9% of the complainants whilst 3.5% of the complainants reported that there were three perpetrators. One complainant (0.7%) reported being attacked by five perpetrators another complainant (0.7%) claimed to have seven perpetrators present during the alleged rape. From these results it may be inferred that the trend for the number of perpetrators present during the alleged rape seems to be one perpetrator that is consistent with Kvam's (2004) assertion that disabled people are more often abused by a single offender from within the family or the circle of acquaintances. This indicates single perpetrator accounts rather than more than one perpetrator involved. Furey's (1994) review of the literature suggests that individuals with a cognitive deficit, in particular mental retardation, may be particularly at risk for abuse by caregivers and acquaintances, rather than strangers supporting the finding that a single perpetrator commits the crime.

5.1.11. Crime scene: The majority (39.4%) of sexual crimes perpetrated against this sample occurred outside the neighbourhood of the complainants' home or distant from the complainants' home. This would include in transit, in daycare facilities, in the woods etc. 31.3% of the sexual crimes perpetrated against this sample occurred in the complainants' residential neighbourhood. 28.5% of the complainants claimed that the rape occurred inside or nearby (in the same street) the complainant's home. These estimates concur with Kvam (2004) description of the contexts or places where sexual crimes are likely o be committed against disabled victims.

5.2 Research question 2

The second research question determined whether there are significant differences in sexual knowledge between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:

g) body part vocabulary
h) conception
i) contraception
j) sexually transmitted diseases
k) overall sexual comprehension
l) ability to consent to sexual intercourse

From the results it becomes evident that significant differences were found in sexual knowledge ($p < .000$) in terms of body part vocabulary ($F = 11.494$), conception ($F= 7.499$), contraception ($F= 5.483$), sexually transmitted diseases ($F= 8.622$), and overall sexual comprehension ($F= 5.490$). However there were no significant differences in terms of ability to consent to sexual intercourse ($F = .826$, $p = .511$). The specific results are discussed below:

A significant inverse correlation between body part vocabulary and degree of cognitive deficit was found. In other words, participants with higher degrees of cognitive deficit had increasingly smaller body part vocabularies. The group with the lowest mean for body part vocabulary, indicating that there is a better vocabulary of body parts, was for the participants diagnosed with a mild cognitive deficit. The group with the highest mean for body part vocabulary, this indicating a lower vocabulary of body parts, was for the participants diagnosed with a severe cognitive deficit.

A significant inverse correlation between knowledge of conception and degree of cognitive deficit was found. In other words, participants with higher degrees of cognitive deficit had increasingly less knowledge of conception. The group with the lowest mean for knowledge of conception, indicating that there is a better knowledge of conception, was for the participants diagnosed with a mild cognitive deficit. The group with the highest mean for knowledge of conception, this indicating a lower knowledge of conception, was for the participants diagnosed with a severe cognitive deficit.

A significant inverse correlation between knowledge of contraception and degree of cognitive deficit was found. In other words, participants with higher degrees of cognitive deficit had increasingly less knowledge of contraception. The group with the lowest mean for knowledge of contraception, this indicating that there is a better knowledge of contraception, was for the participants diagnosed with a mild cognitive

deficit. The group with the highest mean for knowledge of contraception, indicating no knowledge of contraception, was for the participants diagnosed with a severe cognitive deficit.

A significant inverse correlation between knowledge of sexually transmitted diseases and degree of cognitive deficit was found. In other words, participants with higher degrees of cognitive deficit had increasingly less knowledge of sexually transmitted diseases. The group with the lowest mean for knowledge of sexually transmitted diseases, indicating that there is a better knowledge of sexually transmitted diseases, was for the participants diagnosed with a mild cognitive deficit. The group with the highest mean for knowledge of sexually transmitted diseases, this indicating no knowledge of sexually transmitted diseases, was for the participants diagnosed with a severe cognitive deficit.

