

7. Sexual abuse of children with disabilities

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Introduction

The sexual abuse of children with disabilities is a distressing and difficult area of safeguarding practice that demands a coherent and consistent response. It tends to provoke splits where the risks are either dismissed out of hand or escalated into a justification for disproportionately restrictive measures.

If handled wrongly, misconceptions about abuse can seem to justify ways of working that suppress a child or young person's autonomy and *joie de vivre* instead of empowering them to manage and enjoy their relationships. But if downplayed, responsible adults may fail to provide disabled young people with proper sex education and with information that will allow them to avoid undue risks or with permission to enter into relationships safely. They may also fail to give disabled children and young people information about how to report any sexual behaviours that are coercive or disrespectful, using the same channels as other young people.

Historically children with disabilities have been excluded from these ordinary expectations and it was not thought that they would have an independent sexual life or mix freely with their peers. It has taken many years of campaigning to overcome this limiting stereotype. There are now many examples of positive sexual education and staff training (McCarthy and Thompson, 2010) as well as supported social and sporting opportunities that enable young people with disabilities to develop a

strong sense of their own identity, including their sexuality. Addressing sexual abuse must not be allowed to undermine this agenda.

But the sexual abuse of children and young people with disabilities is a serious problem and one that should be coherently addressed within mainstream child protection agencies and by specialist service providers (Brown and Craft, 1989). This short briefing paper sets out some limited evidence¹⁶ as it relates to five important sets of issues, namely that:

- children and young people with disabilities are at risk of sexual abuse in the same ways as other children;
- they are at additional risk because of their disabilities and because of their placements in specialist service settings;
- they tend to be hidden and / or marginalised within ordinary child protection processes;
- specialist agencies are often excluded from training and information about how to report concerns and manage incidents of sexual abuse that do occur;
- sexual abuse of children and young people causes long-term mental health difficulties and disabled young people are not immune from these consequences.

The effect of this is that children and young people with disabilities are deemed to be at more risk of sexual abuse than other children, but to receive less protection from both mainstream and specialist agencies. This places them in double jeopardy.

Where is the evidence?

Evidence about these issues is scant and dispersed. It is not easy to gather and not easy to interpret. Studies of abuse tend to be based

16. This paper draws on international data where this is available but the author is primarily drawing on information from the United Kingdom and Ireland which is not to suggest that sexual abuse is more prevalent in these, than in other, European countries.

on reported cases but one of the features of sexual abuse is that it is covert and that coercing a child or young person into keeping the abuse secret is a common integral feature of the abusive relationship. Much abuse occurs in closed systems where boundaries are enforced and rigid, such as in families, residential homes, church groups and sporting clubs. This works against prompt or consistent reporting of all child sexual abuse, but it particularly affects children with disabilities. Such studies are best thought of as studies of reporting behaviour rather than as a litmus test of actual abuse. More accurate information about childhood sexual abuse tends to be garnered from retrospective disclosures in adulthood but by then it cannot be corroborated or substantiated. Hence much of this information remains informal and is vulnerable to being discredited.

Definitions of sexual abuse are also problematic. Some are limited to abuse of children perpetrated by adults, while others include abuse by peers, and some register only penetrative sex while others include any unwanted and/or coerced sexual activity. Many studies of abuse of disabled children focus on particular groups, for example those with intellectual disabilities, while others explore the issues as they affect children and young people with specific impairments. Some studies of abuse perpetrated against children and young people with disabilities are biased towards abuse by service personnel while others focus primarily on abuse carried out by family members. It is rare to be able to compare like with like when reviewing this literature.

The risks

Children and young people with disabilities are at risk in ordinary ways because they are children first and because they live in ordinary families, attend mainstream schools, attend local churches or faith groups, and engage in leisure pursuits in mainstream settings. But they are also at additional risk because of the increased likelihood that they will be separated from their families, accommodated in congregate settings where they encounter multiple caregivers, and are targeted on account of their visible “difference” or “vulnerability”.

