

AMERICAN ACADEMY OF PEDIATRICS

Committee on Child Abuse and Neglect and Committee on Children With Disabilities

Assessment of Maltreatment of Children With Disabilities

ABSTRACT. Widespread efforts are continuously being made to increase awareness and provide education to pediatricians regarding risk factors of child abuse and neglect. The purpose of this statement is to ensure that children with disabilities are recognized as a population that is also at risk for maltreatment. The need for early recognition and intervention of child abuse and neglect in this population, as well as the ways that a medical home can facilitate the prevention and early detection of child maltreatment, should be acknowledged.

ABBREVIATIONS. CPS, child protective services; IFSP, Individual Family Service Plan; IEP, Individual Education Plan.

BACKGROUND

The maltreatment of children, including those with disabilities, is a critical public health issue that must be addressed. The Third National Incidence Study of Child Abuse and Neglect showed that the estimated number of abused and neglected children more than doubled between 1986 and 1993.¹ According to a report from the National Child Abuse and Neglect Data System, child protective services (CPS) agencies investigated nearly 2 million reports of alleged maltreatment of an estimated 3 million children in 1995.² More than 1 million children were identified as victims of abuse and neglect during that year.

The numbers of children surviving disabling medical conditions as a result of technologic advances and children being recognized and identified as having disabilities are increasing.³ The rates of child maltreatment have been found to be high with both the child population in general as well as with children who are blind, deaf, chronically ill, developmentally delayed, behaviorally or emotionally disordered, and multiply disabled.⁴ Furthermore, child maltreatment may result in the development of disabilities, which in turn can precipitate further abuse.⁵ Previous studies have been unable to accurately document the extent or rate of abuse among children with disabilities or determine if disabilities were present before the abuse or were the direct result of maltreatment.⁶ Little research on child abuse has focused specifically on children with disabilities.⁷

INCIDENCE

The Child Abuse and Prevention, Adoption, and Family Services Act of 1988⁸ mandated the study of

the incidence of child maltreatment among children with disabilities. This research was funded by the National Center on Child Abuse and Neglect and conducted by the Center for Abused Children With Disabilities at the Boys Town National Research Center.⁴ A study by Westat Inc determined the incidence of abuse among children with disabilities and the relationship between child abuse and disabilities.⁷ Data were collected from 35 CPS agencies across the country, and results indicated that 14.1% of children whose maltreatment was substantiated by CPS workers had 1 or more disabilities. Disabilities were found to be twice as prevalent among maltreated children in hospitals as among hospital controls, which is consistent with the hypothesis that disabilities increase the risk for maltreatment. However, the data are also consistent with the hypothesis that maltreatment contributes to disabilities.⁹

According to the Boys Town National Research Hospital, children with disabilities were found to be at greater risk of becoming victims of abuse and neglect than children without disabilities. The study showed that children with disabilities are 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 than children without disabilities.⁴ The study by Westat Inc determined that, overall, the estimated incidence of maltreatment among children with disabilities was 1.7 times greater than the estimated incidence in children without disabilities.⁹ One study found the overall incidence of child maltreatment to be 39% in 150 children with multiple disabilities admitted to a psychiatric hospital. Of those children, 60% had been physically abused, 45% had been neglected, and 36% had been sexually abused.¹⁰

CURRENT RESEARCH LIMITATIONS

A major problem cited by literature is the definition of "disabilities."⁶ There is currently no universal definition of what constitutes a disability. The Americans With Disabilities Act¹¹ defines "disability" as a physical or mental impairment that substantially limits 1 or more of the major life activities of an individual. This definition includes all types of disabilities, including physical disabilities, cognitive or learning disabilities, motor and sensory dysfunctions, mental illness, or any other kind of physical, mental, or emotional impairment.¹² The term "developmental disability" applies to children who have significant developmental delays, congenital abnormalities, or acquired conditions that may result in disability if adequate resources and services are not

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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provided.¹³ The term “children with special health care needs” is less limiting than some other terms.