A significant inverse correlation between overall sexual comprehension and degree of cognitive deficit was found. In other words, participants with higher degrees of cognitive deficit had increasingly lower sexual comprehension. The group with the lowest mean for sexual comprehension, this indicating that there is an adequate/good vocabulary for sexual comprehension, was for the participants diagnosed with a mild cognitive deficit. The group with the highest mean for sexual comprehension, indicating a lower vocabulary of sexual comprehension, was for the participants diagnosed with a severe cognitive deficit.

As anticipated, the findings indicated a decrease in sexual knowledge with an increase in the extent of cognitive deficit. This inverse relationship concurs with Tharinger et al., (1990) who cited impoverished sexual knowledge as a risk factor for sexual abuse. In addition to the limitations in cognitive processing, individual risk factors e.g. a lack of sex education, lifelong physical and emotional dependence on adults, impaired verbal and social abilities, and a lack of knowledge on sexual abuse preventive skills, further increase the vulnerability of people with cognitive deficit to sexual victimization. Tang and Lee (1999) stated that people with mental retardation are often sexually stigmatized and perceived as asexual, sexually incompetent, or possessing uncontrollable libido and perverted sexual habits. This makes them a target for sexual abuse as they do not have knowledge regarding sexual matters and they are not viewed as

sexual beings, so it is easily kept secret by the perpetrators and the mentally retarded individuals.

No significant difference was found in terms of the ability to consent to sexual interactions between the groups of varying cognitive deficits. The null finding is a very important finding as this indicates that persons with cognitive deficit are unable to consent to sexual intercourse regardless of the extent of cognitive deficit and the significant differences in sexual knowledge discussed above. The criteria for diagnosing a person with mental retardation includes significantly subaverage intellectual functioning with concurrent deficits in adaptive functioning (American Psychiatric Association, 2000). This inherently means for people with a cognitive deficit, their cognitive processes and reasoning capabilities are limited. Linked to this are the ISGSA age equivalents which range from the age of 1 to 12 years of age. This means that all of the complainants have the intellectual capabilities, in terms of ability to consent to sexual intercourse, of a minor. It is considered legal for a person to consent to sexual intercourse from the age of 16, yet all the complainants function intellectually below this age. Therefore sexual knowledge does not influence one's ability to consent to sexual abuse but rather the intellectual age equivalent that one functions at. The older a person gets, in terms of intellectual age equivalent, the better a person's reasoning and judgment becomes and their ability to consent to sexual intercourse increases. This is not so for the complainants as they all have the intellectual abilities of a minor.

In short, the null finding negates the assumption that people with mild cognitive deficits are more capable to negotiate sexual interactions. If in fact, there is no significant difference (practically or statistically), and the null finding in terms of ability to consent to sexual intercourse holds true, then by definition sexual interactions between a person diagnosed with cognitive deficit and a person of normal intellectual functioning might be construed in the same way as sex with a minor. An inference to this effect, however, is beyond the scope of this thesis and should be tested further empirically with larger and more heterogenous samples.

5.3 Research question 3

The third research question tested for significant differences in competence as witness between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:

a) competence as witness
b) understanding the purpose of court proceedings
c) ability to provide consistent account of the alleged rape
d) whether court preparation is needed
e) ability to answer clarifying questions
f) whether an intermediary is needed

From the results it becomes evident that significant differences were found in competence as witness (p <.000)in terms of competence as witness (F= 8.106); understanding of court proceedings (F= 15.908); whether court preparation is needed (F= 6.290); and the ability to answer clarifying questions (F= 9.783). Significant differences were also found in terms of the ability to provide a consistent account of the alleged rape (F= 4.842, p < 001), as well as whether participants would require an intermediary to assist during trial (F= 2.922, p < .05). The specific results are discussed below:

The significant differences in competence as witness between varying degrees of cognitive deficit manifested as follows: Participants with higher degrees of cognitive deficit had increasingly lower abilities to act as a competent witness. Participants diagnosed with mild cognitive deficit were significantly more competent as witnesses than participants diagnosed with moderate cognitive deficit. The latter in turn were significantly more competent as witnesses than participants diagnosed with severe cognitive deficit.

