
Management of sexually abused children with learning disabilities

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Children who have a learning disability are at increased risk of sexual and physical abuse and neglect. They and their families are more likely to be socially isolated and to suffer material and emotional poverty. The range of emotional reactions in carers can vary at different times from extreme overprotection, through relative equanimity, to sometimes outright hatred and rejection of the child. Society largely reflects this, only rarely viewing the individual with learning disability in a positive way, choosing often to pity, patronise, ignore, ridicule or openly despise. These attitudes are internalised by children with the disability, who invariably suffer from low self-esteem. All of these factors combine to facilitate abuse.

Recognition of sexual abuse in children who have a learning disability can be very difficult. Not least among the problems is getting professionals to 'think the unthinkable', as the issue is a profoundly unsettling one for most people, who prefer to regard children and adults with learning disabilities as being asexual.

When abuse is uncovered in the UK there is a statutory obligation to inform social services, who act as the lead agent. Multi-agency cooperation between health professionals, child protection teams and, where appropriate, the education authority should always be sought. Across the UK, services specifically geared to the psychological needs of children with learning disability are relatively rare. In many areas no service will agree to see these children, a major health inequality that needs urgently to be addressed.

Information about risk factors, possible presenting symptoms and help on seeking justice for this vulnerable group is improving, although there is

still a very long way to go. Box 1 shows some possible resources. Material on how to help young people once abuse has been recognised is scarce, and papers are almost exclusively based on single case reports. No studies are available that provide evidence for the efficacy of any particular treatment. There are reasons why this situation is unlikely to change in the foreseeable future. Children who have a learning disability vary widely in the level of their intellectual impairment, their ability to communicate and the presence or absence of additional sensory, physical or social disabilities. No single treatment strategy will be suitable for everybody and this makes it near impossible to have enough young people in a study to yield statistically significant data.

Evidence is emerging on the treatment of 'normal' children and it is to that literature that one must look to find treatments that can then be adapted to the individual who has a learning disability. Evaluation of existing strategies should be a priority among those who do therapeutic work with these children.

Vulnerability to abuse

Although the sexual abuse of children with learning disabilities has become more widely acknowledged in recent years, this awareness has not been accompanied by a substantial body of research. Ellis & Hendry (1998) state that it is not possible to speak with confidence about the extent of sexual abuse of British children who have learning disabilities. Westcott & Cross (1996) indicate that much of the

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Box 1 Resources

Voice UK A support and information group for people with learning disabilities who experience crime or abuse, and for their families and carers. (College Business Centre, Uttoxeter New Road, Derby DE22 3WZ. Tel.: 01332 202 555; <http://www.voiceuk.clara.net>)

The Ann Craft Trust (formerly NAPSAC) A national association dedicated to the protection from abuse of adults and children with learning disabilities. (Centre for Social Work, Law and Social Sciences Building, University of Nottingham, University Park, Nottingham NG7 2RD. Tel.: 0115 9515400; <http://www.nottingham.ac.uk/sociology/act>)

Respond A national association challenging vulnerability and sexual abuse in the lives of people with learning disabilities. (3rd floor, 24–32 Stephenson Way, London NW1 2HD (tel.: 0207 383 0700; <http://www.respond.org.uk>)

Triangle Providing services for children with complex needs, it offers training and consultancy work. (Unit 310, 91 Western Road, Brighton BN1 2NW. Tel.: 01273 241015; <http://www.triangle-services.co.uk>)

Jenny Speaks Out and **Bob Tells All** (Hollins & Sinason, 1992, 1993) Titles in the Books Beyond Words series, designed for people who have a learning disability. Available from the Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG (tel.: 020 7235 2351, ext. 146)

The Abuse of Children Who are Disabled (ABCD): Training and Resource Pack Available from Caroline Riley, c/o NSPCC, National Training Centre, 3 Gilmour Close, Beaumont Leys, Leicester LE4 1EZ (tel.: 0116 234 7200)

research has been based on retrospective prevalence studies, which have been subject to methodological limitations and variations. Definitions of child maltreatment or abuse may vary and include or integrate categories such as neglect and emotional, physical and sexual abuse. Research design has often been based on clinical data and case records, with little involvement from those who have been abused. Furthermore, many of the studies from which data have been extrapolated used American samples that rarely contained control groups and pertained to children with any disability, rather than specifically identifying those with learning disabilities.

