

Child Abuse and Disabilities: A Medical Perspective

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Children with disabilities are believed to be maltreated at a higher rate than children in the general population. Rates of abuse and maltreatment in disabled populations have been reported to be between 3 and 61%. Current estimates suggest that children with disabilities are sexually abused at a much greater rate than the general population. When disabilities are identified in abused populations, it is estimated that between 9 and 40% of children served by child protective services have a developmental disability.

In an individual who is older than the age of 5 years, disability refers to a physical or mental impairment that results in functional limitations in one or more of life's major activities. Consistent with the Americans with Disabilities Act, a person has such a disability if the impairment manifested before the age of 22 years, if the person has a history of such an impairment or is regarded as having such an impairment. The term "developmental disability" applies to children from birth to 5 years old who have significant developmental delay or congenital or acquired conditions that may result in a disability if services are not provided. This legal definition provides limited guidance for assessing whether or not a child should be considered to have a disability. Developmental disabilities span a range of diagnoses, including communicative/language disorders, motor delays or conditions, and any combination of functional losses or impairments. Disabilities can be congenital, result from disease states, occur as a result of trauma or can be the result of abusive trauma. Because of the wide range of etiologies there is no one specific treatment or management plan.

The medical provider (physician, nurse practitioner, physician assistant, etc.) who is involved with the direct primary care of a disabled child should monitor the child for signs of abuse. Other medical providers who perform expert child abuse evaluations should consider screening for disabilities. Pediatric medical practitioners are an often overlooked resource for screening for disabilities in abused populations and for training other professionals in the child abuse field about developmental disabilities. In the following review we discuss the medical practitioner's role in developmental assessments of abused children, examine medical literature regarding abuse and disabilities and provide guidance for professionals who must consider abuse in disabled children.

The role of the medical provider in developmental monitoring

The American Academy of Pediatrics recommends

routine monitoring of a child's developmental progress as part of preventive health care. Moreover, Public Law 99-457 (reauthorized as the Individuals with Disabilities Education Act) mandates early identification of and intervention for developmental disabilities. The medical provider is in a critical position to assess children's development because he or she is often the only professional with knowledge of development who has routine contact with the child. This same medical provider is in a unique position to understand the social situation of the family and assess for risk factors of abuse. The medical provider is, therefore, responsible for identifying children at developmental risk, children needing further evaluation, and assisting families in obtaining appropriate services for their child.

Pediatric medical practitioners are an often overlooked resource for screening for disabilities in abused populations and for training other professionals in the child abuse field about developmental disabilities.

Despite the high degree of agreement within the pediatric community about the need for ongoing monitoring of a child's developmental progress, no uniform standard is practiced. Pediatricians use a wide variety of techniques, including the "Aunt Tilly" approach, a combination of careful observation and listening to parents, intuition, and gut response (Cunningham, 1996). Unfortunately, research suggests that less than half the children with mild mental retardation or serious emotional/behavioral disturbances are identified by clinical judgement alone (Scott, Lingaraju, Kilgo & Lazzari, 1993). Relying solely on

parent report is another commonly used screening instrument for development. While good reliability has been shown using this method, lack of parental concern about their child's development does not ensure that development is normal (Glascoe, 1996).

Developmental screening is a brief but formal method for sorting out children who probably have developmental problems from children who do not. Several developmental screening tests are available to assist the medical provider in assessing a child; however, these must be used accurately or they fail to be useful. The most widely recognized tool is the Denver Developmental Screening Test-II (Frankenburg & Dodds, 1990). This test was standardized to identify global developmental delay and practitioners are cautioned about making assumptions regarding specific delay in isolated domains of development. Although several questions have been raised regarding the validity of this tool, it remains the sole formal instrument in many pediatric offices. First STEP is a new, popular and easy to use screening tool for the evaluation of preschoolers (Miller, 1995). It takes about fifteen minutes to perform and has excellent sensitivity and speci-

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ficity. The Bayley Infant Neurodevelopmental Screen (Bayley, 1993) uses directly elicited items to assess neurodevelopmental skills and developmental milestones. The ELM Scale-2 is a very quick and accurate screening tool for language abilities in children under three years of age and has been shown to correlate highly with Bayley Infant Scale of Development mental index scores (Church & Coplan, 1996).