The significant differences in understanding the purpose of court proceedings between varying degrees of cognitive deficit manifested as follows: Participants with higher degrees of cognitive deficit had increasingly less understanding of the purpose of court proceedings. Participants diagnosed with mild cognitive deficit possessed a significantly greater understanding of the purpose of court proceedings than participants diagnosed with moderate cognitive deficit. The latter in turn possessed a significantly

greater understanding of the purpose of court proceedings than participants diagnosed with severe cognitive deficit.

The significant differences in needing court preparation between varying degrees of cognitive deficit manifested as follows: Participants with higher degrees of cognitive deficit had increasingly less need for court preparation. Participants diagnosed with mild cognitive deficit needed significantly less court preparation than participants diagnosed with moderate cognitive deficit. The latter in turn needed significantly less court preparation than participants diagnosed with severe cognitive deficit.

The significant differences in the ability to give a consistent account of the alleged sexual crime between varying degrees of cognitive deficit manifested as follows: Participants with higher degrees of cognitive deficit had increasingly less ability to give a consistent account of the alleged rape. Participants diagnosed with mild cognitive deficit were significantly more capable of giving a consistent account of the alleged sexual crime than participants diagnosed with moderate cognitive deficit. The latter in turn were significantly more capable of giving a consistent account of the alleged sexual crime than participants diagnosed with severe cognitive deficit.

The significant differences in the ability to answer clarifying questions between varying degrees of cognitive deficit manifested as follows: Participants with higher degrees of cognitive deficit had increasingly less ability to answer clarifying questions. Participants diagnosed with mild cognitive deficit were significantly more capable of answering clarifying questions than participants diagnosed with moderate cognitive deficit. The latter in turn were significantly more capable of answering clarifying questions than participants diagnosed with severe cognitive deficit.

The significant differences in the need for an intermediary between varying degrees of cognitive deficit manifested as follows: Participants with higher degrees of cognitive deficit had increasingly less need for an intermediary. Participants with higher degrees of cognitive deficit had increasingly less ability to answer clarifying questions. Participants diagnosed with severe cognitive deficit had a significantly greater need for an intermediary than participants diagnosed with moderate cognitive deficit. The latter in turn had a significantly greater need for an intermediary than participants diagnosed with mild cognitive deficit.

The findings indicated a decrease in competence as a witness with an increase in the extent of cognitive deficit. This finding concurs with Cooke and Davies (2001) as they stated that assessing people with a cognitive deficit to determine if they will be competent to act as a witness is challenging, as people with cognitive deficits rarely appear as witnesses in court. Kebbell and Hatton (1999) stated this is especially challenging when the person with a cognitive deficit is the victim of sexual abuse and/or are the sole witness against the accused. Historically, justice systems and particularly the criminal justice system, have regarded people with a cognitive deficit as unreliable witnesses. Perlman et al. (1994) said that it has been believed that their memory systems are inherently defective, and therefore, it has been assumed that they are susceptible to suggestion and lack the skills to accurately report the events that took place. Recalling information, in other words remembering, can often be difficult for people with a cognitive deficit because they tend to take longer to encode, understand and store information than their peers in the general population (Bull, 1995). Milne and Bull (1999) said that this influences the reliability of a witness with a cognitive deficit to be able to give an accurate and consistent account of the alleged rape. As a consequence, people with a cognitive deficit may have incomplete free recall abilities. Thus in short, people with cognitive deficits are not readily seen to be competent witnesses, and the findings of the present study indicate that their competence as a witness decreases with incremental cognitive deficit.

5.4 Research question 4

The fourth research question tested whether there were significant differences in adaptive functioning between complainants with mild, moderate, severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:

e) communication skills
f) daily living skills
g) socialization skills
h) overall adaptive functioning

It becomes evident from the results that there were no significant differences found in adaptive functioning in terms of communication skills (F= .996, p = .413), daily living skills (F= .749, p = .561) and overall adaptive functioning (F= 1.644, p = .168) between the varying levels of cognitive deficit.

