

Annotation: The Abuse of Disabled Children¹

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Abbreviations: CPS: Child Protection Service.

Introduction

Open almost any recent social work magazine, or child protection text, and some reference to the abuse of disabled children will be included. Yet awareness of abuse within this group has resulted from a relatively recent growth of interest on the part of psychologists and social work and child protection professionals. Previously, sociocultural and political factors contributed to an otherwise muted response to research dating back to the 1960s, which clearly documents abuse of children who have an impairment or “developmental disability” of some kind. Reviewing this research reveals as much about society’s reaction to disability and to disabled children, as it does about the abuse itself. This Annotation presents research in relation to three issues: (1) prevalence of abuse of disabled children; (2) responding to abuse; and (3) preventing abuse.

Prevalence of Abuse of Disabled Children—A Chronology

Early Research

Birrell and Birrell (1968) examined the nursing and social work records of 42 children under 3 years who were the victims of abuse and/or neglect. They also had personal experience of some cases. Birrell and Birrell

found “congenital anomalies” in over 25% of the children, and also noted that 10 children (24%) had marked “retardation” as a result of abuse. Johnson and Morse (1968) studied the case records of 101 children under the age of 14 years who had been physically abused or neglected, noting that nearly 70% showed “physical or developmental disability” before the injury was reported. Sixteen per cent of children had a physical or learning impairment as a result of the abuse.

Such early studies typify much of the research that has succeeded them in later years. Most notably, researchers have generally focused on small samples (usually very specific groups) of children: either examining disability in abused children (as above), or abuse in disabled children, rarely including control or comparison groups. Studies have relied heavily on medical records or expert opinion; “disability” and “abuse” are frequently poorly defined, and there are inconsistencies across studies in terms of definitions. Further, most research is American, fails to address racial and cultural issues, and fails to include disabled people themselves in either commissioning or carrying out the research (see critiques by Kelly, 1992; Westcott, 1991a; Westcott & Cross, 1996).

These are not simply methodological oversights; they reflect the prevailing social and political attitudes towards disability and child abuse. That is, until the 1980s, child abuse was conceptualised as physical injury or physical neglect of a child, and disability was predominantly viewed as a medical, and individual, problem—hence most early studies sample abused, not disabled, children.

The remainder of this section reviews research over the last three decades. Major studies are tabulated, retaining authors’ own terminology throughout.

Research in the 1970s

Through the 1970s, with few exceptions, prevalence was studied not of abuse amongst disabled children, but of disability or impairments amongst abused children (see Table 1). Study samples in this period were predominantly American and focused on physically abused and neglected children. Sandgrund, Gaines, and Green (1974) were among the first explicitly to question the

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¹ Throughout this paper the term “disabled children” is used in preference to the term “children with disabilities”. This reflects our support for the social model of disability (e.g. Swain, Finkelstein, French, & Oliver, 1993), which distinguishes between the child’s bodily “impairment” and their experience of “disability”. The latter stems from social factors such as prejudice and discrimination against people who have impairments, which is exemplified, for example, in unequal and inadequate access to facilities, services, and employment. Further, in using this terminology, we view the child’s impairment as an integral part of their identity, not something separate or “additional” to their identity as a child.

