

AN INVESTIGATION OF ABUSE IN CHILDREN WITH AND WITHOUT  
DISABILITIES WHO ARE IN OR AT RISK

FOR STATE CUSTODY

By

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## CHAPTER I

### INTRODUCTION

When compared to children without disabilities, children with disabilities are at increased risk of experiencing maltreatment. A recent meta-analysis performed by Horner-Johnson and Drum (2006) revealed that maltreatment of individuals with disabilities ranged between 11.5% and 28%, compared to a rate of 1.24% for children without disabilities (based on data from U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2005). Thus, while children of all ages, races, and socioeconomic statuses face the possibility of child abuse and neglect, it is evident that those with disabilities are at increased risk.

Within recent years, a handful of studies have been conducted to determine the prevalence of maltreatment among children with disabilities. Less studied, however, has been the reason why children with disabilities are at increased risk of abuse and if children with disabilities differ from children without disabilities in certain abuse-risk characteristics. Further, few studies have looked at children only in state custody, using those in state custody who have not been abused as a comparison group.

This paper will begin, therefore, with a brief description of recent prevalence studies of abuse and neglect among children with disabilities. Then, I will discuss factors determined to increase the risk of the maltreatment of children without disabilities, while also discussing how such risk factors are related to children with disabilities. This background will lead to

the current study, which examines characteristics of a sample of children who are in state custody.

### Prevalence Studies

Three comprehensive, population-based studies illustrate that maltreatment is greater among children with disabilities. In 1991, Cross, Kaye, and Ratnofsky (1993) examined cases of substantiated abuse provided by 35 Child Protective Service agencies (a nationally representative sample). Children with disabilities were 1.7 times more likely to experience abuse than were children without disabilities. These authors, however, stated that these numbers likely underestimated the true percentages.

More recently, Sullivan and Knutson (2000) conducted a population-based examination of abuse and neglect among children in Omaha, Nebraska. Their study examined 50,278 children, ages 0 to 21, who were enrolled in early intervention services or schools during 1994-1995. To determine the prevalence of child maltreatment among these children, the authors merged the schools' electronic databases with records from the Department of Social Services and foster care review board, the police department and the sheriff's office. Enrollment in special education or early intervention services was used to determine which children had disabilities. Specific disabilities included behavior disorders, mental retardation, learning disabilities, health-related disorders, speech and language disorders, physical and orthopedic disabilities, hearing impairments, visual impairments, and autism.

While the rate of child maltreatment was 11% for the overall population, a prevalence rate of 9% was found for children without disabilities, and a rate of 31% was found for



children with disabilities. Furthermore, children with disabilities were more likely than children without disabilities to experience multiple forms of maltreatment (63% vs. 54.9% respectively) and recurring episodes of maltreatment rather than a single episode (71% vs. 29% respectively). Immediate family members were most often the perpetrators of abuse, accounting for 92.4% of neglect cases, and 82.2% of physical abuse cases. Even in the area of sexual abuse, immediate and extended family members accounted for 53.1% of the cases. In all categories of disability, children were most likely to experience neglect, followed by physical abuse, then sexual abuse.

More recently, to estimate the prevalence of child abuse within the population, Spencer et al. (2005) retrospectively examined all children born between January 1983 and the end of December 2001 in Sussex, England. These authors merged records from a database of health information on all children in the population, which included documentation of disabilities, with records from the Social Services' child-protection register. Disabilities included cerebral palsy, conduct disorder, psychological problems, autism, speech and language disorders, "learning difficulties" (IQ <70), and sensory disabilities (vision and hearing). Of the 119,729 children examined, 1,853 children were entered in the child abuse registry. Just as Sullivan and Knutson (2000) found, Spencer and colleagues found that, with the exception of autism and sensory disorders, children with disabilities were at an increased risk of experiencing child abuse.

Based on the findings from these population-based prevalence studies, and from data of other small-scale studies, it is clear that children with disabilities are at greater risk to experience maltreatment than are children without disabilities. Unfortunately, little is known about *why* this increase of abuse occurs among children with disabilities. Within the literature

on children without disabilities, however, risk factors leading to abuse have been considered to interact, and to escalate situations to become abusive. Understanding how these risk factors relate to one another among children with disabilities also helps to explain why these children are at increased risk of abuse.