From the results it becomes evident that a significant difference in adaptive functioning was found in terms of socialisation skills (F= 3.758, p < .01). The significant differences in socialization skills between varying degrees of cognitive deficit manifested as follows Participants with higher degrees of cognitive deficit had increasingly lower socialisation skills. Participants diagnosed with mild cognitive deficit had significantly more adept in social skills than participants diagnosed with moderate cognitive deficit. The latter in turn were significantly more adept in social skills than participants diagnosed with severe cognitive deficit.

The findings indicate a significant difference in the social skills domain of adaptive functioning between the levels of cognitive deficit. Adaptive functioning refers to how effectively individuals cope with ordinary life demands and how capable they are of living independently and abiding by community standards. The diagnosis of Cognitive Deficit (Mental Retardation) is defined as significantly subaverage general intellectual functioning (having an IQ of 70 or less) resulting in, or associated with, concurrent impairment in adaptive behaviour and manifested during the developmental period, before the age of 18 (APA, 2000). Thus impairments in adaptive functioning is a prerequisite for the diagnosis of cognitive deficit. The findings of the present study illustrate the differential skills level in the social domain for people with cognitive deficit.

The significantly varying degree in this domain is supported by the extant literature. Mash and Wolfe (2002) pointed out that in the social domain children with mild mental retardation typically develop social and communication skills later in the preschool years, perhaps with modest delays in expressive language. These authors emphasized that development in the social domain is delayed and modest rather than gross and absent during children with mild cognitive deficits. Louw (2000) asserted that individuals with moderate cognitive deficits are are more adaptively impaired. With regard to socialisation skills, people with moderate mental retardation have difficulties in recognising social conventions, such as appropriate dress or humour.

Sadock & Sadock (2003) stated that people with severe mental retardation have poor adaptive skills. Communication skills are largely handicapped for persons with severe mental retardation as they tend to communicate in three word phrases. This affects the socialisation skills of people with severe cognitive deficits as they can understand speech but have considerable difficulty expressing themselves. People with severe mental retardation are unable to live independently in the community; they do need to live in a group home or with their families so as to provide them with assistance and care. The theorized differences in adaptive functioning, specifically socialization postulated by Louw (2000), Mash and Wolfe (2002), and Sadock and Sadock (2003) have empirically been validated by the findings of the present study.

However, the theorized differences postulated by Louw (2000); Mash and Wolfe (2002), and Sadock and Sadock (2003) in overall adaptive functioning, specifically in the communication and daily skills domains were not empirically supported. Differences. However, the scores obtained on the skills in the various adaptive domains is clinically less useful than the age equivalents for these domains. Let us consider the hypothesized differences in age equivalents postulated in the fifth research question.

5.5 Research question 5

The fifth research question tested whether there were significant differences in age equivalents in adaptive functioning between complainants with mild, moderate,

severe, borderline mild to moderate and borderline moderate to severe mental retardation in terms of:

d) communication skills age equivalent
e) daily living skills age equivalent
f) socialization skills age equivalent

From the results it becomes evident that significant differences were found in adaptive functioning age equivalents ($p < .000$) in terms of communication skills age equivalent ($F = 41.430$); daily living skills age equivalent ($F = 19.348$) and socialisation skills age equivalent ($F = 19.410$). The specific results are discussed below:

The findings indicate a significant difference in the age equivalents for the communication skills domain of adaptive functioning between the levels of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly lower age equivalents for communication skills. Participants diagnosed with mild cognitive deficit had a significantly higher age equivalent in communication skills than participants diagnosed with moderate cognitive deficit. The latter in turn had a significantly higher age equivalent in communication skills than participants diagnosed with severe cognitive deficit.