Table 1
Research in the 1970s

| Study | Sample | Data source | Control ^a | Results |
|---|--|--|----------------------|--|
| Gil (1970) | 12,610 American children > 15 years, victims of physical abuse and neglect | Survey | No | 22% children deviations in physical or mental functioning |
| Morse, Sahler, & Friedman (1970) | 25 physically abused and neglected American children aged 2–8 years | Family interviews, agency contacts, parent records | No | 1. Only 29% children judged to be within normal intellectual and emotional limits 2. 8 of 9 learning disabled children were disabled prior to abuse |
| Lebsack (in Soeffing, 1975) | 14,083 abused and neglected American children | Home interviews | No | 2% children learning disabled, 2% physically disabled, and 1% with a physical abnormality |
| Martin, Beezley, Conway, & Kempe (1974) | 37 American abused children with no history of head trauma | Psychological testing, observation and parent interviews | No | 43% children slight to severe neurological dysfunction |
| Sandgrund, Gaines, & Green (1974) | 60 abused, 30 neglected and 30 nonabused American children aged 5–13 years | Psychological and psychiatric interviews | Yes | Significant differences in IQ between three groups of children: 25% abused, 20% neglected, and 3% nonabused children IQ below 70 |
| Kline (1977) | 138 abused and neglected American children | Case records | No | Abuse possible cause of retardation noted in 11% sample |
| Eppler & Brown (1977) | 436 retarded American children | Clinical records | No | 1. 65 (15%) children had been abused or neglected 2. For 6% children strong suggestive evidence abuse/neglect caused retardation |
| Buchanan & Oliver (1977) | 140 mildly to profoundly handicapped hospitalised English children, aged under 16 years | Medical and social work records, clinical assessments | No | 1. 22% children physically abused 2. 10% children at risk of abuse 3. 11% children could have been disabled by abuse |
| Glaser & Bentovim (1979) | 174 English children under 10 years, chronically sick or physically or learning disabled | Medical records | Yes | 46% disabled children abused compared to 75% nondisabled children |

^a Presence of control or comparison group.

All tables developed from Westcott (1991a) and Westcott and Cross (1996).

For clarity, principal findings related to prevalence only are reported in the tables.

nature of the abuse–disability relationship, although they eventually concluded that they were unable to distinguish the precise number of children for whom abuse was the definite cause of impairment. Kline (1977) came to similar conclusions about the difficulty in pinpointing the direction of the abuse–disability relationship.

Physical injury or neglect may cause impairments or injuries of a temporary or permanent nature in the child. Sexual abuse, particularly incest, may lead to increased risks of mortality, morbidity, genetically linked conditions, and/or learning impairment (“mental handicap”; Jancar & Johnston, 1990). Abuse may also compound preexisting impairments or medical conditions. Alternatively, existing impairments may make children more vulnerable to abuse, for reasons discussed later in this Annotation. As Kelly (1992) has noted, a large-scale,

longitudinal, prospective tracking study, using clear definitions of abuse and impairment, is required to “unpick” in detail the “connections” between abuse and childhood impairments.

In the first well-cited abuse prevalence study with a sample of disabled children, Eppler and Brown (1977) reported on the records of American retarded children. Two U.K. studies in this period supported this change of sampling emphasis, with Buchanan and Oliver (1977) and Glaser and Bentovim (1979) examining the records of disabled or sick children.

Research in the 1980s

The 1980s saw a continuing growth of studies in this area, as shown in Table 2. In contrast to the 1970s, most

studies in this period were concerned with prevalence of abuse (not disability), and a wider range of populations was sampled. Also, an increasing variety of methodologies (e.g. interviews, questionnaires) was employed rather than just relying on case records.

In one of the first studies to document sexual abuse of disabled children, Welbourne, Lipschitz, Selvin, and Green (1983) interviewed blind women, eliciting their experiences. From this point onwards, sexual abuse of disabled children became a significant issue in the reported literature. Jaudes and Diamond (1985), for example, studied abuse of children who had cerebral palsy, this time including three cases of sexual abuse in their prevalence figure for physical abuse. This awareness of the sexual abuse of disabled children coincided with growing public and professional recognition of the issue—including, in the U.K., the launch of ChildLine in 1986, and the addition of “sexual abuse” as a category on child protection registers in 1988 (Creighton, 1992).

In a further important development, Sullivan, Vernon, and Scanlan (1987) published an account of sexual abuse of deaf children in residential schools, highlighting the vulnerability of disabled children cared for away from home (see Morris, 1995, 1998a, b; Utting, Baines, Stuart, Rowlands, & Vialva, 1997). Institutional abuse is now regarded by many as a risk factor, in itself, for abuse for all children (e.g. Westcott, 1991b). A number of cases have involved the abuse of disabled children, e.g. *Scotforth House*, where autistic children were subjected to a harsh and punitive regime, especially concerning meal-times (Howlin & Clements, 1995; Smith, 1992). The continuing vulnerability of adults with learning disabilities to abuse in institutional and community care has also been highlighted (e.g. Turk & Brown, 1992; Westcott, 1993).