Ordinary risks

Child abuse, but specifically sexual abuse, has been an important public policy issue over the last two decades in many European countries. Physical and emotional abuse are more likely to be condoned or excused whereas sexual abuse of children is almost universally condemned. There is a growing consensus about the prevalence and dynamics of such abuse. For example, in Ireland two studies were commissioned that provide background information about the abuse of all children (McGee et al., 2002; Goode, McGee and O'Boyle, 2003). McGee et al. suggested in the SAVI report that 20% of all women had been sexually abused with physical contact as girls and that 16% of men had been similarly abused as boys. A further 10% of girls and 7% of boys had been abused in non-contact ways. A total of 40% of these incidents were ongoing and not single occurrences. Of these 5.6% of girls and 2.7% of boys had been raped as children or adolescents and most shockingly 40% had told no one about it. These figures are of a similar order to those emerging in other countries and broadly in line with Kinsey's initial estimate in the United States in 1953 that 1 in 4 girls and 1 in 9 boys were victims of child sexual abuse. US figures from a congressionally mandated series of incidence studies, (NCCAN, 1996) suggested that girls are three times more likely than boys to be sexually abused. A range of international studies cited by Goode et al. (2003:10) arrive at estimates of sexual victimisation of between 6% and 54% of girls (depending on the definition of the abuse and the method of study) and 4-16% of boys. But in these studies disabled children, if they are represented at all, have melted into the background and cannot be distinguished from other victims.

This abuse is usually perpetrated by men although there is a growing recognition that some abusers are women, but it is predominately men who become repeat offenders. Men who are motivated to abuse do so within their family networks; they assume positions of authority from which they can access children with a view to offending against them while protecting their own reputations as "pillars of the community" (Turk and Brown, 1993), and they also prey on single

or vulnerable mothers in order to abuse their children. The National Center on Child Abuse and Neglect (NCCAN) reported that the typical child sex offender molests an average of 117 children, most of whom do not report the offence. It is estimated that approximately 71% of child sex offenders are under 35 and know the victim at least casually. A total of 59% of abusers gained sexual access to their victims by targeting and grooming them and this is an important dynamic for professionals to understand if they are to remain vigilant to the risk of exploitation. Children with disabilities may also be abused by their peers and by strangers in public places. They may be at risk within sporting networks (see Brackenridge, 2008) and within the care system.

About 80% of the perpetrators reported in the NCCAN report fell within normal intelligence ranges, but a significant element of abuse of disabled children and young people may be perpetrated by other disabled people who need help in understanding and establishing sexual boundaries. This abuse may not be motivated by malevolence, but sometimes demonstrates the same kinds of targeting of a more vulnerable person. A parallel stream of work has grown up around addressing potentially abusive behaviour on the part of disabled boys and young men (Thompson and Brown, 1997, 1998).

Additional risks as a result of disability

Attempts to quantify the additional vulnerability of disabled children can only be guestimates due to the lack of available and comprehensive information. Abuse of disabled children is not often visible in the information gathered by mainstream child-care agencies or the criminal justice system (Cooke, 2000).

The pattern of targeting and grooming is of particular importance in relation to disabled children and as mainstream services become more vigilant, perpetrators may move into other less attentive services, such as voluntary agencies that serve disabled children and young people, in order to access potential victims. Any visible disabilities might mark a child out as vulnerable, and if they are

isolated from their peer group, have communication difficulties and less information about what to expect from adults and to whom they could report abuse, then they are more likely to be seen as targets. Disabled children and young people who have a negative self-image may also be particularly susceptible to grooming and deception, and to “tricks or treats”.

Sobsey (1994) hypothesised that this additional risk was less a feature of a child’s impairment than of the settings in which they were placed, and which would expose them to multiple carers, thereby increasing the statistical risk of encountering a paedophile. A social model of vulnerability (Brown, 2002) analyses these issues in terms of the ways in which disabled children are placed at more risk than other children in settings that have not attended to safety (for example in the design of buildings or the recruitment of staff). They are then further disadvantaged because they are not heard or believed when they report and their experiences are not afforded the same significance as those of other children, leaving disabled children with a shortage of therapeutic and supportive services to aid recovery.

Thus children with disabilities face additional risks alongside those they share with other children and young people. Informed estimates as to the extent of this heightened risk have varied. NCCAN in the United States estimated that the increased risk runs at 1.7 times more than for children without disabilities across all types of abuse and that they are 4 to 10 times more vulnerable to sexual abuse than their non-disabled peers. Sobsey thought that disabled children were approximately twice as likely to have experienced abuse as their non-disabled peers (Sobsey, 1994:4).