The findings indicate a significant difference in the age equivalents for the daily living skills domain of adaptive functioning between the levels of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly lower age equivalents for daily living skills. Participants diagnosed with mild cognitive deficit had a significantly higher age equivalent in daily living skills than participants diagnosed with moderate cognitive deficit. The latter in turn had a significantly higher age equivalent in daily living skills than participants diagnosed with severe cognitive deficit.

The findings indicate a significant difference in the age equivalents for the socialisation skills domain of adaptive functioning between the levels of cognitive deficit. In other words, participants with higher degrees of cognitive deficit had increasingly lower age equivalents for social skill. Participants diagnosed with mild cognitive deficit had a significantly higher age equivalent in socialisation skills than participants diagnosed with moderate cognitive deficit. The latter in turn had a significantly higher

age equivalent in socialisation skills than participants diagnosed with severe cognitive deficit.

The findings indicated a decrease in age equivalents for all adaptive functioning domains with a corresponding increase in the extent of cognitive deficit. As mentioned before, Louw (2000), Mash and Wolfe (2002), and Sadock and Sadock (2003) postulated that there would be significant differences in all domains of adaptive functioning. The findings of the present study, in terms of age equivalents for all domains, empirically supported the theorized differences in adaptive functioning. Thus as a group, people with mild cognitive deficit will have higher age equivalents for adaptive functioning compared to people with moderate and severe cognitive deficit. Louw (2000) stated that individuals with moderate cognitive deficit are more adaptively impaired. Communication is usually handicapped as communication may be done through single words and gestures, that similar to the average two year old; however at adulthood communication is better. For daily living skills, people with moderate cognitive deficit usually require supportive assistance. With regard to socialisation skills, people with moderate cognitive deficit have difficulties in recognising social conventions, such as appropriate dress or humour. Thus as a group, people with moderate cognitive deficit will have lower age equivalents for adaptive functioning than people with mild cognitive deficit but higher age equivalents for adaptive functioning than people with severe cognitive deficit. Sadock & Sadock (2003) stated that people with severe cognitive deficit have poor adaptive skills. Communication skills are largely handicapped for persons with severe cognitive deficit as they tend to communicate in three word phrases. In terms of daily living skills, people with severe cognitive deficit may be able to perform simple tasks in closely supervised settings. People with severe cognitive deficit are unable to live successfully in the community independently; they do need to live in a group home or with their families so as to provide them with assistance and care. Thus as a group, people with severe cognitive deficit will have lower age equivalents for adaptive functioning compared to people with mild and moderate cognitive deficit.

5.6 Conclusion

Sexual abuse of individuals with cognitive deficits appears to be an extremely prevalent problem in contemporary society (Pillay & Sargent, 2000). Although it appears that many cases go unreported and remain unknown to everyone other than the victim and the perpetrator (Ryerson, 1981), reported rates of sexual abuse of children with cognitive deficits and sexual assault of adults with cognitive deficits are high (Sobersey & Varnhagen, 1990). The Sexual Abuse Victim Empowerment programme (SAVE) at Cape Mental Health Society (CMH) offers mental health services to indigent people living in the community in Cape Town with intellectual disabilities. It is a specialized programme that offers assistance to those with cognitive deficits to gain redress for the sexual abuse committed against them which, would be otherwise impossible for this population to accomplish on their own due to their cognitive handicap.

The demographic profile of the complainants making use of the services rendered in the SAVE programme was compiled. The service users were mainly female between the ages of 12 and 22 years. Most complainants are referred to the SAVE programme by the sexual offences court. It is mostly a parent who assists the complainant by acting as the informant on behalf of the complainant in delivering the account of the sexual abuse to the staff members part of the SAVE programme. The perpetrator is usually someone known to the complainant and the sexual abuse generally took place further from the complainant's home or in the complainant's home. There was mostly only one perpetrator involved in performing the sexual abuse. Most complainants have an ISGSA score which states that they have moderate mental retardation with an average age equivalent of 6 years of age. For overall adaptive functioning, most complainants functioned at a severe level of cognitive deficit. For communication skills the average complainant functions at a severe level of cognitive deficit with an age equivalent of 4 years of age. For daily living skills most complainants function at a severe level of cognitive deficit with an age equivalent of between 3 to 4 years of age. For socialisation skills most complainants function at a severe level of cognitive deficit with an age equivalent of 4 years of age. Rape and sodomy were the most frequent forms of sexual abuse.

