CHILD ABUSE

Definition:
1 Child abuse and neglect: The physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child < 18 yr.

DESCRIPTION OF CHILD ABUSE AND NEGLECT

Physical abuse involves the physical battery of a child.

Emotional abuse involves the emotional or mental battery of a child, which often damages the child’s emotional growth and self-esteem.

Sexual abuse or molestation includes exposure, genital manipulation, sodomy, fellatio, and coitus. Vaginal penetration by an unrelated person constitutes rape. Often, the adult is a close family friend. If the adult is biologically related, the offense is termed incest. When young children are involved, the offense most often is nonviolent and repetitive and may be concealed within the family.

Neglect includes failure to meet a child’s basic physical and medical needs, emotional deprivation, and desertion.

All social classes and races contribute to incidents of abuse and neglect, but poor children suffer such incidents 12 times more frequently than others. About 25% of abused or neglected children are < 2 yr. Both sexes are affected equally. In 1994 in the USA, 2 million cases were reported, of which 1 million were confirmed. Of confirmed cases, 53% involved neglect; 26%, physical abuse; 14%, sexual abuse; and 5%, emotional abuse. About 20% of physically abused children are permanently injured, and 1000 to 1200 children die each year in the USA.

Physicians are required by law to report incidents of suspected abuse or neglect in any child whom they examine or treat and are granted immunity from suit or liability for so reporting. The reports usually are made to a designated child protection agency.

ETIOLOGY
Abuse and neglect are complicated problems of adult-child interactions that often coexist and may not be easily differentiated.

Abuse:
Generally, abuse is caused by the breakdown of impulse control in the parent or guardian. Four contributing factors are recognized:

1. Parental personality features: The childhood experience of the parent may have lacked affection and warmth, often included abuse, and was not conducive to the development of adequate self-esteem or emotional maturity. Lacking an early loving environment, abusive parents may look toward their children as a source of the affection and support they never received. As a result, they may have unrealistic expectations of what their child can supply for them; they are frustrated easily and lose control, unable to give what they never experienced. Drug or alcohol use may provoke impulsive and uncontrolled behaviors toward the child. Less commonly, a parent may be frankly psychotic.

2. A "difficult" child: Irritable, demanding, or hyperactive children may provoke parents' tempers, as may a handicapped child, who often is more dependent for care. Premature or sick infants separated from parents early in infancy and biologically unrelated children (eg, stepchildren) may not form strong emotional ties with their parents or guardians. Even in the absence of these conditions, parents may have unrealistic expectations of what a child's performance should be and may punish him severely with little justification.

3. Inadequate support: Parents may feel isolated, unprotected, and vulnerable without the physical and psychological support of relatives, friends, neighbors, or peers, particularly in times of stress.

4. A crisis: Situational stress may precipitate abuse, particularly when support is unavailable.

Neglect:
Often, neglect is seen among families with physical, psychological, or substance abuse problems. Acute or chronic depression, especially maternal, is often present; chronic medical problems of a parent may also contribute. Drug or alcohol abuse by one or both parents frequently results in chronic impoverishment and a distortion of priorities in family life. Desertion by the father, himself inadequate, unable or unwilling to assert a controlling influence in the family, may precipitate neglect. Children of cocaine-using mothers are particularly at risk for desertion.

MANIFESTATIONS OF ABUSE

History:
Features suggestive of abuse are (1) parental reluctance to give a history of injury; (2) a history that may be inconsistent with the apparent stage of resolution of the injury and may vary depending on the information source; (3) a history of injury that is incompatible with the child's developmental capability; (4) an inappropriate response by the parents to the severity of the injury; and (5) delay in reporting the injury.

Physical:
Common signs are skin lesions, such as ecchymoses, hematomas, burns, welts, and abrasions in various stages of development (eg, cigarette burns, arcuate bruises from extension cord whipping, symmetric scald burns of upper or lower extremities); serious traumatic injury to the mouth, eye, abdominal organs, and CNS, which may produce permanent damage; and fractures. Fractures may be single or multiple, and a skeletal survey may show bony injuries in various stages of resolution. Metaphyseal fractures and subperiosteal elevations in long bones occur in infants. Major diagnostic considerations in the examination are (1)
multiple injuries at different stages of resolution or development; (2) cutaneous lesions specific for particular sources of injury; and (3) repeated injury, which is suggestive of abuse or inadequate supervision.