Legal definitions do not always match clinical data. Child development evaluations do not always allow an immediate and precise diagnosis of disability, and some studies rely on evaluations by untrained observers. Therefore, research efforts are hindered by different definitions of terms (eg, disabilities and maltreatment), noncomparable methods, various study sample sizes, and lack of uniform data collection. Furthermore, changes in reporting laws and societal attitudes can occur during a study period.¹⁴

Another problem that has been cited in the literature is the lack of recognition and documentation of disabilities by CPS workers and their lack of training on evaluating children with disabilities.⁶ In the study by Westat Inc, analyses were based on CPS workers' opinions rather than data empirically derived from physicians or other professionals trained to diagnose disabilities.⁷ Bonner et al demonstrated that since 1982, correct and consistent use of the CPS system of collecting information regarding disabilities in maltreated children had decreased, suggesting that disabilities were unlikely to be identified as children enter the CPS system.⁶ A survey of 51 state CPS agencies found that in 86% of states, CPS workers used a standardized form to record child maltreatment cases, but in only 59% of those states did the workers record information regarding preexisting disabilities on the form.¹⁵

The Westat study was limited to intrafamilial cases.⁷ Because it is well known that individuals other than family members can commit harm to children, statistics limited to intrafamilial cases would be likely to underestimate the overall incidence of maltreatment among children with disabilities.

CAUSAL FACTORS

In general, the causes of abuse and neglect of children with disabilities are the same as those for all children; however, several elements may increase the risk of abuse for children with disabilities. Children with chronic illnesses or disabilities often place higher emotional, physical, economic, and social demands on their families.¹⁴ For example, a physical disability that causes difficulty in ambulation can place a child at risk for accidental falls. Therefore, close supervision would be needed. Parents with limited social and community support may be at especially high risk for maltreating children with disabilities, because they may feel more overwhelmed and unable to cope with the care and supervision responsibilities that are required.¹² Lack of respite or breaks in child care responsibilities can contribute to an increased risk of abuse and neglect.

The requirement of special health and educational needs can result in failure of the child to receive needed medications, adequate medical care, and appropriate educational placements, resulting in child neglect.¹² Numerous problems have been cited with the provision of care for foster children with disabilities. Foster parents are sometimes not told about a child's medical and emotional problems and are,

therefore, not sufficiently educated or prepared to deal with the specific condition. Other problems for foster children with disabilities include lack of permanent placement, lack of a medical home, lack of financial support, and failure to select appropriate foster parents.⁵

Parents or caregivers may feel increased stress because children with disabilities may not respond to traditional means of reinforcement, and children's behavioral characteristics (ie, aggressiveness, non-compliance, and communication problems, which may appear to be temper tantrums) may become frustrating.⁴ A behaviorally challenging child may further increase the likelihood of physical abuse.¹² Parents of children with communication problems may resort to physical discipline because of frustration over what they perceive as intentional failure to respond to verbal guidance. It has been noted, however, that families who report higher stress levels may actually have greater insight into problems associated with caring for a disabled child, whereas parents with a history of neglect of a child may not experience the level of stress that a more involved parent may experience.¹⁶

In regard to sexual abuse, infrequent contact of a child with disabilities with others may facilitate molestation, because there is decreased opportunity for the child to develop a trusting relationship with an individual to whom he or she may disclose the abuse.¹² Also, children who have increased dependency on caregivers for their physical needs may be accustomed to having their bodies touched by adults on a regular basis. Children with disabilities who require multiple caregivers or providers may have contact with numerous individuals, thereby increasing the opportunity for abuse. However, an advantage to having a large number of caregivers is that not only may someone detect the injuries or signs of abuse, but also the amount of stress placed on the primary caregiver is decreased.

Children with disabilities often have limited access to critical information pertaining to personal safety and sexual abuse prevention. Parents may object to their child being provided with education on human sexuality. Children with disabilities may also be conditioned to comply with authority, which could result in them failing to recognize abusive behaviors as maltreatment.⁴ Children with disabilities are often perceived as easy targets, because their intellectual limitations may prevent them from being able to discern the experience as abuse. Impaired communication abilities may prevent them from disclosing abuse. Because some forms of therapy may be painful (eg, injections or manipulation as part of physical therapy), the child may not be able to differentiate appropriate pain from inappropriate pain.

PEDIATRICIAN'S ROLE

Pediatricians should be aware that the presence of disabilities in a child could be a risk factor for victimization and that disabilities can also be the result of child maltreatment. The pediatrician should work with families, other health care providers, and other

community resources to ensure the safety of all children.

Identification and Reporting

Pediatricians should always be alert to signs or symptoms that are suggestive of abuse, no less in children with disabilities than in others. However, recognizing the signs and symptoms of maltreatment among children with disabilities may be difficult, because children may not be able to verbalize that they were abused or they may not understand that what took place was wrong.¹² Children with motor and balance disabilities may experience increased injuries from accidents. However, children with neurosensory disabilities may be predisposed to fractures, and in the absence of pain, there may be a delay in seeking medical attention. Pediatricians and other professionals who work with children must be aware of injury patterns from inflicted versus noninflicted trauma. Signs and symptoms of maltreatment in children with disabilities are commonly ignored, misinterpreted, or misunderstood. Furthermore, many institutions may have a disincentive to recognize or report child maltreatment because of fear of negative publicity or loss of funding or licensure.