Box 2 Risk factors for sexual abuse in children with learning disabilities

Multiple carers

Care away from the family home:

in residential schools

respite care

shared care

during transport to and from care or school

Continuing need for intimate care

Communication problems

Sensory impairment

Low self-esteem

Lack of sexual knowledge

Physical disability – inability to escape

Emotional distress wrongly attributed to disability

A seminal study by Crosse *et al* (1993) not only addressed many of these methodological issues but also demonstrated that children with disabilities are subject to an increased risk of abuse in all forms. The overall incidence of abuse among children with disabilities was 1.7 times that for those without, with an estimated 147 per 1000 impairments among the former being attributed to abuse. Ticoll (1994) noted that 39–68% of girls and 16–30% of boys with intellectual impairments had been subjected to sexual abuse before the age of 18 years. American estimates suggest that between 1 in 3 and 1 in 4 adolescents with learning disabilities have been sexually abused, compared with a UK figure of 1 in 10.

A number of factors increase the risk of abuse in people with a learning disability (Box 2). Determined paedophiles may target services for young people with disabilities, either as paid or voluntary workers. Unfortunately, very few convictions are obtained against abusers. Young people may be unable or are perceived as being unable to give evidence in court.

Recognition of sexual abuse

In the absence of disclosure, there is no typical pattern of behavioural symptoms resulting from emotional distress indicating that abuse has taken place. It is essential to compare the current symptoms with the previous functioning of the individual, and a detailed history should be obtained, if possible (and with permission) from the young person, the parents and the teacher.

Box 3 Recognising sexual abuse

Symptoms of sexual abuse can include

Sexualised behaviours
 Behavioural problems
 Avoidance of people or places
 Regression of abilities
 Elective mutism
 Increased stereotypical behaviour, e.g. rocking
 Running away
 Self-injury
 Generalised anxiety
 Encopresis and enuresis
 Nightmares
 Eating and/or sleeping problems

Certain behaviours (summarised in Box 3), although not diagnostic on their own, should be viewed as a cause for concern and lead to further investigation. Sexualised behaviour is one of the most frequent sequelae of sexual abuse. However, it is also quite common in children with a learning disability who have not been abused. Particularly with the onset of puberty come feelings that the child may not be able to understand. Lack of sexual knowledge, together with a reluctance on the part of some parents to discuss these issues with their child, can lead to frustration and sexualised behaviour at inappropriate times and in public places. Suspicion of sexual abuse should be aroused if the sophistication of sexual talk or actions are out of keeping with the child's developmental level, if the child attempts to involve other children or adults in sexual acts and if masturbation becomes compulsive.

An abused child may show regression of behaviour, with a return to encopresis and enuresis, and previously acquired skills may be lost. Behaviour may deteriorate, with the child showing aggression, overcompliance, withdrawal or depression. There may be an increase in or onset of stereotypical behaviours such as rocking. The child may self-injure by biting, head-banging and hair-pulling. Speech may be lost or the child may imitate the sounds of sexual pleasure (groaning, screaming) or repeat echoed phrases such as "don't tell", "get under" or "suck this". There may be a fear of going to bed, nightmares and sleep difficulties. The child may suddenly not want to go to certain places or be with particular people.

In the older child, in particular, symptoms may be confused with the onset of psychiatric illness. Children with bizarre and difficult behaviours of recent onset can be diagnosed with mood disorders or psychotic illnesses. In many, however, the symptoms are wrongly ascribed to the learning disability

itself. In children with autism it can be particularly hard to make sense of the symptomatology.

Emotional and behavioural disturbance following abuse

Children are usually presented to therapeutic services once abuse has been detected. Finkelhor & Berliner (1995) point out that it is important to remember that sexual abuse is an experience and not a disorder or a syndrome. The experience can lead to disorders and syndromes but up to 40% of sexually abused children (without learning disability) are asymptomatic at the time of presentation. Some may develop symptoms later. This leads to the question of whether all children who have been abused should be offered therapy.

Kendall-Tackett *et al* (1993) reviewed 45 studies describing symptoms in children (without learning disability) who had been sexually abused and in those who had not but who had been referred to child psychiatric services. Only two symptoms were consistently seen more often in the sexually abused children. These were sexualised behaviour and the clinical picture of post-traumatic stress disorder (PTSD). The symptoms most likely to persist even after therapeutic interventions were aggressiveness and sexual preoccupations. The authors identified a number of factors that were most likely to result in a symptomatic child (Box 4).