Physical signs of sexual abuse may include difficulty in walking or sitting, genital trauma, vaginal discharge or pruritus, recurrent UTIs, or a sexually transmitted infection. However, there may be no physical indications of injury. Sexually transmitted disease of any sort in any child < 12 or 13 yr must be viewed as the result of sexual molestation until ruled out.

EMOTIONAL MANIFESTATIONS

Emotional:
Emotional manifestations of abuse are less easily defined than are physical signs. In infants, failure to thrive (Weight consistently below the 3rd percentile for age; progressive decrease in weight to below the 3rd percentile; weight < 80% of ideal weight for height-age; or a decrease in expected rate of growth based on the child’s previously defined growth curve, irrespective of whether below the 3rd percentile) is a common early observation. Delayed development of social and language skills often results from inadequate parental stimulation and interaction. Small children may be distrustful, superficial in interpersonal relationships, passive, and overly concerned with pleasing adults. The emotional impact on children usually becomes obvious at school age, when difficulties develop in forming relationships with teachers and peers. Often, emotional effects can be documented only after the child has been placed in another environment, at which time aberrant behaviors abate.

When a child has been sexually abused, his behavior (eg, irritability, fearfulness, insomnia) may be the only clue for diagnosis. Careful interviewing of the child by a trained professional may be the only means of adding necessary details. Older children may be threatened with physical injury by the offender if they tell and, thus, may conceal repeated assaults.

MANIFESTATIONS OF NEGLECT

Malnutrition, fatigue, and lack of hygiene or appropriate clothing are common due to inadequate provision of food, clothing, or shelter, despite available supportive community resources. Desertion or death by starvation is seen in extreme cases. As many as 1/2 of infantile failure-to-thrive cases may be due to neglect.

In early infancy, retardation of emotional growth may occur with blunting of affect and lack of interest in the environment. This commonly accompanies failure to thrive and is often misdiagnosed as mental retardation or physical illness. Signs of emotional deprivation in older children include poor attendance and performance at school and bad relationships with peers and adults.

Failure to seek preventive medical or dental attention, such as immunizations and routine health supervision, and delay in seeking care for illness may be clues to inadequate family functioning.

PREVENTION

Knowing which settings are conducive to abuse and neglect helps identify at-risk families. Parents who have been victims of abuse or neglect are especially apt to interact in like fashion with their children. Such parents often verbalize anxiety about their abusive background and are amenable to assistance. First-time parents and teenage mothers rebelling against their parents are also at risk. Medical problems during pregnancy, delivery, or early infancy that may affect the baby’s health can weaken parent-infant bonding (see also Parent-Infant Bonding: The Sick Newborn in Ch. 257). During such times it is important to elicit the
parents' feelings about their own inadequacies and the baby's well-being. How well can they tolerate a small or sickly baby in the house? Does the father give moral and physical support to the mother? Are there relatives or friends to help in times of need? The care provider who is alert to clues and able to provide support in such settings goes a long way toward preventing tragic events.

**TREATMENT**

Treatment must involve a long-range perspective, because the disturbed patterns of personal interaction are usually long-standing. In both abuse and neglect settings, families should be approached in a helping rather than a punitive manner.

A careful review of the family setting and of the parents' deficiencies and needs is essential diagnostically and is the first step in treatment. Hospitalization of the child (emergency temporary removal from the home) usually is not required and depends on the rapport established with the parents. When hospitalization is necessary, parents should be told that they will be interviewed and that their child will undergo diagnostic tests.

**Social work consultation:**
Adequate understanding of the parents' backgrounds usually requires considerable review of medical records and of prior contacts with various community service agencies. A social worker can help conduct such reviews and may help with interviews and family counseling.

**Reporting to a social service or welfare department:**
When abuse or neglect cases are reported, a face-to-face conference should be held if possible with a child protective services representative to ensure clear understanding and to help in treatment planning. The parents should be told beforehand by the physician that a report is being made pursuant to the law.