If abuse or neglect is suspected after a careful assessment, a report must be made to the appropriate CPS agency. Every child suspected of being abused or neglected should have a thorough evaluation by an experienced professional trained in the field of child abuse and neglect.¹⁷ The evaluation process should consist of a structured interview with the child, if possible, and a comprehensive physical examination, including appropriate laboratory and radiologic studies.

Treatment

Appropriate medical treatment for injuries, infections, or other conditions should be provided. Each case of abuse or neglect that is clinically confirmed or strongly suspected should include a multidisciplinary treatment plan, which includes a mental health therapy component appropriate for the child's cognitive and developmental level and counseling for the family. This treatment plan should be integrated with other intervention plans that may have already been developed for the child. Federal legislation requires that each child identified as having a disability should have a written plan of service (an Individual Family Service Plan [IFSP] for children from birth through 2 years of age or an Individual Education Plan [IEP] for children 3 through 21 years of age).¹⁷ A recommendation may be the simple provision of protective gear for the head or other anatomic regions to minimize the consequences of accidental falls or impacts. Removal of the child from the home or therapeutic foster care placement should be at the discretion of the CPS agency after a thorough investigation.

Education

One study found that only 7 states require training in disabilities for child welfare workers and that training averages 4 hours.¹⁷ In-service training for

CPS workers, law enforcement professionals, health care providers, child care professionals, early childhood educators, teachers, and judges should be provided; and protocols should be developed for the identification, reporting, and referral of all cases of suspected child maltreatment in all institutional settings. In addition, risk factors for maltreatment of children with disabilities should be emphasized. Health care providers should be trained to monitor children with disabilities for signs of abuse and neglect and screen suspected victims of child maltreatment for disabilities.¹³

Prevention

Support and assistance with parenting skills are often needed by families with children with special health care needs. Medical and nonmedical needs of the child and family should be addressed at each health supervision visit. Child and family strengths should be recognized and fostered at each encounter. Family stressors should be addressed, and referrals for appropriate services should be made. The availability of parent support groups, respite care, and home health services, when appropriate, should be explored. Pediatricians should educate parents of children with disabilities about respite waiver subsidies and how to qualify for such funds as well as the need to get on a waiting list as early as possible.

Children with disabilities need a medical home consisting of a health care provider readily accessible to the family to answer questions, help coordinate care, and discuss concerns.¹⁹ Developmental and behavioral pediatricians who are trained and experienced in the diagnosis and evaluation of children with disabilities can also serve as excellent resources. Families should be encouraged to work with a variety of disciplines and pursue resources and services that they need. Child abuse prevention, including indicators of abuse, should be discussed with parents and caregivers.¹⁶

Advocacy

The physician must act as his or her patient's advocate by assuming oversight and ultimate responsibility for the overall care that is provided by the various agencies and resources, which can be done by coordinating efforts and ensuring that recommendations are conducted.¹⁹ By doing so, if child maltreatment is suspected, the need for appropriate referrals can be immediately identified. State, educational, social, foster care, financial, and health care systems often function in isolation from each other, with very little coordination or communication.⁴ Community involvement can also encourage the development of needed resources. Foster children with disabilities and their foster parents often suffer from lack of adequate support systems.⁶ Communication with schools and other systems with which families with disabled children interact is another avenue to heighten the awareness of the needs of children with special health care needs.

As child advocates, pediatricians are in an ideal position to influence public policy by sharing information and giving educational presentations on

child maltreatment and the needs of children with disabilities. They should advocate for state practices or policies that mandate CPS agencies to gather disability information on child maltreatment cases. This could help emphasize the devastating costs of child maltreatment to lawmakers, policymakers, and the public.⁶ Pediatricians should also advocate for screening procedures for potential employees in educational, recreational, and residential settings to help ensure the safety of all children in their care.²⁰

RECOMMENDATIONS

1. All pediatricians should be capable of recognizing signs and symptoms of child maltreatment in all children and adolescents, including those with disabilities.
2. Because children with disabilities may be at increased risk for maltreatment, pediatricians should be vigilant not only in their assessment for indications of abuse but also in their offerings of emotional and instrumental support.
3. Pediatricians should ensure that any child in whom abuse has been identified is thoroughly evaluated for disabilities.
4. All children with disabilities should have a medical home.
5. Pediatricians should be actively involved with treatment plans developed for children with disabilities.
6. Health supervision visits should be used as a time to assess a family's strengths and need for resources to counterbalance family stressors and parenting demands.
7. Pediatricians should advocate for changes in state and local policies in which system failures seem to occur regarding the identification, treatment, and prevention of maltreatment of children with disabilities.
8. Pediatricians should advocate for better health care coverage by both private insurers and governmental funding.