There were significant differences in sexual knowledge, specifically in terms of body part vocabulary, conception, contraception, sexually transmitted diseases and overall sexual comprehension, between the varying levels of cognitive deficit. However there were no significant differences in terms of the ability to consent to sexual intercourse.

Significant differences in competence as witness, in terms of competence as witness, understanding of court proceedings, ability to provide a consistent account of the alleged rape, whether court preparation is needed, the ability to answer clarifying questions, and needing an intermediary, were found between the varying levels of cognitive deficit.

Significant differences were found in terms of socialisation skills between the varying levels of cognitive deficit suggesting that participants with higher degrees of cognitive deficit had increasingly lower socialisation skills. No significant differences were found between the different levels of cognitive deficit for adaptive functioning in terms of communication skills, daily living skills and overall adaptive functioning. However, significant differences were found in the age equivalents between the varying levels of cognitive deficits in terms of socialisation skills, communication skills, daily living skills and overall adaptive functioning. These findings empirically supported the theorized differences in adaptive functioning postulated in the extant literature.

In short, the findings of the study suggest that

- Despite the general belief that people with cognitive deficit are not competent witnesses, there is a gradation of competence that varies significantly among the various levels of cognitive deficit.
- There are significant variations in sexual knowledge in relation to the various levels of cognitive deficit.
- People with cognitive handicap are not able to consent to sexual interaction regardless of the level of cognitive deficit since they are the level of their intellectual and adaptive functioning is such that they have age equivalents of minors. Thus the legal status of all people with cognitive deficit should be revisited, as opposed to the current legislation

that defines sexual intercourse with anyone who has an IQ score less than 50 as statutory rape.

5.7 Limitations of the study

The study was restricted in terms of access to complainants registered with CMH. After many meetings with the staff at CMH it was concluded that due to the fact that the population under study is a triple vulnerable population, as the complainants 1) have mental retardation; 2) are sexually abused and 3) may have another psychiatric diagnosis, the researcher was allowed no access what so ever to the complainants. It was decided that the researcher may only have access to the complainant's case files and the staff members working at CMH.

A limitation includes the data. Since the only access to the complainants was through their case files, information was limited by the extent to which archived case files were comprehensive and complete. For example, case files did not consistently contain information about the ethnicity and socioeconomic status of participants that limits generalization to the population of people with mental retardation.

The sample consisted of 144 participants and the distribution of complainants with mild, moderate and severe mental retardation was not equal. The levels of significance could have been affected by this.

5.8 Recommendations for future study

For future studies carrying out research focusing on the narrow band population of people with mental retardation who have been sexually abused, ensure that total access is allowed to the participants and there families to gain as much information as possible that could be lacking in the participant's case files. Since this is an extremely vulnerable population make sure to follow the ethical standards by ensuring strict and total confidentiality.

In collecting demographic details about the participants in the sample, be sure to include the participant's ethnicity, race and socioeconomic status. South Africa is a multicultural nation with many different people of many different ethnic backgrounds and races. South Africa too has a spread of different people with different socioeconomic backgrounds. There are people living in South Africa under conditions of dire poverty through to some of the wealthiest and most powerful people in the world. This would make for a good comparative study to research the incidences of sexual abuse among people with mental retardation living in the different socioeconomic status classes.

If completing a study on people with mental retardation who have been sexually abused, ensure the distribution of people with mild, moderate and severe mental retardation is equal. Thus having equal numbers of participants with mild, moderate and severe mental retardation will allow for better generalisation to the population of people with mental retardation.