**Care planning:**
Many communities have a multidisciplinary team consisting of a social worker, psychiatrist, pediatrician, and primary care person to provide diagnostic assistance and guidance in designing a treatment program. A source of primary medical care is fundamental and should be acceptable to both the family and the reporting physician. Periodic or ongoing social work contact usually is needed. Psychiatric assistance in understanding personality disorders and in dealing with specific conditions, such as depression, often is indicated.

**TREATMENT CONTINUED**

**Managing the effects of sexual molestation:**
Sex offenses may have lasting psychologic effects on the child's development and sexual adaptation, particularly among older children and teenagers. Counseling or psychotherapy for the child and the adults concerned may lessen these effects.

**Community care programs:**
Day care centers for small children and homemaker services can relieve a mother under stress, allowing her a few hours each day for herself. Parent-aide programs, which employ trained nonprofessionals to relate closely to abusive and negligent parents, are being developed in some communities. Parents Anonymous groups also have been successful.
Temporary removal from the home:
If the home setting carries a high risk to the child's health, if the abused child is < 1 yr of age, or if work with the family has not progressed, temporary removal may be indicated, particularly if the child has identified his abuser and will be returning to the care of that person and other caregivers do not support the child's allegations. Removal requires a court petition, presented by the legal counsel of the appropriate welfare department. The procedure varies from state to state but usually entails family court testimony by a physician. When the court decides in favor of removing the child from the home, a disposition is arranged. The family's physician should participate in this disposition planning; if not, his agreement and consent to the disposition should be sought. While the child is in temporary placement, the physician should, if possible, maintain contact with the parents and ensure that adequate efforts are being made to help them. He should also participate when the decision is made to reunite child and parents. As the dynamics of the family setting improve, the child may be able to return to the parents' care. However, recurrences of abuse are common. Permanent removal may be indicated.

Follow-up:
The families of abused and neglected children frequently relocate, making continuity of care very difficult. Broken appointments are common; outreach and home visits by social workers or a public health nurse may be needed to relay the patient's progress to all concerned.
BACKGROUND

Over the past 35 years, tremendous strides have been made in identifying and increasing awareness about patterns of abusive relationships. Child abuse and domestic violence have received significantly more recognition than elder abuse and continue to receive more attention in both public and medical domains, although abuse clearly occurs in persons of all ages.

People are living longer with current medical advances and healthier lifestyles. In 1990, it was estimated that older persons comprised just 13% of the US population. By the year 2050, this proportion is projected to increase to 25%; the number of people older than 85 years is expected to double.

As a result, the number of elder abuse cases will increase, and the impact of elder abuse as a public health issue will grow. Aging adults involved in abusive relationships often visit the ED for treatment. Emergency physicians are well positioned to help these victims.

TERMINOLOGY

The terminology used to describe elder abuse is not consistent. Terms vary among researchers, and usage is not consistent in the laws of different states. Even the age at which a person is considered elderly, usually 60 or 65 years, is debated. Seven categories of elder abuse have been described by the National Center on Elder Abuse (NCEA), formerly the National Aging Resource Center on Elder Abuse. Categories include the following:

- Physical abuse is defined as any act of violence that causes pain, injury, impairment, or disease, including striking, pushing, force-feeding, and improper use of physical restraints or medication.
- Psychological or emotional abuse is conduct that causes mental anguish. Examples include threats, verbal or nonverbal insults, isolation, and humiliation. Some legal definitions require identification of at least 10 episodes of this type of behavior within a single year to constitute abuse.
- Financial abuse is misuse of an elderly person’s money or assets for personal gain. Acts such as stealing (eg, money, social security checks, possessions) or coercion (eg, changing a will, assuming power of attorney) constitute financial abuse.
- Neglect is the failure of a caretaker to provide for the patient’s basic needs. As in the previous examples of abuse, neglect can be physical, emotional, or financial. Physical neglect is failure to provide eyeglasses or dentures, preventive health care, safety precautions, or hygiene. Emotional neglect includes failure to provide social stimulation (eg, leaving an older person alone for extended periods). Financial neglect involves failure to use the resources available to restore or maintain the well-being of the aging adult.
- Sexual abuse is defined as nonconsensual intimate contact or exposure or any similar activity when the patient is incapable of giving consent. Family members, friends, institutional employees, and fellow patients can commit sexual abuse.
- Self-neglect is behavior in which seniors compromise their own health and safety, as when an aging adult refuses needed help with various daily activities. When the patient is deemed competent, many ethical questions arise regarding the patient’s right of autonomy and the physician’s oath of beneficence.
The miscellaneous category includes all other types of abuse, including violation of personal rights (e.g., failing to respect the aging person’s dignity and autonomy), medical abuse, and abandonment.