### Risk Factors Related to Child Abuse

Risk factors of maltreatment among typically developing children are generally described as characteristics present among the parent, family, and child. The interaction of these characteristics causes an increased risk of the child suffering from abuse at the hands of parents and caregivers. Interestingly, many risk factors described for typically developing children are even more prevalent among children with disabilities.

#### Parent and Family Characteristics

Within the literature on abuse of children without disabilities, parents under stress have been identified as at risk for maltreating their children. Many of the identified factors among parents with typically developing children, however, are not only present among parents of children with disabilities, but they occur at a higher prevalence.

The first of these characteristics includes families of lower socio-economic status (SES), and parents who are under- or unemployed (Emery & Laumann-Billings, 1998). The increased stress could be because when parents are living in lower-income households it is more difficult to gain the resources necessary to effectively raise a child. Further, being a single parent (Rodriguez & Murphy, 1997) or having many children (Baumrind, 1994) can increase parental stress.

These risk characteristics are also present among parents of children with disabilities. Such parents are often of lower SES and often live in single-parent households. Surveying over 10,000 families in the 1981 National Health Interview Survey, Mauldon (1993) found that parents were more likely to divorce if their child had a disability or chronic health condition. Fujiura (1998) also found that single-parent-headed households with children with disabilities comprised 40% of the households in his survey (all with children aged 15 years and older), compared to only 21% of single-parent-headed households among families of children without disabilities (see Cohen & Petrescu-Prahova, 2006; Fujiura & Yamaki, 2000 for similar findings with younger children).

#### Child Characteristics

Several past studies have also identified factors within the typically developing child that are related to increased abuse potential. In the 2003 report on child abuse and neglect, it was determined that children aged between birth and 3 were the most vulnerable to abuse and neglect (U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2005). This vulnerability decreased with age, such that children aged 4 to 7 were the next most vulnerable, followed by children aged 8-11, 12-15, and finally, 16-17. Cross and colleagues (1993), on the other hand, found that children over age 4 were at the greatest risk of abuse. Similarly, Sullivan and Knutson (2000) reported that children without disabilities were most susceptible to abuse from ages 5 to 9.

Relating to age and risk of abuse, Sullivan and Knutson (2000) found that among children with disabilities, those with health or orthopedic and communication disabilities are most likely to be abused between birth and 5 years of age (similar to children without

disabilities). On the other hand, children with behavior disorders and mental retardation experience abuse across the age ranges.

Among children who do not have disabilities, males and females are usually found as either equally susceptible to abuse or females are slightly more likely to be victims of abuse than are males (Sobsey, Randall, & Parrila, 1997; Sullivan & Knutson, 2000; U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2005). The findings are opposite, however, in terms of children with disabilities. Males with disabilities are more likely to experience abuse compared to females with disabilities (Sobsey, et al., 1997; Sullivan & Knutson, 2000).

Finally, it is well documented that a child with a difficult temperament is at increased risk of child abuse (Belskey, 1980; Jaffee, Caspi et al., 2004; Zirpoli, Snell, & Loyd, 1987). This difficult temperament most likely interacts with parent characteristics to increase abuse potential. Ammerman (1990), for example, found that certain child temperament traits, such as hyperactivity and child irritability, increased parental stress, thereby challenging the parents' coping skills and disrupting the parent-child bond.

Difficult temperament is generally found at increased rates among children with disabilities, as many children with disabilities display behaviors parents perceive as challenging and/or unmanageable (e.g., self-injurious behaviors, aggression, hyperactivity; Soeffing, 1975). Ammerman and Patz (1996) also determined that certain child qualities among children with disabilities, such as adaptability to changes in the environment, moodiness, and irritability, were likely to lead to abuse.

Overall, then, many of the characteristics determined to increase the risk of child abuse among children without disabilities are actually more likely to occur among children

with disabilities or to occur differently within children with disabilities. Further, among research specifically investigating characteristics of children with disabilities, a few other risk factors have been identified among children with disabilities.