CONCLUSION

The American Academy of Pediatrics supports the belief that pediatricians play a significant role in the prevention, identification, and treatment of child abuse and neglect, especially in children with disabilities, who may be at increased risk of maltreatment. Furthermore, children suspected of maltreatment should be evaluated for developmental disabilities. Pediatricians with experience in child abuse evaluations should provide training to other individuals. In addition, CPS workers and others involved in the investigation of child maltreatment should work closely with pediatricians to identify disabilities in children.¹² Every effort should be made to ensure the safety of children through collaboration with families, other health care providers, schools, CPS agencies, and other appropriate resources.

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REFERENCES

1. Sedlak AJ, Broadhurst DD. *The Third National Incidence Study of Child Abuse and Neglect*. Washington, DC: US Department of Health and Human Services; 1996
2. US Department of Health and Human Services, Administration for Children and Families. *Child Maltreatment 1995: Reports From the States to the National Child Abuse and Neglect Data System*. Available at: <http://www.acf.dhhs.gov/programs/cb/stats/ncands/>. Accessed November 21, 2000
3. Goldson EJ. Commentary: gender, disability, and abuse. *Child Abuse Negl.* 1997;21:703–705
4. Sullivan P, Cork, PM. *Developmental Disabilities Training Project*. Omaha, NE: Center for Abused Children with Disabilities, Boys Town National

- Research Hospital, Nebraska Department of Health and Human Services; 1996
5. Jaudes PK, Diamond LJ. The handicapped child and child abuse. *Child Abuse Negl.* 1985;9:341-347
 6. Bonner BL, Crow SM, Hensley LD. State efforts to identify children with disabilities: a follow-up study. *Child Maltreat.* 1997;2:52-60
 7. Westat Inc. *A Report on the Maltreatment of Children With Disabilities.* Washington, DC: National Center on Child Abuse and Neglect; 1994
 8. Child Abuse Prevention, Adoption, and Family Services Act. Pub L No. 100-294, 102 Stat 102 (1988)
 9. Sullivan PM, Knutson JF. The association between child maltreatment and disabilities in a hospital-based epidemiological study. *Child Abuse Negl.* 1998;22:271-288
 10. Ammerman RT, Van Hasselt VB, Hersen M, McGonigle JJ, Lubetsky MJ. Abuse and neglect in psychiatrically hospitalized multihandicapped children. *Child Abuse Negl.* 1989;13:335-343
 11. Americans With Disabilities Act. Pub L No. 101-336, 104 Stat 327 (1990)
 12. Ammerman RT, Baladerian NJ. *Maltreatment of Children With Disabilities.* Chicago, IL: National Committee to Prevent Child Abuse; 1993
 13. Botash AS, Church CC. Child abuse and disabilities: a medical perspective. *APSAAC Advisor.* 1999;12:10-18
 14. Benedict MI, White RB, Wulff LM, Hall BJ. Reported maltreatment in children with multiple disabilities. *Child Abuse Negl.* 1990;14:207-217
 15. Camblin LD. A survey of state efforts in gathering information on child abuse and neglect in handicapped populations. *Child Abuse Negl.* 1982;6:465-472
 16. Benedict MI, Wulff LM, White RB. Current parental stress in maltreating and nonmaltreating families of children with multiple disabilities. *Child Abuse Negl.* 1992;16:155-163
 17. American Academy of Pediatrics, Committee on Child Abuse and Neglect. Guidelines for the evaluation of sexual abuse of children: subject review. *Pediatrics.* 1999;103:186-191
 18. American Academy of Pediatrics, Committee on Children with Disabilities. Pediatrician's role in the development and implementation of an Individual Education Plan (IEP) and/or an Individual Family Service Plan (IFSP). *Pediatrics.* 1999;104:124-127
 19. American Academy of Pediatrics, Ad Hoc Task Force on Definition of Medical Home. The medical home. 1992;90:774
 20. Sullivan PM, Brookhouser PE, Scanlan JM, Knutson JF, Schulte LE. Patterns of physical and sexual abuse of communicatively handicapped children. *Ann Otol Rhinol Laryngol.* 1991;100:188-194

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