Research in the 1990s

In 1989 Kennedy published a survey of teachers and social workers for the deaf. Although a small study, this research was to catalyse U.K. policy and practice initiatives to protect disabled children from abuse. Other small but important British research studies resulting from such initiatives also appeared in the 1990s. A seminal American publication by Crosse, Kaye, and Ratnofsky (1993) addressed many of the methodological criticisms of earlier work, and provided *incidence* data to demonstrate the increased risk of abuse to disabled compared to nondisabled children (see Table 3). Data were collected from 35 Child Protection Service (CPS) agencies statistically selected to be nationally representative. Each agency provided information on all substantiated cases of child abuse within a 4–6 week period in early 1991. A total of 1834 children involved in 1249 cases were included. Among the methodological improvements in this research were prospective data collection from a large number of cases in a national sample, comparison of disabled and nondisabled children in the same sample, stated definitions of abuse and disability (impairment), and analysis of the abuse–impairment relationship. The study’s limitations include a reliance on Child Protection Service workers’ assessment of impairments, an under-

representation of children cared for in residential settings, and consideration only of abuse reported to CPS agencies.

An impressive large-scale study by Sullivan supported the findings of Crosse et al. (1993) (Sullivan & Knutson, 1998; Sullivan, Knutson, Scanlan, & Cork, 1997). An electronic merger of databases comprising hospital, central registry, foster care, and law enforcement records was used to identify unduplicated records of child abuse among all child patients of one particular hospital in Nebraska. Three computerised random samples were drawn from the data mergers: 2209 children with a record of abuse in one or more of the above agencies, 792 children from the hospital sample in residential care, and 880 control children who had no record of abuse in any of the agencies. This study, although archival and retrospective, builds on the strengths of Crosse et al. (1993), and overcomes some of the earlier study’s limitations: it used professional diagnoses of impairments rather than assessments by CPS workers, it included extra- as well as intra-familial cases of abuse, and it utilised reports of abuse made to different authorities and agencies.

The different studies described in Table 3 have raised questions that go beyond providing prevalence estimates. Newport (1991), for example, carefully considered definitions of abuse *with specific reference to children who are disabled*, raising awareness of how estimates based on definitions from work only with nondisabled children may be insufficient. The nature of a child’s impairment may make some acts abusive when they would not necessarily be considered so with a nondisabled child. It is possible to argue that the duty of care is to an even higher order when the impairment results in the child being more dependent. This in turn raises issues for authorities and agencies providing social support to carers (Westcott & Cross, 1996).

Sobsey, Randall, and Parrila’s (1997) results also suggest the need to reconsider existing knowledge about patterns of abuse within this group (see also Morris, 1998b; Sullivan & Knutson, 1998). They conducted further analyses on the Crosse et al. (1993) data (see Table 3) and found that disabled children showed different gender/abuse relationships to nondisabled children, with disabled boys over-represented in all categories of abuse, including, unusually, sexual abuse. Although it appears that disabled boys may be particularly vulnerable, more research is required to investigate whether this finding is “real” or is a consequence of other factors, such as the under-reporting of impairments among abused girls, or the larger proportion of boys in the general population who have impairments.

Westcott’s (1993) research is important for several reasons: first, it involved disabled people in the research from the very beginning; second, it emphasised the personal experiences of the disabled (and nondisabled) victims; third, it focused attention on circumstances surrounding disabled children and adults that contributed to their increased vulnerability. Westcott (1993, p. 43) concluded that

The vulnerability of disabled children stems from their experience of having disabilities in a society which puts value on being nondisabled (“able