The first of these “disability-specific” risk factors relates to the severity of the child’s disability. Children with mild disabilities are at greater risk of child abuse than are children with more severe disabilities. Zirpoli et al. (1987) studied 91 cases of abuse of individuals with disabilities by residential caregivers. They found that individuals with a profound intellectual disability, as rated by their caregivers, were less likely to be abused than were those who were higher functioning. Verdugo, Bermejo, and Fuertes (1995) also stated that children with “milder disabilities” were at the greatest risk of maltreatment.

In addition, children with certain disabilities may be at increased risk of abuse than other disabilities. Sullivan and Knutson (2000) found that maltreatment was more prevalent among children with behavior disorders, speech and language impairments, and mental retardation. Similarly, Verdugo et al. (1995) found 75% of the children with speech deficits in their sample were abused, 37% of whom were nonverbal.

### The Current Study

Based on risk factors identified for children with and without disabilities, the current study was conducted to determine if such factors were evident among a sample of children who are in or are at risk for state custody. Specifically, records of children who were evaluated at a state-run center were examined to identify which parent, family, and child characteristics were present in children who had and had not suffered abuse. Moreover, risk

factors were examined to determine whether differences existed for children with disabilities compared to children without disabilities.

### State Custody

Children most often enter state custody for one of two reasons. They are either declared dependent and neglected, in which the parent was unable or unwilling to care for the child, or the child suffered from abuse. Other children are declared juvenile justice, in which their own trouble with the justice system has placed them in the custody of the state. This general system of state custody is in place in the large majority of states across the country.

In Tennessee, the main department designated to meet the needs of children in state custody is the Tennessee Department of Children's Services (DCS). Through this system, over 37,000 reports of child abuse and neglect are received yearly. The child protection services then work to protect the children whose lives or health are seriously at risk. Those at risk receive services to reduce risk, through interventions and evaluations.

When in state custody most children are placed in temporary care or foster care. The goal of foster care is to provide a stable caring environment to children. Thus, foster placements include living with other relatives of the child, or living in foster homes, group homes, or a treatment facility. Treatment facilities often treat children in a variety of areas, such as responding to delinquent offences and or dependent/neglect commitments. In such facilities, children receive treatment and rehabilitation services.

Working in collaboration with DCS, Tennessee also has another, newly developed program called the Center of Excellence for Children in State Custody (COE). The COE was established in 2001 to serve as a referral center for children in or at-risk for state custody.

Three centers were established to serve Eastern, Middle, and Western Tennessee. Children are referred to the COE when questions are raised about the child's mental or physical health, or if the child has developmental, medication, or placement issues. Further, the COE was developed to assist the state in administering Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children. When a child is referred, the COE develops an individualized Care Plan for that child. The Care Plan is developed by a multidisciplinary team, and is based on the child's previous records and the COE's clinical evaluations. The Care Plan includes results of clinical testing as well as diagnoses, and specific treatment and placement recommendations.

#### Record Review

In order to carry out the current study, a record review was conducted at two COE locations (Nashville and Memphis). Record reviews are useful when evaluating clinical data, because they provide large amounts of information, which can be used in exploratory studies before hypotheses are developed. If the information is pulled from records in a systematic way, then the data can be used statistically to glean information about certain populations (Strauss & Harder, 1981).

Because records are not kept explicitly for research purposes, however, record review studies have several limitations. First, most record reviews code data from information presented in a narrative form; yet, there is usually no standardized way of writing the narrative. Because of this lack of standardization, reliability is sometimes limited (Strauss & Harder, 1981).

Second, when coding for information within a record, it is easy to overlook a variable of interest if it is only mentioned briefly. While reliability checks help account for this, it is still possible to miss important data. Third, some records may contain contradictory data (Strauss & Harder, 1981). For example, in one part of the record, physical child abuse may be noted. Later in the record, however, a different clinician may rule out child abuse. It is then up to the coder to judge which clinician gave the accurate information. Finally, missing data are sometimes a problem. When information is absent record, it must be determined if it the variable did not occur, or if it simply was not mentioned (Strauss & Harder, 1981).