Deaf children seemed to experience a particularly high level of sexual abuse. Kvam (2004) reported that deaf women in Norway reported childhood sexual abuse more than twice as often as the hearing population (39.6% as compared to 19.2%) and that deaf men were more than three times as likely to have been abused (32.8% compared to 9.6% in the general population).

The response – Inclusion of children and young people with disabilities in mainstream child protection processes

Despite the consensus that there is an increased risk to children with disabilities, this has not filtered through into increased reporting within statutory child protection systems. Kvam (2000) noted a discrepancy in the other direction within the Norwegian system in that despite the expectation that there would be a higher rate of abuse there was actually a lower rate of reporting. Overall disabled children formed 11% of her sample population, and if the estimates of increased risk are sound, disabled children would have been expected to feature in about one third of the overall cases reported to the authorities; but instead they accounted for only 6.4% of the total reports. Children with severe disabilities were the subject of only 1.7% of cases. The author suggested a number of mechanisms that might explain this fall off in reporting: disabled children are less likely to disclose; they are less likely to have their disclosure listened to; and more likely to have their abuse minimised or brushed aside.

Considerable advances have been made in judicial processes that allow all children and specifically children with additional needs to participate as victims and witnesses. Marchant and Page (1992, 1997) have begun to set out how innovative communication methods could be used in interviews that had twin evidential and therapeutic aims. Research into credibility and capacity to act as a reliable witness in court has also been the subject of recent research (Gudjonsson et al., 2000). There have also been helpful developments in legislation and practice in the UK, including the increased use of video interviews, live video links to allow children to give evidence and be cross examined without having to come face to face with their abuser in court, and in some cases using advocates and intermediaries in the courtroom.

Knowledge of child protection within specialist service agencies

In specialist agencies a primary focus on disability may blind those responsible to the signs and symptoms of abuse. There cannot be

definitive lists of how abuse will be manifested by children of different ages, (dis)abilities and personality. What is needed is a careful vigilance coupled with a commitment to provide children with disabilities with “permission” to tell responsible adults if anyone acts inappropriately around them and to provide disabled young people with information that will allow them to enter into age-appropriate sexual relationships from a position of confidence. Where a child or young person is unable to communicate any concerns, the service should make explicit and ongoing provision for independent advocacy and professional input.

Specialist agencies should design safety into their services from the outset. They should remember that this is not a matter that can or should be dealt with behind closed doors. Disability services should make training in child protection a mandatory requirement for *all* their staff and not an optional extra that is disregarded or downplayed. Policies should set out guidance about how individual staff can raise concerns, about their responsibility to share information on a careful, need-to-know basis, and about their duty to involve outside agencies. But abuse should also be flagged up in generic policies, particularly regarding recruitment, where rigorous checks, gathering of references and careful interviewing are crucial.

The informal culture of a service should also be attended to and any hint that it is inappropriately sexualised should be confronted at the earliest opportunity. Personal care – a feature of many services for children and young people with disabilities – is a sensitive area and must be managed with tact and care. It is not appropriate for this to become a site of sexualised remarks, embarrassment, humiliation or blurred boundaries. Because young people with disabilities may be living in specialist settings and cared for by staff near to their own ages, they may develop attractions that they need help in managing, and which young, often inexperienced staff must be helped to contain (Thompson, Clare and Brown, 1997).

Sexual abuse within the Church

Abuse by clergy shows similar features to that perpetrated by other sex offenders, and the response of the Church bears the hallmarks of resistance and denial as has been witnessed in other organisations. There are, however, some aspects to this abuse that have proved particularly troubling to affected communities, and particularly in those countries, such as Ireland, where social care services and institutional care for disabled children has been organised and run by religious bodies. The separation of church and state, and the secular government's responsibilities for "policing" these arrangements must be rigorously upheld. In Ireland, abuse by clergy was carried out disproportionately against boys: three times as many boys as girls were abused (Goode et al., 2003:25). Most (64%) of this abuse was targeted at children under 13. A significant result has been the sense of betrayal of what was regarded as a privileged relationship between priest and community, especially where the community had trusted their most vulnerable children and young people to the care of the church. These issues have been the subject of considerable public fact-finding and deliberation in Ireland over the last 10 years but this is not to suggest that other countries and other faith groups are immune.

Consequences of sexual abuse for children and young people with disabilities

Sexual abuse of *any* child or young person is a breach of trust that permeates their expectations of others, whether caregivers or future partners. Of course people recover and become strong, but they are left with scars on their souls and in their minds (Higgins and Swain, 2010).