Developmental Surveillance (Glascoe, 1996) is a concept gaining increased attention. In this approach, the medical provider identifies parent concerns and makes regular skilled observations of the child in order to monitor developmental progress. This approach uses formal screening tests and informal observations, repeated measures at different ages, and reports from multiple sources of information, such as parents, teachers, and day care staff. Developmental surveillance is best handled within the context of the routine history and physical examination. This more fluid approach to developmental assessment is undergoing research scrutiny and will likely gain more recognition.

Once the developmental screening or surveillance identifies a child as being either at risk or demonstrating delay, a comprehensive evaluation is in order. This type of evaluation is best performed by a child development specialist, developmental pediatrician, neurologist or team of early intervention therapists who will be able to establish a developmental diagnosis, determine an etiology for the disorder, provide a developmental prognosis, and assist the family in educating themselves about the disorder and establishing appropriate intervention and academic programs. This same approach should be used when child abuse is suspected. The child should be referred to a medical specialist who is familiar with the medical findings of physical and sexual abuse and who is able to work most efficiently with community agencies to provide needed services.

Risk factors for abuse in disabled children

There are many possible causes for increased risk of abuse in developmentally disabled children. These include:

- Enhanced vulnerability as a result of increased demands for care by multiple caregivers
- Chronic stress of child care providers
- Parental attachment problems
- Parental isolation
- Unrealistic expectations of the child's performance
- Aggressive behaviors in the child
- Concurrent risk factors that may be associated with abuse as well as disabilities (such as alcohol and drug abuse)

- Communication limitations resulting in a decreased ability to relay information
- Inability to communicate needs (resulting in neglect)
- Dependency on a large number of caretakers

The relative influence of each of these factors needs further study. There are many limitations to the studies that examine the relationship between abuse and disabilities. These include subject selection biases, disparities between studies on the definitions of disabilities and differing operational definitions of maltreatment. In addition, there is often difficulty in determining the causal relationship between the abuse and disability (within the study population) and sometimes questionable validation of procedures for determining disabilities.

Identifying disabilities in abused children

Recent focus has been directed to the need for child protective services to keep accurate records on maltreated children with disabilities (Bonner, Crow & Hensley, 1997). Bonner et al. conducted a survey of child abuse and neglect state liaison officers which replicated an earlier study by Camblin (Camblin, 1982). Bonner et al's prediction of an improvement in training of Child Protective Services personnel and better identification of disabilities among populations of maltreated children in the 12 years between the two studies was not demonstrated. In fact,

Bonner et al's study demonstrated that the regular collection of information regarding disabilities in maltreated children had declined since 1982. The authors postulate that children's disabilities are unlikely to be identified as they enter the child protection system, resulting in a lack of provision of necessary services.

A team approach, utilizing child protective workers and pediatric medical practitioners, should help to identify disabled children and therefore enable appropriate referrals for services. Pediatric medical practitioners who provide ongoing primary care to the child should have significant insight into the child's past developmental issues.

Identifying abuse in disabled children

Evaluating a disabled child for abuse may be much more complicated than evaluating a developmentally normal child. Communication issues may inhibit the elicitation of an accurate history from the child. Resources for home placement may be scarce because of the increased daily caregiver needs. The medical professional who is experienced in child abuse evaluations should also be able to perform a brief developmental assessment, as outlined above.

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Ammerman, Herson, and Van Hasselt (1988) prospectively examined factors associated with risk of child maltreatment and assessed maternal and child functioning in 138 hospitalized children and adolescents (aged 3-18 years) with both developmental disabilities and psychiatric disorders. Diagnoses included mental retardation, pervasive developmental disorders, disruptive behavioral disorders and affective disorders. According to the author's rating scales, 61% of the children studied had experienced some form of maltreatment by a care provider during their lifetime. Mothers' use of more severe disciplinary techniques was associated with children who were young, oppositional and higher functioning.