Despite the limitations of record reviews, such reviews can provide large amounts of information on many subjects. With a good rating and high reliability, record reviews can provide important exploratory data. As such, the current record review was conducted as an exploratory analysis of children in state custody.

### Research Questions

Through the record review, I hoped to answer the following questions.

1) Among children seen at the COE, how do children who were abused differ from those who were not abused?

2) Among children seen at the COE, do children with disabilities differ from children without disabilities?

3) Among children seen at the COE, is there a relationship between whether child had a disability and whether a child experienced abuse?

4) Among children seen at the COE, do children with particular disabilities differ in terms of abuse?



## CHAPTER II

### METHOD

#### Participants

Data on 443 children seen between 2004 and 2006 were collected from existing records at the COE of Vanderbilt University, Nashville and the University of Tennessee, Health Science Center, Memphis. The mean age at which the children entered custody was 8.88 (SD= 4.97). The age of the children when they were evaluated at the COE, however, ranged from 1 to 20, with a mean age of 11.90 (SD= 4.22). More specifically, 3.6% of the children were aged between birth and 3 years, 15% were 4-7 years old, 19.3% were 8-11, 41.7% were 12-15, and 20.4% were 16 and older. See Table 1 further demographic information.

#### Procedure

The first author and 3 other coders coded files in the order in which the children were seen at the COE, starting from the most recent record and working backwards. If a file was missing (usually meaning the evaluation was still being written), that record was skipped. Each record was coded for specific parent, family, child, and abuse factors.

#### Records

The records at the COE usually contained a summary of the assessment performed at the COE, as well as past assessments that the child had received, and the child's DCS record.

Table 1

*Demographic Information of all Subjects in the Sample*

	N	%
<b>Location</b>		
Nashville	339	76.5
Memphis	104	23.5
<b>Gender</b>		
Male	228	65.0
Female	155	35.0
<b>Race</b>		
Caucasian	245	60.3
African American	134	33.0
Other	27	6.7
<b>Custody</b>		
Not in Custody	119	27.5
Dependent/Neglect	223	51.6
Juvenile Justice	90	20.8
<b>Placement</b>		
Family	136	32.2
Home	214	50.7
Other	72	17.1

Sometimes files also included school reports, Individualized Education Plans, and other information provided by or requested from the school. Most children who were seen at the COE received either psychiatric or psychological evaluations. The evaluations involved a review of the child's records, an interview with the child and a caregiver, and formal testing by a psychologist. The evaluations were performed to determine diagnoses, educational and/or specific treatment needs.

#### COE Assessment

Within the COE evaluation, a social history was first presented. This social history outlined who the child was, why the child was being seen, and pertinent information explaining the situation that led to the child's presence in state custody. Most social histories described if the child was abused, and the details of that abuse; including who abused the child, how often the abuse occurred, and what happened following the abuse. Also present in the evaluation was a summary of the assessments, the child's diagnoses, and the COE's treatment and placement recommendations.

#### DCS Record

The DCS record also gave a social history, which outlined the child's background and abuse history. The parent's age, occupation, and education was described within this record, as well as other brothers and sisters of the child. The child's past placements were listed, as were the number of times the child was in custody. Finally, the child's grade and classroom placement was listed.

## Other Materials

Other records often involved past assessments given to the child. These assessments were often performed by the school or by private organizations involved with the child and family. Such organizations were involved due to a child's risk-status or psychiatric illness. Assessments often included developmental and language evaluations, as well as psychiatric evaluations.

## Coding

In order to collect pertinent information from each record, a coding sheet was developed. This coding sheet was separated into different sections (a copy of the coding sheet is provided in Appendix A).

## Demographic Information

The first section of the coding sheet collected basic demographic information, including the child's gender, date of birth, and race. Also collected was the date which the child was evaluated at the COE, the child's current placement, and if the child was in state custody (including whether custody was dependent/neglect or juvenile justice).