Mansell *et al* (1997) examined 193 cases of sexual abuse in children with disabilities in the USA, Canada and New Zealand using a 21-item survey. They found that the children had a wide range of disabilities and a third had multiple disabilities. The victims were predominately female (70%), the risk for males being highest in the younger age group. The majority of offenders were male (92%), with the

Box 4 Factors most likely to engender symptoms in abused children (Kendall-Tackett *et al*, 1993)

Older child
 Oral, anal or vaginal penetration
 High frequency of abuse
 Long duration of abuse
 Perpetrator having a close relationship with the child
 Lack of maternal support
 Use of force

highest proportion of offenders being family members, acquaintances or neighbours. The risk of being abused by a service provider was highest for adolescents and these perpetrators accounted for 30% of abusers of this age group.

Assessment

In considering the needs of sexually abused children with learning disabilities a wide range of variables must be taken into account. The age and developmental maturity of the child must be carefully thought about, since these children are likely to show a greater spread of developmental maturity across different areas of functioning than peers without disability. Thus, for example, relative sexual sophistication and apparent social skill may hide large developmental deficits in cognitive or emotional maturity, or vice versa. Also to be considered is the nature of the abuse, its chronicity, and its impact on the child and on significant others. The degree of current support for the child and the likelihood that this support will be successfully maintained for the duration of treatment should also be part of any assessment. Additional factors to be borne in mind when assessing children who have learning disabilities and their significant others with a view to treatment are discussed in the following three sections; all of the issues mentioned are summarised in Box 5.

Attachment difficulties

Children with learning disabilities are likely to have evoked repeated criticisms from an early age for their 'stupidity'. This response appears mostly to stem from the frustrations of others at an unexplained lack of ability and is more extremely felt and expressed when a child has no visible additional handicaps that might evince sympathy. This routine

and chronic stress in the attachments between the child and others is so common and so profoundly influential that attachment difficulties must form a key component of all assessments.

The needs of parents and family members for mental health services must be regarded as normal in the field of learning disability, where adjustment to loss of the hoped-for child can be damaging to both individual family members and the family unit as a whole. These needs will often become apparent only with a crisis such as the disclosure of childhood sexual abuse.

The impact on such children of the possible experience of insecure attachments with their primary caregivers must also be routinely assessed before any treatment is planned. Although some children with learning disabilities develop remarkable confidence and ability to use assistance from others, this is far from the norm and professionals should anticipate an even greater degree of egocentric shame than is usual. Substantial attachment difficulties with any therapist will require particularly sensitive handling and probably dictate a much longer treatment time than is normal for a similarly aged child who does not have a learning disability. We should not expect children who have often been severely admonished for their slowness to make therapeutic attachment and treatment progress at the same rate as their more able peers. Their ability to think without anxiety will have been impaired by a history of failure and subsequent criticism well before the onset of any sexual abuse. Therapists will usually find themselves obliged to address in some form the question "Why am I different?", even if it is unasked, so that the child may begin to trust that his or her unique difficulties in understanding and thinking will evoke helpful rather than destructive responses. In our view, prior experience addressing these profound concerns is helpful but not absolutely necessary, since a posture of openness and willingness to accept and understand each particular child's confusion and anxiety is often sufficient in itself as a starting point for building a therapeutic alliance.

Knowledge and understanding

Children who have learning disabilities will almost certainly show gaps in knowledge and erroneous beliefs when compared with more able peers of the same age, and the degree of these problems will correspond to the extent and nature of their learning disability. They will also reflect the child's history of exposure to comprehensible family and school-based education about personal relationships, privacy, safe touching and, later, sexual expression, dating and choosing partners.

Box 5 Issues in assessment

- Developmental abilities and deficits
- Attachment problems
- Self-esteem
- Sexual knowledge
- Erroneous beliefs
- Sensory impairments
- Communication difficulties
- Family stress and support needs

These gaps in knowledge and understanding will probably reflect the general belief that children (and adults) with learning disabilities are best excluded from sexual education and expression, lest they 'get into trouble' or pose a danger to themselves or others.