Table 2
Research in the 1980s

| Study | Sample | Data source | Control ^a | Results |
|---|---|--|----------------------|--|
| Frisch & Rhoads (1982) | 430 American children referred for an evaluation of learning problems | Assessment records | No | 7% suspected abuse/neglect victims, 3.5 times higher rate than for other children of same age |
| Lightcap, Kurland, & Burgess (1982) | 24 American abused children and their families | Questionnaire | No | 1. 22% children disabled 2. 43% abused children disabled |
| Diamond & Jaudes (1983) | 86 American children with cerebral palsy and learning impairments | Hospital records and assessments | No | 1. 8 (9%) children disabled by abuse 2. 8 (9%) of disabled children abused, and 19 (22%) at risk of abuse |
| Welbourne, Lipschitz, Selvin, & Green (1983) | 39 American women blind from birth or prior to 10 years | Interviews | No | Over 50% women had experienced one or more incidents of forced sexual contact |
| Chamberlain, Rauh, Passer, McGrath, & Burkett (1984) | 87 young American women (mean age 17 years) with mild-severe learning difficulties | Records and interviews | No | 25% young women had been sexually assaulted, mean age at time of assault 14 years |
| Jaudes & Diamond (1985) | 37 American children with cerebral palsy | Records | No | 1. 23 (62%) children abused or neglected 2. For 14 children, abuse caused cerebral palsy |
| Doucette (1986) | 30 disabled and 32 nondisabled American women | Self-reports of childhood experiences | Yes | 1. 67% disabled, 34% nondisabled women physically abused 2. 47% disabled, 34% nondisabled women sexually abused |
| Sullivan, Vernon, & Scanlan (1987) | 4 different samples of deaf American children and students in residential and mainstream schools | Interviews and questionnaires | No | 1. In two studies, 50% deaf children reported sexual abuse 2. In a third study, 16% hearing-impaired students reported physical abuse, 4% sexual abuse, and 7% physical and sexual abuse 3. In fourth study, 63% deaf children in residential schools reported sexual abuse at school, compared to 26% deaf children at mainstream schools |
| Cohen & Warren (1987) | 1. 2771 preschool American children with different physical and learning impairments in programmes run by United Cerebral Palsy Affiliates 2. 435 preschool children in UCP respite care | Questionnaire survey of UCP staff | No | 1. 94 (3%) children known physically abused/neglected, with 209 (8%) suspected physically abused/neglected; 27 (1%) children disabled by known abuse, further 28 (1%) suspected to be disabled by abuse 2. 1% children known physically abused; 1% children disabled as a result of known or suspected abuse |
| Ammerman, Hersen, Van Hasselt, McConigle, & Lubetsky (1989) | 148 American children aged 3-19 years, psychiatrically referred and having multiple impairments | Medical, psychiatric, nursing, and social work records | Yes | 1. 39% children abused (19% definite, 20% probable/possible) 2. Of that 39%, 69% physical abuse, 45% neglect, 36% sexual abuse |
| Hard (in Mayer & Brenner, 1989) | 95 American developmentally disabled adults | Not known | No | 83% females and 32% males had been abused (in 45% cases prior to victim's 18th birthday) |
| Kennedy (1989) | 156 teachers and social workers for the deaf in the U.K. | Survey | No | 1. 86 children confirmed victims of physical and emotional abuse, further 192 suspected victims 2. 50 children confirmed sexually abused, further 70 children suspected victims |

^a Presence of control or comparison group.