## Referral Source

The second section included data on who referred the child to the COE (most often DCS) and the reason for the referral. Referral reasons could include a request for a diagnosis, treatment, medication, placement, or educational recommendation, or it could have been court ordered. The problem with which the child presented was coded and could include

aggression, mood problems, suicidal/homicidal ideation or attempts, placement disruptions, hyperactivity, impulsivity, alcohol and drug problems, sexualized behavior, defiance, and running away. Finally, the service type provided was coded (i.e., psychological, psychiatric, record review) as well as who accompanied the child.

#### Child's custody History.

The third section of the coding sheet was related to the child's custody history. Therefore, information included the age the child entered custody, the number of times the child had been in custody, the length of time in custody, and the number of placements in which the child was placed during each stay in custody, as well as what types of placements.

#### Child's Current and Past Diagnoses

The fourth section noted all past diagnoses the child had received and all past medications the child had been prescribed. Further, this section collected the diagnoses given to the child by the COE, in DSM-IV Axis 1 and Axis 2 specification, and the current medications the child was taking. Finally, this section included any IQ tests the child had been administered and the child's IQ.

#### Child's Current and Recommended Services

The fifth section collected information on any current services the child was receiving and those services recommended by the COE. These services could include therapy (individual, family, group), alcohol and drug treatment, in-home services, behavior

modification, sex offender treatment, hospitalization, medication, and education and placement recommendations.

### Family Information

Family information was collected in the sixth section of the coding sheet. This information included the date of birth, occupation, and education level of both parents. Further, the zip code of the primary parent was collected, as was the parent's marital status (married, divorced, never married, separated, live-in, widow). Information on the siblings included how many children there were and their genders.

### Abuse Information

The seventh section included information about the abuse. Data were collected on the perpetrator of abuse and what type of abuse occurred by each perpetrator. Further, whether the abuse occurred once or multiple times and the age at which the abuse occurred were collected. Whether the child remained in the home or was placed in state custody was noted as well. Finally, whether or not the siblings were abused was collected.

### Child Psychiatric Information and Measures

The last section of the coding sheet included information about the child. Such information included the top two ICD-9 diagnoses the child received, as well as DSM-IV Axis 3, 4, and 5 diagnoses. A checklist was provided to mark specific disabilities, such as autism, ADHD, hearing/visual impairment, and asthma. For educational data, the child's grade and classroom placement (regular education, special education, resource room) were

collected. Finally, when available, the scores on the child behavior checklist and teacher report form were recorded.

### Inter-Rater Reliability

Because inter-rater reliability has historically been an issue in record review studies, this study took great care to achieve reliable coding. As most judgments involved “yes-no” decisions whether something did or did not occur, reliability was determined by the kappa statistic, with fair (.40 to .59), good (.59-.75), and excellent (above .75) levels of reliability noted, as determined by Cicchetti (1994). Twenty-nine records were coded independently by two coders; disagreements were resolved through consultation with the child’s file.

For this study, some of the collected data were not used in analyses. In determining reliability, it also became apparent that several specific items present on the coding sheet did not appear frequently enough to merit retention in final analyses. In reporting levels of reliability, variables not occurring in 50% or more of coded records are noted as not being retained in subsequent analyses. Also, this study did not use information from the sections on referral source, child current and past diagnoses, and child’s current and recommended services.

### Demographic Information

Within the demographic section, some variables were not used in this study. These variables included the region in which the child lived, the child’s current placement, the placement level, whether the placement was therapeutic, and what type of placement it was (foster home, group home). For the 7 variables retained in this study, reliability was in the

good to excellent range. Median kappa for these variables was .65, ranging from a low of .61 (for the variable “dependent neglect”) to .89 (for if this child was or was not in custody).

#### Child’s Custody History.

Within this section, three variables were not used for this study, including the types of placements in which the child had lived, the age at which the child was removed from the mother or “other” person, and whether the child had witnessed domestic violence. Further, all variables regarding other stays in custody, (age entering custody [2], number of placements [2], and length of time in custody[2]) occurred significantly less than 50% of the time, and were thus removed from analyses. For the 7 remaining variables, the median kappa was .75, ranging from a low of .64 (for the variable “was the child neglected”) to .92 (for “was the child physically abused”).