The denial of these children's sexual rights, including the right to knowledge to help protect themselves from sexual abuse, will commonly present at assessment. It may further complicate the therapists' work to achieve treatment ownership because non-abusing parents or carers might prefer that the whole matter be left undisturbed. An assessment of each individual child's knowledge will probably prove necessary to augment the therapist's own direct assessment of the child's understanding, which may in itself yield surprising and clinically important results. It is common in psychometric assessments to discover children and young people who show a high ability to mask their disability by nodding and apparently following ordinary conversation when, in fact, they have little understanding of many of the words and concepts that are being used. Available educational and psychometric data should be routinely requested, in addition to family information and direct assessments of the child, to try to ascertain the real level of understanding.

Communication difficulties

The incidence of sensory and other communication difficulties is markedly increased in children with learning disabilities, rendering them both more vulnerable to, and less likely to report, abuse. The provision of multi-modal assessment (and treatment) services alongside communication aids and adaptations must be regarded as a priority if these children are to receive anything resembling a service appropriate to their needs. As always with children (or adults) with special needs, it is necessary to find a way to drop the barriers to allow them access to services, whether they be interpretive psychotherapies or arts therapies. Technical aids can be used to establish communication, as can the co-opting of trustworthy advocates or family members as surrogate communicators. Our practice tells us that flexibility provides the key to developing novel assessment and treatment packages based on an approach individually tailored to the child. A standard 'one size fits all' approach will manifestly fail the majority of these exceptionally vulnerable children.

Treatment

Psychological treatments (including formal psychotherapies) have historically been discounted or

withheld from both children and adults with learning disabilities. Sovner & Hurley (1983) called for professional attention to the emotional lives of this population but the historical segregation of learning disability services from mainstream child and adolescent mental health services, together with relatively poor resourcing in learning disability services, may have encouraged this damaging exclusion to persist. It does take more time, care and ingenuity to tailor and adapt any particular working method to allow effective treatment of a child who needs greater assistance than usual to participate in it. There are, however, no grounds we know of to support the routine conclusion that these children cannot benefit from treatment. Psychodynamic psychotherapists such as Valerie Sinason, Sheila Hollins and Sophie Thompson in London, and other innovators with a broader theoretical approach such as Sheila Mansell in Alberta and Anne Hurley in Boston, have offered useful guidance on the extension and adaptation of routine treatments to make them available to children (and adults) with learning disabilities (for examples see Hollins *et al*, 1994; Hurley *et al*, 1996, 1998; Mansell & Sobsey, 2001).

Useful guidance on the content of work with children who have been sexually abused is given by McCurie & Walford (1991). This is directed at general child psychiatrists but equally applies to professionals treating young people with learning disabilities. They suggest questions that therapists should ask themselves when planning treatment, including how much the child has been able to understand what has happened and has been able to resolve his or her conflicting emotions. A child may be feeling responsible for the abuse and, by disclosing it, blame herself for the consequent disruption to the family and the consequences for the abuser. Or she may no longer feel that her parents are able to keep her from further harm and may have feelings of anger at their failure to protect her. The therapist should consider how this child can protect herself from further unwanted sexual advances and still be able to develop appropriate social and relationship skills. Finally, the therapist should consider whether the child has started to feel better about herself.

McCurie & Walford also suggested treatment tasks for family therapy in order to explore whether the family has been able to accept what the child has reported, or what has been discovered, and communicate with their child about it. For example have they told their son that it is not his fault, empathised with him and allowed him, where possible, to discuss what has happened? Have they been able to deal with his associated feelings of guilt and anger? Have they been able to talk about their own feelings of guilt at not being able to protect their son? Are they able to set limits on his behaviour and do they have appropriate expectations of him?

The treatment of choice

The current paucity of large-scale studies at any one site or meta-analysis of a range of treatment methods and outcomes for children who have learning disabilities is striking. Of necessity, therefore, our thoughts about treatment methods are more suggestive than prescriptive. Even in mainstream populations without learning disabilities there is little consensus on which approach offers maximum benefit.

Psychoanalytical and other interpretive methods

Developmental delay will almost certainly bring with it an impaired ability to communicate. Therefore, even when speech and eye contact are available, the content of the child's communication is much more likely to be anxious, fragmented and often apparently disconnected from the agenda set by any therapist. Psychoanalytical and other interpretive methods appear to offer particular advantages in this respect, by allowing children with communication and concentration difficulties to engage at their own pace and using a range of modes (projective storytelling, symbolic play, use of expressive art materials, drama, etc.) in which the therapist's demands for competence are reduced to a bare minimum. Irrespective of the child's level of disability, interpretive psychotherapies can offer a meaning to all communications. Provided that the therapist's responses are sufficiently sensitive and attuned to the communications and pace set by the child, these approaches can offer children with learning disabilities a very powerful experience of being truly attended to by an adult that they are unlikely to have experienced before. Equally, the traditions of longer-term treatment with these approaches may relieve these children of the all too common pressure from those around them to hurry to keep pace with others.