Table 3
Research in the 1990s

| Study | Sample | Data source | Control ^a | Results |
|---|---|--|----------------------|---|
| Benedict, White Wulff, & Hull (1990) | 500 American children with multiple physical and learning impairments | Medical, nursing, social work, and clinical records | No ^b | 1. Reports of abuse filed in 11% cases, 64% abuse (mostly physical) and 26% neglect 2. Concluded no over-representation of abuse in sample |
| Newport (1991) | 57 children with physical and learning impairments receiving care from a U.K. charity project | Survey of staff providing care | No | 35 (61%) children had been abused and neglected |
| Westcott (1993) | 34 adults abused as children living in U.K., of whom 9 had learning difficulties, and 8 physical impairments | In-depth interviews | Yes ^c | 17 disabled men and women reported 25 episodes of physical, sexual, emotional abuse, and neglect by a variety of personal and professional carers |
| Crosse, Kaye, & Ratnofsky (1993) | 1834 American children in 1249 nationally representative substantiated cases of child abuse | Case files | Yes | 1. Overall incidence for all types of abuse of disabled children 1.7 times that of nondisabled children; disabled children 2.8 times more likely to be emotionally neglected, 2.1 times more likely to be physically abused, 1.8 times more likely to be sexually abused, and 1.6 times more likely to be physically neglected 2. For 47% abused disabled children, CPS workers reported that impairments had "led to" or "contributed to" child abuse 3. 147 per 1000 children's impairments caused/likely to be caused by abuse |
| Sullivan, Knutson, Scanlan, & Cork (1997) (also reported in Sullivan & Knutson, 1998) | American children in two samples: 1. 2209 abused/neglected and 880 nonabused controls from hospital sample 2. 792 abused children in residential facility | Merger of records held by hospital, police agencies, and social services | Yes | 1. 64% maltreated sample had some type of impairment (37% multiply disabled) 2. Disabled children 1.8 times more likely to be neglected, 1.6 times more likely to be physically abused, and 2.2 times more likely to be sexually abused |

^a Presence of control or comparison group.

^b DSS statistics used for comparison.

^c Seventeen nondisabled adults also interviewed.

bodied") and which discriminates against disabled people.

Specifically, disabled children were judged more vulnerable since they experienced: greater physical and social isolation (including institutional care); a lack of control over their life and bodies (e.g. insensitive and/or intrusive medical interventions); greater dependency on others (including the provision of intimate care); and problems in communication (including, for example, a lack of vocabulary to describe abuse in some alternative communication systems). We return to these issues later.

Problems with Prevalence

The general recognition and reporting difficulties that exist in relation to allegations or suspicions of abuse are

further compounded when the child is disabled. For example, children may be unable to communicate verbally what has happened, or may not be believed as a result of their impairment (Coles, 1990; Robb, 1990). Westcott and Cross (1996), reviewing research in this area, noted that prevalence rates for neglect ranged from 1–41%, for physical abuse from 1–67%, and for sexual abuse from 4–83%, across different studies. In large part, this variability can be accounted for by the differences and weaknesses in methodology noted above. However, such wide-ranging prevalence rates do leave scope for empirical debate as to whether disabled children are more or less vulnerable than nondisabled children—in contrast to practice experience, which definitely suggests increased vulnerability. The Crosse et al. (1993) and Sullivan and Knutson (1998) studies addressed this empirical question,

underlining the greater risk of abuse to disabled children (see also Morris, 1998b).

A Change in Emphasis—from Prevalence to Provision

A chronological review of studies reveals the beginning of a change of emphasis within research in this area. First, there has been a move away from treatment of disabled children, and their abuse, as something of a “medical curiosity” (Goldson, 1998) to an emphasis on disabled children’s rights to protection. Several studies, notably in the 1970s and 1980s, explored the relationship between “degree of disability” and degree of risk for abuse (e.g. Benedict, White, Wulff, & Hall, 1990; Chamberlain, Rauh, Passer, McGrath, & Burkett, 1984; Glaser & Bentovim, 1979; Klopping, 1984; Starr, Dietrich, Fischhoff, Ceresnie, & Zweier, 1984). Results have been equivocal, with some authors arguing that more severely disabled children are at greater risk (e.g. Klopping, 1984), others arguing that less severely disabled children are more vulnerable (e.g. Benedict et al., 1990; Chamberlain et al., 1984), and others that the relationship is complex (e.g. Glaser & Bentovim, 1979). From a contemporary position, however, these arguments appear somewhat tangential to the real issues raised by disabled children’s dependency in relation to abuse (e.g. Morris, 1995, 1998a, b; Sobsey & Doe, 1991; Westcott, 1993).