5.9 Significance of the study

- The study provided a demographic profile of the complainants included in the SAVE programme. This has given frequency distributions and descriptive statistics of the various variables that were included for creating the demographic profile. This profile may contribute directly to the literature in describing the population of people with mental retardation who are sexually abused. The profile is inclusive and comprehensive which may give needed information to the literature where it may be lacking. This profile covered a large area of information.
- The study carefully operationalized the key variables as they are used in forensic investigation and evaluation. Thus the findings of the study will be in a format that will expedite the consumption of the findings of the study.
- The study explored the relationship between adaptive functioning and intellectual functioning as the criteria for the diagnosis of cognitive deficit,

and provide useful insights that might inform policy and forensic, expert testimony in cases of sexual abuse among the cognitively deficient.

- The study provided useful statistics for staff working at Cape Mental Health, specifically in the SAVE programme that can be used for advocacy, fundraising and psycho-education.

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APPENDICES

APPENDIX A

CODE SHEET

COLUMN NO.	COLUMN NAME	CODE NO.	CODE NAME
A	Name		
B	Gender	1 2	Female Male
C	Date of birth		
D	Date of assessment		
E	Age at assessment		
F	Referred by	1 2 3 4	Sexual offences court CMH SAPS Rape crisis & child and family welfare
G	Informant	0 1 2 3 4 5 6	Unknown Parent Sibling Extended family member Guardian Other Self
H	Relationship to perpetrator	0 1 2 3 4 5 6	Unknown Nuclear family member Extended family member Friend Care giver Acquaintance Step relative & live-in

			boyfriend
		7	Neighbor
		8	Landlord
		9	Pastor
I	Communication (Vineland subscale 1)	0	Not administered
		1	Mild
		2	Moderate
		3	Severe
		4	Borderline mild
		5	Borderline moderate
		6	Borderline
		7	Average
J	Communication age equivalence		
K	Daily living (Vineland subscale 2)	0	Not administered
		1	Mild
		2	Moderate
		3	Severe
		4	Borderline mild
		5	Borderline moderate
		6	Borderline
		7	Average
L	Daily living age equivalence		
M	Socialization (Vineland subscale 3)	0	Not administered
		1	Mild
		2	Moderate
		3	Severe
		4	Borderline mild
		5	Borderline moderate
		6	Borderline
		7	Average
N	Socialization age equivalence		

O	Adaptive behaviour composite score	0	Not administered
		1	Mild
		2	Moderate
		3	Severe
		4	Borderline mild
		5	Borderline moderate
		6	Borderline
		7	Average
P	ISGSA IQ	0	Not administered
		1	Mild
		2	Moderate
		3	Severe
		4	Borderline mild
		5	Borderline moderate
		6	Borderline
		7	Average
Q	ISGSA age equivalent		
R	Body parts	1	Yes
		2	No
S	Conception	1	Yes
		2	No
T	Contraception	1	Yes
		2	No
U	Sexually transmitted diseases	1	Yes
		2	No
V	Sexual comprehension	1	Basic
		2	Adequate
		3	Good
		4	Insufficient
W	Sexual consent	1	Yes
		2	No

		3 4	Not stated Minor
X	Competence as witness	1 2	Yes No
Y	Understanding of purpose and procedures of the court	1 2	Yes No
Z	Court preparation	1 2	Yes No
AA	Consistent account of rape	1 2	Yes No
AB	Ability to answer clarifying questions	1 2	Yes No
AC	Intermediary needed	1 2	Yes No
AD	Mental illness (according to the mental health act, sec 1, act 18 of 1973	1 2	Yes No
AE	Rape	1 2	Yes No
AF	Sodomy	1 2	Yes No
AG	Oral sex	1 2	Yes No
AH	Masturbation	1 2	Yes No
AI	Number of perpetrators		
AJ	Proximity	1 2 3	Nearby/ close Intermediary Distant
AK	Co-morbidity		

AL	Raw ISGSA score		
AM	SA score		