#### Family Information

Within the family information section, the parent’s date of birth, years of education, occupation, and marital status did not occur often enough to be used in analyses. Information about who was in the house at the time of abuse was most often not clearly stated in the records and so was not used in this study. The remaining variables involved the age of siblings and their gender. While reliability was excellent for these variables—median = .73 for gender and .78 for age— for this study one the number of siblings was analyzed.



## Abuse Information

Within the child abuse information section, 8 variables were not used for this study. These included the number of times abuse occurred (this was too difficult to judge), the age at which the abuse occurred (neglect is often ambiguous), who reported the abuse, what happened to the child after abuse was reported, and if the siblings were abused. Also, emotional abuse was not analyzed in this study, nor if the abuse was substantiated, or not specified. For those kept, reliability was assessed on the types of abuse experienced and the perpetrators of the abuse. Median kappa for these variables was .86, ranging from a low of .52 (for the variable “was the child neglected”) to .92 (for “if the perpetrator was a family member”).

## Child Psychiatric Information and Measures

Within the final section, the child behavior checklist and teacher report form were not reported often enough for evaluation. The only information used in this study was the specific disability categories that were checked, and if the child had mental retardation. While reliability was excellent in this section, many kappas did not come out. Low kappa values generally resulted because some disability variables occurred so infrequently, that no files were coded in which those disabilities were seen (e.g., autism or PDD [N= 16], cystic fibrosis [N= 0], Down syndrome [N= 2], motor impairments [N= 0], spina bifida [N= 0], diabetes [N=1], and severe mental retardation [N=6]). For the rest of the disabilities, the median kappa was .78, with a low of .63 (for mild mental retardation) to a high of 1.00 (for moderate mental retardation and vision impairments).

## CHAPTER III

### RESULTS

#### Preliminary Findings

Records were coded from two locations, Memphis and Nashville, Tennessee. While most data were similar between groups, a few differences were noted (see Tables 2 and 3). Specifically, as compared to the sample from the Nashville COE, children seen at the Memphis COE were more likely to be male. Also, while the majority of children seen in Nashville were Caucasian, those seen in Memphis were equally likely to be Caucasian or African American. Children seen at the COE in Memphis were less likely to be abused; these children also suffered from fewer forms of abuse and were abused by fewer people. Interestingly, children seen at the COE in Memphis entered state custody at a younger age and were diagnosed with fewer disabilities. Despite the differences between the samples, findings were similar in both locations, except where mentioned.

*Research question 1: Among children seen at the COE, how do children who were abused differ from those who were not abused?*

Within the 443 coded files, 304 of the children had been maltreated, accounting for 68.6% of the sample. The mean age of the maltreated children when seen at the COE (11.40 [SD= 4.26]) was significantly lower than the age of those who were not abused (13.00 [SD= 3.93]),  $t(282.70) = 3.85, p < .001$ . In the COE sample, a larger percentage of females were

Table 2

*ANOVA Test of Differences between Children Seen at the  
COE in Nashville and the COE in Memphis*

	Nashville	Memphis	<i>t</i>
	X (SD)	X (SD)	
Age seen at COE	12.08 (3.99)	11.33 (4.85)	1.43
Count of abuse- all types by all people	1.76 (1.64)	1.36 (1.66)	2.11*
Number of types of abuse suffered	1.32 (1.09)	0.98 (1.04)	2.83**
Age entering custody for the 1 <sup>st</sup> time	9.23 (4.88)	7.84 (5.12)	2.17*
Number of times in custody	1.24 (0.54)	1.38 (0.83)	-1.60
Number of placements while in custody	4.55 (4.22)	3.97 (4.94)	0.95
Length of time in custody	2.93 (3.53)	3.66 (3.52)	-1.59
Number of disabilities child has	0.91 (1.08)	0.67 (0.93)	2.06*
Mom's age at time child was seen	35.19 (8.29)	34.14 (9.95)	0.72
Dad's age at time child was seen	38.57 (7.09)	39.64 (9.84)	-0.55
Mom's age when child was born	22.99 (7.62)	23.42 (6.51)	-0.34
Dad's age when child was born	26.37 (6.83)	28.50 (7.97)	-1.47