Although this study did not describe the physical findings of the children, the study results indicating that higher functioning children may predispose their mothers to more severe disciplinary techniques may help practitioners focus their screening efforts for abuse in disabled populations. Unrealistic expectations of a child, in terms of their developmental functioning, is a significant risk factor for disabled children. This may be a more significant risk when the child is less physically challenging for the caregiver and more emotionally challenging. For example, a child with behavioral problems due to hearing loss may be more at risk than a child who requires feeding and diaper changes but who has no behavioral problems. Future studies which may help practitioners further focus their screening efforts for child abuse in disabled populations are greatly needed.

In another study of developmentally disabled children, Jaudes and Diamond examined cases of 37 children with developmental disabilities and child abuse (from a cohort of 162 children diagnosed with cerebral palsy) and reviewed the problems of children whose development was affected by the compounded influences of maltreatment and the presence of a handicapping condition (Jaudes & Diamond, 1985). Four areas were identified as crucial to the study of abuse and neglect with respect to the child with developmental disabilities: 1) abuse that causes handicaps; 2) abuse that occurs to the handicapped child; 3) compromises in care that can occur when the handicapped child becomes involved with the medical and legal systems; and 4) arrangements for foster care or other out-of-home placement for the child with handicaps. In 14 of the 37 abused children, the abuse was believed to have caused the cerebral palsy. The abuse in these children involved severe head injuries resulting in brain injury before the age of 1 year. In 23 cases, the abuse followed the diagnosis of cerebral palsy and in 3 children, the abuse both preceded and followed the diagnosis. Most of these children (15 of the 23) suffered from starvation/malnutrition, medical neglect or abandonment. The authors point out that repeated battering of these chil-

dren was a significant problem, occurring for five of the children. Clearly, there is a need for practitioners to look for signs of abuse in children who are diagnosed with cerebral palsy. Since these children may present to the practitioner often for medical care issues, the practitioner may have the opportunity to search for signs of abuse at multiple intervals.

Amundson, Sherbondy, Van Dyke, and Alexander (1994) review and discuss two case presentations of children with severe malnutrition and growth retardation which complicated the course of medical treatment. Both adolescents had severe mental retardation, cerebral palsy, seizure disorders, scoliosis and growth retardation, and were admitted to hospitals and evaluated for feeding disorders. In the first case, the child suffered from superior

mesenteric artery syndrome which may have been precipitated by severe malnutrition. In their discussion, the authors indicate that malnutrition in disabled children may be associated with poor oral intake, gastro-esophageal reflux with aspiration, and chronic constipation. There are few established parameters for defining expectations of growth. People with disabilities may differ from standard norms, and malnutrition is sometimes accepted as part of the disability.

Children with disabilities may be at higher risk for serious nutrition problems and practitioners should strive to provide early identification and treatment of protein-energy malnutrition in order to avoid complications. Abnormal growth in a disabled child, just as in a non-disabled child, should trigger a comprehensive evaluation.

Elvik, Berkowitz, Nicholaas, Lipman, and Inkelis (1990) describe their experience of evaluating 35 developmentally disabled females from a residential treatment facility for physical signs of sexual abuse. This study specifically reviewed the medical findings in a group of disabled adults. The task was undertaken after one of the residents became pregnant, resulting in the suspicion of sexual abuse perpetrated at the facility. Patients ranged in age from 13 to 55 years, 69% were categorized as profoundly retarded and no patients were able to provide a history. Two had a prior history of rape and two had a prior history of infection with *Chlamydia trachomatis*. None of the patients had acute physical findings associated with recent penetrating trauma. The two with prior *Chlamydia trachomatis* infections had normal examinations. Two patients had a prior history of rape and had normal examination findings. Thirteen had abnormal genital findings which were consistent with healed penetration. In these cases, no perpetrator was identified and the dilemma of determining the significance and implications of the abnormal genital findings was evident. Since it is rare to see abnormal findings in individuals with known

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sexual abuse, it is clearly unusual to report so many with physical findings of sexual abuse (Adams, Harper, Knudson, and Revilla, 1994) The authors recommend that pediatric medical practitioners who are longitudinally following a disabled patient perform a complete examination at every visit including an external genital examination of pre-pubertal children, and a pelvic exam, when indicated, for pubertal females