Second, there has been a change of emphasis away from the focus on individual factors (or impairments) as predispositions to abuse (e.g. Zirpoli, 1986) to analyses of social factors that create a context within which disabled children are more likely to be maltreated (e.g. Sobsey, 1994; Westcott & Cross, 1996). Thus some earlier studies labelled disabled children as “abuse provoking” (e.g. Ammerman, Van Hasselt, & Hersen, 1988), frequently describing the disabled child as an additional stress factor in typically fraught families, with abuse being the result (see Westcott & Cross, 1996, for a review). Later researchers have argued that labelling disabled children in this way is misleading, and that a myriad of social factors stemming from the way disabled children are viewed and treated within social, health, education, and welfare systems creates situations and dynamics within which abuse is more likely to occur. Typically, these researchers work within the frameworks offered by the social model of disability (e.g. Swain et al., 1993), and the ecological model of abuse (e.g. Doe, 1990; Sobsey, 1994; Westcott & Cross, 1996).

Finally, there have been moves away from simply documenting the abuse of children who are disabled, to exploring differential dynamics when victims are disabled, presenting victims’ own accounts, and highlighting the implications for service provision (e.g. Howlin & Clements, 1995; Sobsey & Mansell, 1990; Sullivan et al., 1991, 1997; Westcott, 1993). Research into the effectiveness of interventions is still in its infancy, but sufficient knowledge has been gleaned from existing studies, from practice, and from the experiences of disabled children and adults to inform professional recognition and response to abuse within this group.

Responding to the Abuse of Disabled Children

Westcott and Cross (1996) offer a conceptual model for change that emphasises responses to disability and abuse at three levels (and maps onto the ecological model of abuse). Three principles underpin such change: the paramountcy of the child’s welfare; active consultation with disabled children and adults; and partnership between organisations, professionals, and carers. At the *personal* level, prejudice against disabled and abused children must be confronted; at the *professional* level discrimination in service provision must be acknowledged and reduced, and finally, at the *organisational* level, oppression of disabled people, whatever their age, must be challenged through strategic and structural change.

Taking the professional level as an example here, then difficulties in responding to the abuse of disabled children within child protection structures are apparent. Marchant and Page (1993) have highlighted the professional “gap” that exists between authorities and agencies charged to investigate suspicions of child abuse, and between those authorities and agencies who provide services to disabled children and adults (paradoxically these are often the same social services departments and charitable organisations). Professionals working in one area are typically ill-informed about the other domain, so that, for example, social workers have in the past received little training or information about disabled children and their lifestyles, and Area Child Protection Committee (ACPC) policies and procedures frequently do not provide specific guidance on disabled children. Conversely, carers working with disabled people have not been trained to recognise possible signs of abuse, nor how to act upon suspicions.

Identifying abuse amongst children who are disabled, especially if they have moderate or severe learning difficulties, or do not have speech, is one of the most pressing difficulties facing practitioners (Howlin & Clements, 1995). Behaviours that may indicate abuse, such as self-mutilation and repetitive behaviours, may in a disabled child instead be mistakenly attributed to their impairment. Practitioners may be forced to rely on alternative sources of information, such as carers’ feedback, observation, and specially constructed indices of risk (Howlin & Clements, 1995; Marchant & Page, 1993). Kennedy (1990) explores how a child’s responses such as self-blame, anger, and depression can either result from experiences of abuse or from experiences of being disabled in a society that discriminates against them. Such dual-aetiology responses may present further difficulties for those who wish to investigate abuse (or work therapeutically with the abused child).

Assessment of abuse allegations therefore requires well-integrated multidisciplinary arrangements between child protection services and services with expertise in particular impairments (Marchant & Page, 1993). Interview and assessment approaches will need to be suitably adapted, so that developmentally appropriate methods are employed (Marchant & Page, 1997; Westcott, 1994). Recent research has demonstrated that with careful questioning disabled children are able to provide accurate information about events they have witnessed (e.g. Gordon, Jens, Hollings, & Watson, 1994;

Porter, Yuille, & Gent, 1995). The cognitive interview has been shown to be helpful with adults with learning difficulties in forensic situations, and preliminary research with children who have learning difficulties has shown promise (Milne & Bull, 1996). However, lack of adequate strategic planning in investigations has also led to the inappropriate use of untested techniques, such as facilitated communication amongst autistic children (see special issue of *Child Abuse and Neglect*, 1994, on this topic), resulting in confused outcomes and a lack of clarity as to whether or not abuse has occurred. In such circumstances, indirect methods of assessment may be useful in order to assess suspicions of abuse (Howlin & Jones, 1996).