**FREQUENCY**

In the US:
Due to the inconsistencies in definitions of elder abuse, obtaining accurate information on elder abuse incidence is difficult. A 1991 report from the House Select Committee on Aging suggests that 1-2 million adults older than 60 years are abused each year. Other studies suggest that 3-10% of elders are abused or neglected.

Many factors (e.g., fear, shame, guilt, ignorance) play a role in the likely underestimation of the number of abused elders. In addition, many studies routinely exclude certain populations (e.g., persons possibly unable to respond to a survey, speakers of languages other than English, persons with mental illness), further complicating accurate tallies of the number of older persons who are abused.

**RACE**

Elder abuse occurs among members of all racial, socioeconomic, and religious backgrounds. The NCEA found the following racial and ethnic distribution among older persons who had been abused:

- White, non-Hispanic – 66.4%
- Black – 18.7%
- Hispanic – 10%
- Other – 4.9%

**SEX**

Women are believed to be the most common victims of abuse, perhaps because they report abuse at higher rates or because the severity of injury in women typically is greater than in men. Numerous studies, however, have found no differences based on sex.

**AGE**

By definition, elder abuse occurs in the elderly, although there is no universally accepted definition of when old age begins. Typically, 60 or 65 years is considered the threshold of old age.

**HISTORY**

The American Medical Association recommends that doctors routinely ask geriatric patients about abuse, even if signs are absent. Keeping questions direct and simple and asking in a nonjudgmental or non-threatening manner increases the likelihood that patients will respond candidly. The patient and the caregiver should be interviewed together and separately to detect disparities offering clues to the diagnosis of abuse. Accurate, objective documentation of the interview is essential. The following questions can be used to elicit information about elder abuse.

**Physical abuse**
- Are you afraid of anyone at home?
- Have you been struck, slapped, or kicked?
- Have you been tied down or locked in a room?
- Have you been force-fed?

**Psychological abuse**

- Do you ever feel alone?
- Have you been threatened with punishment, deprivation, or institutionalization?
- Have you received “the silent treatment”?
- Do you receive routine news or information?
- What happens when you and your caregiver disagree?

**Sexual abuse: Has anyone touched you in a sexual way without permission?**

**Neglect**

- Do you lack items such as eyeglasses, hearing aids, or false teeth?
- Have you been left alone for long periods?
- Is your home safe?
- Has anyone failed to help you care for yourself when you needed assistance?

**Financial abuse**

- Is money being stolen from you or used inappropriately?
- Have you been forced to sign a power of attorney, will, or another document against your wishes?
- Have you been forced to make purchases against your wishes?
- Does your caregiver depend on you for financial support?

**Follow-up questions (if abuse is identified)**

- How long has the abuse been occurring?
- Is it an isolated incident?
- Why do you think this happens?
- When do you think the next episode will occur?
- Is the abuser present in the ED?
- Is it safe for you to return home?
- What would you like to see happen?

**Have you ever received help for this problem before?**

**PHYSICAL**
As with other abusive relationships, elder abuse rarely resolves itself and probably will escalate over time. Signs of abuse may be blatant or subtle. A study by Lachs et al failed to show a specific injury type or pattern common to elderly persons who had been abused; therefore, consider abuse in the differential diagnosis of every elderly person entering the ED. A number of clinical findings and observations make elder abuse a strong possibility, including the following:

- Several injuries in various stages of evolution
- Unexplained injuries
- Delay in seeking treatment
- Injuries inconsistent with history
- Contradictory explanations given by the patient and caregiver
- Laboratory findings indicating underdosage or overdosage of medications
- Bruises, welts, lacerations, rope marks, burns
- Venereal disease or genital infections
- Dehydration, malnutrition, decubitus ulcers, poor hygiene
- Signs of withdrawal, depression, agitation, or infantile behavior

CAUSES

Many theories have been developed to explain abusive behavior toward elderly people. Clearly, no single answer exists to explain behavior in an abusive relationship. A number of psychosocial and cultural factors are involved. Theories of the origin of mistreatment of elders have been divided into 4 major categories, as follows: physical and mental impairment of the patient, caregiver stress, transgenerational violence, and psychopathology in the abuser.