Mental health problems have been increasingly acknowledged as one of the most common consequences of child sexual abuse so that children and young people who suffer sustained assaults, particularly from someone in a position of trust, often go on to exhibit symptoms

of post-traumatic stress disorder, borderline personality disorder and /or dissociative identity disorders.

Short-term impact of sexual abuse may include withdrawal from school, difficulties in communication and academic delay. This can sometimes lead to confusion about whether a presentation that is defined as a mild intellectual disability or a mental health problem signals a pre-existing condition or a consequence of abuse.

Long-term effects of child abuse include fear, anxiety, depression, anger, hostility, inappropriate sexual behaviour, poor self-esteem, a tendency toward substance abuse and difficulty with close relationships.

These conditions are helpfully thought about as specialised presentations of cumulative post-traumatic stress disorder, since they demonstrate ways of coping with unbearable and terrifying experiences, and of blanking off from traumatic memories, typified by episodes of dissociation and rapid changes of mood and mental states. More recent studies have explored the impact of sexual abuse specifically on children with severe intellectual disabilities, confirming that they share some of these long-term impacts of abuse in childhood (O'Callaghan, Murphy and Clare, 2003).

This fall out from childhood sexual abuse leads many survivors to seek help from mental health services in adolescence or adulthood and, depending on the nature and extent of their suffering, their personal resilience and social supports, they may *become* more “disabled” as a result of this abuse. This should require all mental health services for young people to take both abuse and disability into account. They should ensure that their provision is accessible to people with mobility or sensory impairments, is equipped to offer services to people using different modes of communication and be very clear about which elements of their service are offered in mainstream mental health provision and which in specific disability services. Services for children and young people with intellectual disabilities should not propose a second class, or watered

down service to survivors of sexual abuse, but one that is informed by best practice with other survivors.

Disabled children and young people who develop mental health problems or challenging behaviours as a result of abuse are rendered vulnerable to further stigmatisation, and their experiences may be lost behind medicalised diagnoses that fail to acknowledge the events that caused them such distress (Rose, Peabody and Stratigeas, 1991). Plans should be in place to ensure that all staff are proactive in asking about abuse during clinical assessments and that mental health services are explicit about their remit in providing services for survivors (NHS Confederation, 2008).

So in this field disability should be perceived as both a predisposing risk factor to abuse *and* a consequence of it.

Concluding remarks and recommendations

Children and young people with disabilities require professionals to keep a close watch on their sexual safety without compromising their hard won freedoms and sexual autonomy. They need safe services that are committed to careful recruitment. They need independent scrutiny and regulation of these agencies and of the individuals who work in them, and they need clear channels for reporting so that any allegations or complaints can be directed to the proper civil authorities in the event that they are harmed. They need recourse to justice just as other children and young people need the law to take their needs into account in the judicial process. They need the criminal justice system to act for them as victims and to respect them as witnesses.

They need mainstream child protection agencies to look out for them, to remember them and their particular needs and vulnerabilities when acting for other children in a family, school or neighbourhood. Professionals and criminal justice officials should remember that disability does not confer an immunity to sexual abuse but creates an additional risk factor and that if they overlook children with disabili-

ties they add to a perception that abuse against a disabled child or young person matters less than abuse against other more “normal” children and/or that perpetrators will not be as rigorously pursued or brought to justice. Mainstream schools, youth clubs and sports associations should also be mindful of the safety of disabled young people and of their particular vulnerability to bullying, intimidation and sexual abuse. Abuse of disabled children should also be made visible in official statistics so that professionals across all agencies can begin to learn about their particular experiences of sexual abuse and their own agencies’ responses to it.

Specialist agencies also need to remember that they are a part of, and are accountable to, wider professional networks which confer on them responsibilities to report abuse, to cooperate with investigations and to impose appropriate sanctions on individuals who have offended against the children and young people in their care. The evidence suggests that children and young people with disabilities are at greater risk of sexual abuse but are less protected and supported than their peers. They do not want to be wrapped in cotton wool but they, and their parents, do demand that an equivalent level of consideration be given to their protection as is given to other children. Disabled children and young people should be placed at the centre of robust safeguarding procedures within a criminal justice and social welfare system that is newly sensitised to the sexual abuse of *all* children and young people.

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