\*  $p < .05$ ; \*\*  $p < .01$

Table 3

*Chi-Square Test of Differences Between Children Seen at  
the COE in Nashville and the COE in Memphis*

	Nashville	Memphis	$\chi^2$
	N (%)	N (%)	
Gender			5.96*
Male	210 (61.9)	78 (75.0)	
Female	129 (38.1)	26 (25.0)	
Race			11.20**
Caucasian	194 (62.8)	51 (52.6)	
African American	90 (29.1)	44 (45.4)	
Other	25 (8.1)	2 (2.1)	
Child Abused			10.43**
Yes	246 (72.6)	58 (55.8)	
No	93 (27.4)	46 (44.2)	
Custody			4.78
Not in custody	99 (30.1)	20 (19.4)	
Dependent/Neglect	162 (49.2)	61 (59.2)	
Juvenile Justice	68 (20.7)	22 (21.4)	

\*  $p < .05$ ; \*\*  $p < .01$

abused than not abused, while a larger percentage of males were not abused than abused. Abuse status also varied by race of the child, such that a higher percentage of Caucasians were abused compared to percentages seen in the African Americans or “Other” ethnicity categories. More children who were abused were in custody as dependent neglect, compared to those who were not abused. There were no differences in whether the child had a disability and if the child was in custody (see Table 4).

Children who were abused entered state custody at a significantly younger age (8.22[SD = 4.80]) than those who were not abused (11.15 [4.92]),  $t = 4.51, p < .01$ . This finding, however, is confounded by differences between children seen in Nashville and Memphis. A 2 (location: Memphis vs. Nashville) X 2 (abuse vs. no abuse) ANOVA revealed that, while children who were abused entered custody at a younger age in both Memphis and Nashville, this discrepancy (with children who were not abused being older) was much more pronounced in the Nashville COE,  $F(1, 200) = 5.95, p < .05$ . Among COE children at both locations, however, there were no differences between abused and non-abused children in the length of time children spent in custody, the number of times the children were in custody, or the number of placements the children had while in custody.

In terms of parent and family characteristics, one large difference was found. Compared to those who were not abused, more children who were abused had at least one sibling (49.5% vs. 74.3%),  $X^2(1, N= 442) = 22.58, p < .01$ . Furthermore, those children who were abused had significantly more siblings (2.18 [SD = 1.66]) than did those who were not abused (1.54 [1.66]),  $t = -3.75, p < .01$ . No other parent factors were significantly different between children who were and were not abused.

Table 4

*Difference between children who were abused and  
who were not abused and seen at the COE*

	Abused	Not Abused	$X^2$
Gender			11.27**
Male	59.9	76.3	
Female	40.1	23.7	
Race			6.10*
Caucasian	62.0	56.6	
African American	29.9	40.2	
Other	8.1	3.3	
Disability			2.59
Yes	45.7	54.0	
No	54.3	46.0	
Custody			33.87**
Not in custody	23.2	37.0	
Dependent/Neglect	60.9	31.1	
Juvenile Justice	15.8	31.9	

\*  $p < .05$ ; \*\* $p < .01$

*Research question 2: Among children seen at the COE, do children with disabilities differ from children without disabilities?*

Of the records coded at the COE, 229 children (51.7%) were identified as having a disability. The mean age of the children was 11.77 (SD= 3.96), which was not significantly different from those who did not have a disability (12.04 [SD= 4.48]). Children with disabilities did not differ from those without disabilities in terms of most child and custody characteristics (see Table 5).

The exception to these “no-difference findings” involved the age at which children with or without disabilities were evaluated at the COE. Fewer children with disabilities were evaluated at the COE when they were very young (0 and 3 years) or very old (16 and up). In contrast, higher proportions of COE children with (versus without ) disabilities were seen in the “middle years,” particularly between the ages of 8 and 11,  $X^2(4, N = 441) = 12.91, p = .01$  (Figure 1).