- Physical and mental impairment of the patient
  - Recent studies have failed to show direct correlation between patient frailty and abuse, even though it had been assumed that frailty itself was a risk factor for abuse.
  - Physical and mental impairment nevertheless appear to play an indirect role in elder abuse, decreasing seniors' ability to defend themselves or to escape, thus increasing vulnerability.

- Caregiver stress
  - This theory suggests that elder abuse is caused by the stress associated with caring for an elderly patient, compounded by stresses from the outside world.
  - The effect of stress factors (eg, alcohol or drug abuse, potential for injury from falls, incontinence, elderly persons’ violent verbal behavior, employment problems, low income on the part of the abuser) may all culminate in caregivers’ expressions of anger or antagonism toward the elderly person, resulting in violence.
  - This theory, however, does not explain how individuals in identically stressful situations manage without abusing seniors in their care. Stress should be seen more as a trigger for abuse than as a cause.

- Transgenerational violence: This theory asserts that family violence is a learned behavior that is passed down from generation to generation. Thus, the child who was once abused by the parent continues the cycle of violence when both are older.

- Psychopathology in the abuser: This theory focuses on a psychological deficiency in the development of the abuser. Drug and alcohol addiction, personality disorders, mental retardation, dementia, and other conditions can increase the likelihood of elder abuse. In fact, family members with such conditions are most likely to be primary caretakers for
elderly relatives because they are the individuals typically at home due to lack of employment.

- Other risk factors in abuse are (1) shared living arrangements between the elder person and the abuser, (2) dependence of the abuser on the victim, and (3) social isolation of the elder person.

**TREATMENT**

Emergency Care: Many factors are involved in the management of older persons who have been abused, including immediate care, long-term assessment and care, education, and prevention. Intervention can be a lengthy process, especially in a busy crisis center. Many behavioral organizations have developed multidisciplinary teams (ie, social workers, physicians, nurses, administrators) to help in these situations. The ultimate goal is to provide the aging adult with a more fulfilling and enjoyable life.

- Immediate care focuses on treating the physical manifestations of abuse and assuring the safety of the patient. This may include the following:
  - Admitting the patient to the hospital
  - Obtaining a court protective order
  - Placing the patient in a safe home
  - Permitting return home if the patient is competent and refuses intervention

No specific medication is used to treat elder abuse. Avoid anxiolytics and hypnotics because they make patients less able to defend themselves against acts of abuse.

**FURTHER OUTPATIENT CARE**

- Long-term assessment and care vary with the needs of the patient. Assessment usually involves a visit to the home to evaluate the patient's functional status, living environment, and the condition of the caregiver. The services needed to optimize the care of the patient can be determined only after a home visit.

Stress to competent patients who refuse help that abuse rarely resolves—it usually escalates. Inform patients that a number of agencies can provide help; provide phone numbers and addresses of these agencies.

**MEDICAL/LEGAL PITFALLS**

Report all cases of suspected elder abuse to Adult Protective Services. Practically every state has a law mandating that physicians report elder mistreatment, and many have penalties for failing to report. Forty-three states mandate reporting of suspected cases of elder abuse. Some statutes require that licensed professionals who have not fulfilled their obligations to report elder abuse can be reported to the appropriate licensing authority.

Mandatory reporting of elder abuse in competent patients is a controversial topic. A mandate to report domestic violence is seen by some as disempowering the abused individual, violating the right of autonomy. Therefore, reporting is not mandated in domestic violence cases.

- Many use the same logic that mandatory reporting of abuse of mentally competent victims of elder abuse disempowers
the abused individual.

- The laws created for elder abuse were based upon child abuse laws; therefore, the inability of patients to make decisions in their own best interests was presumed. The laws are weak on matters such as financial abuse, since children generally have no money to exploit.

While the laws are not perfect, a diagnosis of elder abuse, in fact, is reportable.

**SPECIAL CONCERNS**

Barriers to recognizing and reporting elder abuse also must be addressed. The lack of uniform definitions has been a major obstacle. Conceptual problems in defining elder abuse have hampered clinical, educational, and research efforts.