Within the U.K., recent years have seen some significant improvements in the professional response to disabled children. In 1993 the Department of Health funded training and a resource pack, *ABuse and Children who are Disabled* (the “ABCD” pack)² was launched, covering all aspects of preventive, investigative, and therapeutic intervention. Organisations like NAPSAC (the National Association for the Protection from Sexual abuse of Adults and Children with learning difficulties)³ provide excellent training opportunities, and have also developed some useful materials aimed at professionals working with learning disabled children and adults.⁴ For example, there are leaflets on “whistleblowing” should practitioners fear abusive practice by colleagues (NAPSAC, 1993), and guidelines on preventing and responding to sexual abuse in residential settings (Association for Residential Care [ARC]/NAPSAC, 1993).

Therapeutic or “survival” work with abused disabled children and their families has received comparatively little attention, especially in the published literature. The Tavistock Clinic is probably best known in the U.K. for its work with abused children and adults with learning difficulties (Sinason, 1986, 1988). In the United States, Sullivan and her colleagues have worked predominantly with sexually abused disabled children (e.g. Sullivan & Scanlan, 1987, 1990), drawing on a range of therapeutic techniques. One evaluation has reported significant behavioural improvements for children undergoing this programme (Sullivan, Scanlan, Brookhouser, Schulte, & Knutson, 1992), although some have criticised this approach for not meeting the needs of children who are nonverbal and have more severe impairments (Jones & Garfinkel, 1993).

In the U.K. and internationally, improved responses to the varying needs and requirements of disabled children at all three levels—personal, professional, and organisational—are still required (Bonner, Crow, &

Hensley, 1997; Utting et al., 1997; Westcott & Cross, 1996).

The Particular Vulnerability of Disabled Children: Implications for Prevention

The model for change advocated by Westcott and Cross (1996) indicates that different preventative measures can be initiated at the personal, professional, and organisational levels. Earlier, three core issues in the vulnerability of disabled children were highlighted from Westcott’s (1993) study: dependency, institutional care, and communication, which cross these different levels.

Dependency

The dependency of disabled children on others—be this physical, social, or emotional—is a key factor in their vulnerability, since such dependency may be readily exploited. Increasing the number of adults in contact with a child (e.g. doctors, residential carers, taxi-drivers) increases the number of adults who may use that contact for improper reasons (such as a paedophile seeking to work with children) and also increases the opportunities for weakened inter-agency communication so that safety issues “fall through the net”. Sobsey and Doe (1991) estimated an increased risk to disabled children and adults of 78% based on exposure to their networks of disability service providers alone. Personal care activities such as bathing, dressing, and toileting are obvious areas in which illegitimate intimate activities may be concealed. Further, there is a tendency to deny that professionals caring for disabled children would abuse their position to hurt the child. Routine medical examinations and assessments may also be unthinkingly carried out in ways that are impersonal, insensitive, and traumatic (Westcott & Cross, 1996).

Institutional Care

Institutional care remains controversial for all children (e.g. Utting et al., 1997) but its value for those with disabilities—for whom it represents segregation to an even greater degree—is particularly problematic (Morris, 1995, 1998a, b). Questions remain about the role of residential care—and respite placements—with disabled children, such as: Whose needs are being met? and: What positive outcomes are expected to outweigh the negatives of isolation and increased vulnerability? Strategic planning to prevent individual “one-off” abuse incidents, such as a physical assault, are required, along with heightened awareness of the risks of premeditated sexual abuse (Westcott & Cross, 1996). Actions are required to improve the quality of life (especially education and health) for children in institutional care, to improve the pay and conditions, training, and qualifications of residential staff, and to ensure regular and comprehensive inspections (see Utting et al., 1997).