The dangers of interpretive methods appear to lie in the too rigid application of any particular communication modality (e.g. speech alone) and in a potential to withhold other treatments or strategies until this therapy is finished. Our practical experience suggests that a number of treatment initiatives, such as education and behavioural management, can be put in place and overlap according to the needs of the child.

Cognitive, behavioural and educational methods

These treatments (which may still share the personal empathy and witnessing of psychoanalytical

approaches) place greater demands on the therapist as educator and on the child as active thinking participant in his or her own treatment. They may therefore appear too taxing for children with moderate or even mild learning disabilities. However, the psychoeducational components of these approaches may offer children who have a learning disability exactly what they need in terms of enhancing their understanding of what has happened to them and also offering them some explicit strategies to manage their emotional responses to those events. Although simplification of language and communication is the key task in adapting cognitive and behavioural treatments to children with learning disabilities, there are common dangers in patronising such children by underestimating their receptive comprehension or exaggerating their need for repetition. In our experience, repetition in the same form of something that was not grasped when it was last presented is likely to be felt as punitive, whereas true cognitive gains are usually made when therapists try a different way to communicate a particular message or strategy for the child to take away and use.

Purely educational methods must also play a large part in the active treatment of child-abuse sequelae in these children. This has commonly proved problematic for mental health professionals reluctant to devote time to activity they see as outside their professional competence. By and large, children with these special needs are rarely offered education on relationships, sexuality, emotions and assertiveness, either in groups or as individuals, in a way that is properly matched to their unique abilities and their situations following abuse. The practical difficulties of delivering group education renders post-abuse education with groups of more than two or three unlikely in all but the largest cities. It is clear, however, that responsibility will naturally fall to mental health services working with children who have learning disabilities to either directly provide educational services as a necessary component of treatment or, at the very least, commission someone else to do this work in parallel with mental health treatments.

Summary

Children who have a learning disability are more susceptible to being sexually abused. Where abuse is detected, assessment and treatment should be available to all, irrespective of their intellectual impairment. Interventions will help to resolve maladaptive behaviours, which, if left, will further decrease the child's level of functioning. They will

also reduce the risk of the child seeking to reproduce in later life what may have been their only sexual experiences. Treatment will generally take longer and will need to include strategies to maximise the communicative abilities of the young person. It is helpful for the therapist to have experience with young people with learning disabilities but not absolutely essential. Issues of attachment and of the intellectual disability itself will often need to be addressed. Work with family and carers is a vital component of therapy. Sexual education and management of any associated behavioural problems may need to complement the abuse-centred work. Little research is available on treatment and should be strongly encouraged.

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Multiple choice questions

- Children with learning disabilities:
 - have the same risk of being abused as children of normal intelligence
 - do not need, and can be harmed by, sex education
 - cannot benefit from psychotherapeutic interventions
 - usually disclose if they have been abused
 - should be discouraged from relating their abusive experiences.
- Factors that increase the risk of sexual abuse in children include:
 - multiple caregivers
 - physical disability
 - lack of useful speech
 - low self-esteem
 - an additional sensory impairment.
- Therapists may need to do the following:
 - include some sex education during sessions
 - use non-verbal methods of communication
 - be prepared to address issues about how the child views his or her disability
 - adhere strictly to prescribed treatment guidelines
 - seek available information on the child's cognitive abilities.
- Sexual abuse of children with learning disabilities:
 - always presents in the form of behavioural problems
 - can result in increased stereotypical behaviour
 - may result in a regression of abilities
 - invariably presents in the same way as in children without learning disability
 - may result in sophisticated sexualised behaviours.
- Behavioural problems and emotional distress are more likely when:
 - the abuse has taken place over a long time
 - the child is very young
 - penetration has occurred
 - the perpetrator is a stranger
 - the child has strong maternal support.

MCQ answers

1	2	3	4	5
a F	a T	a T	a F	a T
b F	b T	b T	b T	b F
c F	c T	c T	c T	c T
d F	d T	d F	d F	d F
e F	e T	e T	e T	e F