Various factors serve as barriers to reporting elder abuse (e.g., lack of knowledge, denial, ageism, fear of making the situation worse, desire to maintain family relationships, fear of ending up in court, lack of belief that the situation will improve). The key to eradicating these barriers is education that increases both public and professional awareness.

Increasing awareness is considered instrumental in the prevention of elder abuse. Services for seniors, such as meals on wheels, home health care, homemaker, and chore services, are thought to aid in abuse prevention, although preventing elder abuse needs further study.

Safety and follow-up plans before the patient leaves the crisis unit

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**Abuse of People with Developmental Disabilities**

Nora J. Baladerian, Ph.D., M.F.C.C.

**Introduction**

Abuse is one of the "hidden" areas of life of the disabled person with a developmental disability. Many professionals have trouble dealing with sexuality and developmental disability, much less acknowledging the existence and even pervasiveness of sexual abuse of people with developmental disabilities.

The victims of abuse continue to suffer the short and long term effects, suffer ongoing abuses, and multiple abuses, whether or not professionals choose to see it. This course reviews seven areas:
DEFINING ABUSE

There are many definitions, legal and operational, of abuse. Overall, abuse is the non-accidental injury or committing of acts that could result in injury, through acts of omission or commission. The seriousness and nature of the injury require discretion, on the part of the reporter, to determine if the real or potential injury is "serious", and if the acts or omissions that cause the injury are non-accidental. Those who cause these abuses may be individuals, institutions or society as a whole.

Who "individuals" are, is clear. Institutional abuse includes approved or non-consequated (new word!!) abuse of children in schools, juvenile courts, and other agencies. Societal abuse refers to approved or non-consequated abuse of children by society as a whole, for example the fact that only in 1962 was "child abuse" even recognized by professionals who work with children, after centuries of preferring to turn away from acknowledging the plight of children...to the detriment of children, and in the endeavor to "protect" parents from embarrassment.

IDENTIFYING TYPES OF ABUSE

The types of abuse experienced by children (with disabilities or not) fall into the following categories:

Physical abuse: Any non-accidental physical injury or injuries to a child by a caretaker. This includes: drug use, drug use by infants/children, burning, whipping, scalding, hitting with objects such as hammers, slamming into walls, stomping over, kicking, shaking; resulting in abrasions, lacerations, bruises, scars, fractures, brain damage, sensory impairment (blindness, deafness).

Satanic or cult ritual torture, mutilation or murder of children.

Other types of homicide (drowning, stabbing).

Physical neglect: Failure to provide adequate food, shelter, clothing, protection, supervision and medical and dental care. Signs are: starving, child always sleepy or hungry, unsanitary conditions in the home (garbage, animal or human excrement), lack of heating, fire hazard, abandonment.

EMOTIONAL ABUSE

A pattern of verbal assaults or coercive measures against a child destructive of his self-esteem. For example, belittling, blaming, sarcasm; unpredictable responses (child never knows when the next emotional outburst is coming, and the outbursts are unrelated to child's behavior); constant discord in the home, humiliating the child. (You dummy, you'll never amount to anything; what's the matter with you?; why do you always...; you're no good now, and you never will be; I wish you had never been born...I didn't want you anyhow.) Emotional abuse is always a component of the other types of abuse, as a consequence of
their occurrence. Viewing the cult ritual torture/mutilation/murder of other children and animals takes its toll emotionally. The perpetrators almost always threaten the children if they tell someone about what is going on, and these threats seem real...and often are...to the children. They say, "if you tell, no-one will believe you anyway"; "you can't live at home anymore" ...or, "you're dog will die", "you'll get me in trouble, and then mommy will be mad at you".

EMOTIONAL NEGLECT

The failure to provide the nurturing or stimulation needed for the child's social, intellectual and emotional growth. This includes: ignoring the child, rare demonstration of affection to child (or none).

SEXUAL ABUSE

Any sexual contact, between an adult and a child 16 years of age and under. This includes: exploitation (using the child for one's own sexual excitement through taking pictures, showing pictures), incest, rape, fondling, oral sex, anal sex, penetration with objects, exposure, forcing child to commit sexual acts on other adults and children, forcing a child to masturbate self or others (adults/children), and satanic sexual rituals including sexual mutilation, and torture.