Data concerning the characteristics of physical and sexual abuse of communicatively handicapped children were collected as part of a longitudinal study of therapeutic efficacy among a group of abused children with documented and verified handicapping conditions (Sullivan, Brookhauser, Scanlan, Knutson, and Schulte, 1991) In 482 children consecutively referred to and evaluated at Boys Town National Research Hospital, identified impairments included hearing problems, mental retardation, visual impairment and others. Comparisons were made between children who were educated in mainstream schooling and those who were part of a residential program. Results indicated that the most prevalent type of maltreatment for both boys and girls was sexual abuse (48%). Mainstreamed boys were somewhat more likely to be physically abused (35%) than sexually abused (30%), but boys in residential facilities were much more likely to be sexually abused (58.8%). Sexual abuse was the single most frequently reported type of maltreatment among each of the described handicap-specific subgroups. Stranger

perpetrators accounted for no more than 3% of sexual abuse. Nearly 83% endured multiple episodes of abuse. When considering all types of abuse collectively, the most frequent site at which abuse was perpetrated was the child's home. However, the most common site for cases of isolated sexual abuse was the school (including residential schools) for 39%.

The authors conclude that sexual and/or physical abuse as well as emotional abuse and/or neglect are significant risks for children with communication disorders and related disabilities. The implication is that the relatively increased risk for sexual abuse in males compared to the general population is due to two factors: 1) education and child care practices and 2) communication barriers. Although this study does not report specific physical findings for abuse, it clearly documents the need for close medical evaluations in this population.

Botash, et al. (1994) reported on 13 children who were referred to a tertiary care outpatient child sexual abuse program in Central New York after facilitated communication revealed disclosures of sexual abuse.

These children were examined for physical findings which might indicate sexual abuse. The children, aged 5 to 15 years, had various developmental diagnoses including autistic behavior, mental retardation, cerebral palsy, seizure disorders and Down's syndrome. Four children had corroborating evidence of sexual abuse (one perpetrator confession, one verbal disclosure and

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Child protective workers and others involved in the investigation of child abuse cases should work together with medical child abuse professionals to identify disabilities in children.

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Focused Questions

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- Did ——— ever have to go to jail?
- Did ——— ever have to go to court?
- Did anybody in your house ever steal anything?
What?
- What happened next?
- Does ——— ever get in fights?
When?
- Where?
- Who with?

5. Mental illness

- Does ——— ever act strange/crazy?
- What does ——— do?
Can she take care of you when she's acting strange?
- What do you do when ——— is like that?
- Did ——— ever have to go to the hospital for that?
- Does ——— take medicine to keep from acting strange?
- Does ——— ever not take the medicine?
What happens then?

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two with physical examination findings considered suspicious for sexual abuse), and an additional five had other supportive evidence. The authors discuss issues concerning sexual abuse disclosures utilizing facilitated communication and conclude that their results do not support nor refute validation of this communication technique. Since many of these children had other indicators for sexual abuse, the authors recommend that all allegations of abuse in developmentally disabled children be evaluated, including a complete medical examination. This study also implies that sexual abuse may be more common in communicatively impaired children

In summary, the medical literature provides some useful guidelines to assist the medical practitioner in screening for abuse in disabled populations. Primary care providers should be attentive for signs of abuse in children with higher developmental functioning. All children with disabilities should have complete medical examinations, including a height, weight, and (external) genital examination at every office visit. Abnormal weight loss in children who are severely developmentally disabled should not be overlooked and should be considered a possible sign of neglect. Communicatively impaired children should be considered to be a higher risk for sexual abuse. Child protective workers and others involved in the investigation of child abuse cases should work together with medical child abuse professionals to identify disabilities in children. The primary care medical provider should be able to screen children for developmental problems and to identify risk factors for abuse. Through medical record review, children who are identified by child protective services as suspected of being abused should have records which identify their developmental issues. Child protective workers and others involved in the investigation of child abuse cases should work together with medical professionals to optimize the child's chances for growth and education.

Conclusion

Interviewing children with a possible history of victimization is a challenging task because so much hangs on the evaluator's ability to elicit descriptions of experiences from the child during such interviews. Articles such as this are intended to ease the task of the evaluator and result in accurate and complete disclosures.

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