Communication

Communication is vital in the context of disability and child abuse, since some of the most vulnerable children

²The *ABuse and Children who are Disabled* (ABCD) training and resource pack is available from Caroline Riley, c/o NSPCC National Training Centre, 3 Gilmour Close, Beaumont Leys, Leicester, LE4 1EZ, U.K. Tel: 0116 234 0804.

³NAPSAC (now The Ann Craft Trust) may be contacted at The University of Nottingham, Centre for Social Work, University Park, Nottingham, NG7 2RD. Tel: 0115 951 5400.

⁴Further details of trainers and consultants specialising in the field of abuse of disabled children are available from the first author.

are those whose impairments prevent them from communicating, either verbally or behaviourally, what has happened to them (and who may therefore be deliberately targeted by some perpetrators). Child protection professionals are ill-equipped to communicate with nonverbal children, and for this reason inter-agency cooperation that “bridges the gap” identified above is essential (Marchant & Page, 1993). Westcott and Cross (1996) argue that communication methods, communication styles, and communication content can all be abusive. For example, alternative communication systems may not contain the vocabulary necessary for children to describe intimate or abusive acts. The language used to describe disabled children may be offensive and/or impersonal (e.g. calling them by the name of their medical condition, or the equipment or techniques used to assist them). Positive role-images and models are virtually nonexistent (Hevey, 1992), and sex education is rarely provided. Again, steps to prevent the abuse could begin by overcoming these problems.

“Child abuse prevention” packages such as *Kidscape* (e.g. Elliott, 1991) represent something of a case in point, since “no, go, tell” messages are inappropriate for children who are nonverbal, who are physically immobile, who are visually impaired, or who have learning difficulties. Children who are dependent on others for personal care because of physical or learning difficulties may find concepts such as “private”, “uncomfortable”, or “safe” problematic. Although some attempts have been made to develop or adapt such packages for disabled children (see Westcott & Cross, 1996, for a review), their use with this population raises difficulties that go beyond those encountered with nondisabled children.

Implications for Prevention

Marchant and Cross (1993) suggest six steps to prevent the abuse of children in care (see also Cross, 1992): an explicit commitment to child protection; clear definitions of good practice; environments that are open to criticism and scrutiny; close contact with families, communities, and disabled adults; respect for children’s ethnicity, religion, and individuality; and a high internal awareness of the risks of abuse. Following these steps helps create an environment that is positive for the children, but “unattractive” or even hostile for abusers.

These measures reveal the inter-connectedness of the three issues highlighted in this review: dependency, provision of care, and communication. As an example, Morris (1998b) found that many of the 30 disabled young people living away from home interviewed for her project did not have access to a communication system that suited their needs; did not have routine access to people who understood the way they communicated; and did not have access to independent facilitators. Clearly the facilitation of communication is an essential requirement for the protection of disabled children—that is, with the children and young people themselves, and within and across different agencies and authorities.

Staff recruitment issues are also of importance, not only in terms of thorough police, reference, and background checks, but also in terms of recruiting staff who

are willing and able to contribute to a caring environment that respects the wishes and requirements of the children and young people. Training has a key role in addressing the range of issues highlighted by Marchant and Cross (1993; see above).

Preventing the abuse of disabled children is even more difficult than preventing the abuse of nondisabled children, and even more important, since these children are at increased risk and yet less able to defend themselves. Early recognition and deterrence is particularly valuable. Myths or beliefs that disability somehow protects children from abuse need to be challenged. Strategic and structural change is necessary to overcome the perceived and real difficulty in proving and prosecuting abuse (Home Office, 1998; Utting et al., 1997).

Conclusions

Available research from the 1960s to the present has consistently highlighted the vulnerability of disabled children to abuse in all forms, despite methodological weaknesses and differences. Recent prevalence and incidence studies enable us confidently to state that this vulnerability is greater than that for nondisabled children. Three important factors that contribute to this increased risk have been briefly discussed in this review: dependency, institutional care, and communication difficulties. Abuse is a multi-faceted concept, and the discussion above indicates that prevention and response are multi-faceted too, demanding a review of both day-to-day interactions with disabled children and the professional response when abuse is suspected.

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