MURDER

This really falls under physical abuse, but as it is so important, I like to create a separate category for this. Two examples. Ray Walker, a profoundly retarded man, 28 years old, was found dead in a box that was nailed shut. He had been missing for more than 7 days. He had been living in a licensed residential home for 6 disabled men. This is an example of an individual perpetration of abuse. His murderer was found and prosecuted. The license for the home was revoked for 2 years. Baby Doe Bloomington was also murdered, the perpetrator being both an individual (his physician) and society. He was born with an esophageal fistula, a condition that sent food right back up from the stomach, inhibiting the processing of food.

This is an easily correctable condition, and standard procedure, as this happens to a large number of newborns. However, Baby Doe Bloomington also had Down's Syndrome, which indicates a high probability of retardation, but the level cannot be known until the child is at least 3 to 5 years of age. The physician recommended, and the parents agreed, that the corrective surgery not be performed, that the child not be given any medical treatment at all, which includes food and water, so that he would die. The nurses refused to comply, so private nurses were hired, and the child removed to a private room at the hospital. Appeals to the court upheld the doctors's orders. He starved to death. This case, however, was not considered abuse, nor reported as abuse. He was considered to have died of natural causes.

FINANCIAL ABUSE

The misuse of the funds of another, including the keeping of funds from it's due recipient. This has more application for dependent adults, and frequently goes along with physical and emotional neglect.

STATE LAWS

REPORTING ABUSE AND NEGLECT

The Law:
Chapter 415, Florida Statues provides a central abuse registry
(1-800-96-ABUSE)
Defines who must report abuse
Assigns the Department of Children and Family all responsibility for receiving, investigating and acting on all reports

**Immunity from Liability and Confidentiality:**

- Florida Law Protection
- Reports made “IN GOOD FAITH” immune from civil or criminal charges
- Reporter’s name will not be released to anyone (other than DCF, State Attorney’s Office, or written consent of reporter
- Encourages professionals to inform families that he/she is obligated by law to report

**Privileged Communication:**

- Florida Law - holds that privileged communication may not constitute grounds for failure to report suspected abuse or failure to cooperate with the Department of Children and Families or give evidence in judicial proceedings.
- EXCEPTION: Attorney and client involved with court as result of report, and clergymen and counselee

**When to Report:**

- Injury requiring medical treatment outside of normal discipline
- Old and new bruises, bruises on the face, bruises on child of less than one year of age
- Punishment that consists of hitting with closed fist or instrument, kicking, inflicting burns, throwing child (regardless of severity of resulting injury).
- Any indication of sexual abuse
- Non-physical (indecent exposure, photography)
- Non-violent (fondling, touching sexual organs, sex play
- Violent (forcible rape, sodomy, oral sex)
- Inadequate nourishment, health care, clothing, supervision, shelter
- Deprivation of emotional nourishment

**Reporting:**

- Report as quickly as possible
- Thorough documentation of abuse/neglect indicators or injury
- Report with “Reasonable Cause to Suspect”

**How to Report:**

- Call 1-800-96-ABUSE - 1-800-962-2873 24 hours a day 7 days a week
- Provide - Names, addresses of child, parent(s), guardian(s) or other persons responsible for child/adult’s welfare
- Provide child/adult age, race sex, sibling(s)
IDENTIFYING THE PERPETRATORS

In the case of children with disabilities and dependent adults, 99% of the perpetrators are well known to and trusted by the victim. So who are they: they are parents, extended family members, special education teachers, aides, bus drivers, psychologists, psychiatrists, physical therapists, occupational therapists, medical doctors (pediatricians, gynecologists), recreational specialists: boy/girl scout leaders, camping leaders, residential care providers and aides...in short, any category of person who deals with disabled children and dependent adults has been charged and convicted of abuse of their clients.

Examples:
President of a sheltered workshop for 20 years; chief psychiatrist of the adolescent unit for mentally ill children (also 20 years); physical therapist for children with cerebral palsy; camp leader for young adults with developmental disabilities.

INCIDENCE AND PREVALENCE

Although one would think that data would be kept on such an important item, very little has been done to document abuse of people with disabilities. Some feel this reflects the strong repulsion from the knowledge of the problem. Others believe that children and adults with disabilities represent such a small number percentage-wise it isn't all that important. Some believe the disabled themselves aren't that important (A high ranking staff member of the Los Angeles County Department of Children's Services stated, "I just can't get excited about this issue!") Others, I believe just never thought of it. Whatever the reasons, the following are the accomplishments to date on data collection.

1. The United Cerebral Palsy organization estimates that 11% of their constituents have cerebral palsy as a result of physical abuse!
2. "Child Abuse and Developmental Disabilities" is published by the Regional Developmental Disabilities Offices in Boston. It includes the following data: In an examination by David Gil in 1970 of confirmed cases of child abuse, 29% of the children had demonstrated a developmental disability prior to the abuse. A national survey conducted of Parents Anonymous members showed that 58% of the member's abused children had developmental problems prior to abuse incidents In a study conducted by the Denver Department of Welfare, nearly 70% of the children exhibited either a mental or physical deviation prior to their reported abuse.
3. California Association for Retarded Citizens reported in its 10/12/84 newsletter, that two to two and a half million children a year are born with some effects of Fetal Alcohol syndrome (FAS), which makes it the third most common cause of mental retardation
4. The Seattle Rape Relief Project on the Developmentally Disabled (1) for 1977-79 found of their program participants 70% had had at least 1 incident of sexual abuse (remember the definitions). None of these had been reported prior to involvement in the program. Their estimates are that of the population, of individuals with developmental disabilities approximately 75% experience abuse, prior to age 18.
5. Other estimates on sexual abuse put the number at approximately 10 times the rate in the general population. Estimates
in the general population are 1 in 4 girls, 1 in 6 boys will be molested prior to age 18. Ten times 1 in 4 indicates 99% will experience up to 4 incidents of sexual abuse. This is closer to the experience of Sex and Developmental Disability professionals. As yet, there is not a data back-up on this.

Incidence of dependent adult abuse is really unknown, as laws regarding its remediation and reporting are so new and the guidelines are not even written. Other states are equally delayed in this area of knowledge.

Regional Centers for the Developmentally Disabled vary greatly in their approach to abuse of their clients. Some, for example, Lanterman and San Diego, are rigorous in their reporting and follow-up...others state they NEVER report abuse as a matter of policy. They do not specifically track abuse of their clients as a separate "incident report", and cannot provide any data on the number of incidents of abuse reported, type of abuse, or any demographics for any given time period. Of any agency, it seems to me the Regional Centers should be a major source of information on this topic.

**DEPENDENT ADULTS ALSO NEED TRAINING**

Dependent Adults also need training on what abuse is, how to recognize and report it to someone who can help. Many programs mistakenly focus on stranger danger, which, for those with a developmental disability, represent 1% of the perpetrators of abuse...I suppose these appear more "palatable" to community members who might complain. But, since we know that 99% of the time the perpetrator is well known to and trusted by the person with a disability, a more appropriately focused program is indicated.

Many professionals are unaware of the reporting law for dependent adults, and fail to secure help that can be made available.

**SUMMARY AND RECOMMENDATIONS**

Laws are new, but abuse is not. The child and dependent adult depend for their safety on external protectors, i.e., Regional Center Counselors, Special Education teachers, etc. It is imperative that these "protectors" know and understand abuse issues and feel they have the support they need to help these disabled victims of abuse.

In this paper, there are many issues that have not been addressed: following the report, how is the investigation handled by an investigator who may or may not have training and experience with people with developmental disabilities? Many reports of abuse are simply "shelved" because the witness is disabled and is deemed unable to give a report that can be substantiated.

Many disabled victims are deemed not to be credible witnesses, once the case has been filed, and the case is dropped at that point. Even in court, the prejudices of judge, jury, and others invalidate the case. What are the prevention training techniques that have been found effective with children and adults with developmental disabilities? What are the treatment needs and techniques recommended for this population?

This training was designed as a brief overview, to illuminate some of the issues and problems faced by the abuse victim with a developmental disability and the helping professional. Certain recommendations flow from it:

1. Begin to add "Disability" to the categories such as race, and age, to report forms for child abuse.
2. Create and attend training programs on the identification of abuse, prevention, intervention and treatment, for this
3. Create an awareness among your colleagues, of this problem, and put some energy into the organizations that exist to combat this problem.