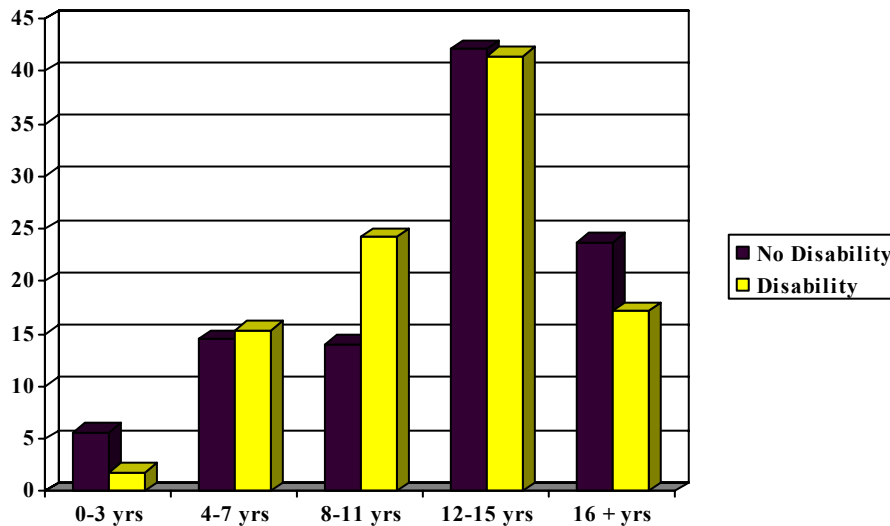


Figure 1. Distribution of Ages of Children Seen at the COE Based on Disability

Table 5

*Difference between children with and without disabilities seen at the COE*

	No disability	Disability	$X^2$
Gender			0.18
Male	64.0	65.9	
Female	36.0	34.1	
Race			1.02
Caucasian	59.5	61.1	
African American	34.9	31.3	
Other	5.6	7.6	
Child Abused			2.59
Yes	65.0	72.1	
No	35.0	27.9	
Custody			4.31
Not in custody	27.3	27.8	
Dependent/Neglect	47.8	55.2	
Juvenile Justice	24.9	17.0	

\*  $p < .05$ ; \*\* $p < .01$



Because of the preliminary differences found between children seen in Nashville and Memphis, the two groups were compared. It was found that while children with disabilities in the Nashville sample who were more likely to have a sibling (57.2% vs. 41.7%, respectively,  $X^2 [N = 338, 1] = 4.80, p < .05$ ), there was not a significant difference in whether or not the child with disabilities in the Memphis sample had a sibling. It was also found that a higher percentage of children with disabilities in the Memphis sample experienced abuse (71.1%) than those who did not have a disability (44.1%),  $X^2 (1, N = 104) = 7.57, p < .01$ , but there was no difference in whether children with and without disabilities experienced abuse in the Nashville sample (72.3% vs. 72.9% respectively). Finally, comparing children in Memphis versus Nashville, more children in Memphis who did not have disabilities were not abused (71.7% vs. 45.2% in Nashville).

*Research question 3: Among children seen at the COE, is there a relationship between whether a child had a disability and whether a child experienced abuse?*

In order to determine interaction effects, a child's disability status was examined in relation to abuse status. There were no interaction effects for any child or parent characteristics. In terms of custody, children with disabilities who were abused were most likely to live in a home (group home or foster home), whereas children with disabilities who were not abused were more likely to live with family (birth parents, adoptive parents, other relative),  $X^2 (2, N=219) = 11.61, p < .01$ . There was also an interaction effect concerning the number of siblings. Among children who did not have disabilities, those who were abused had more siblings (2.25 siblings) than those who were not abused (1.21). Among children

who did not have disabilities, those who were abused had almost twice as many siblings than those who were not abused. In contrast, among children with disabilities, there was a much smaller difference in numbers of siblings between those who were and were not abused,  $F(1, 442) = 6.04, p < .05$ . See Figure 2.

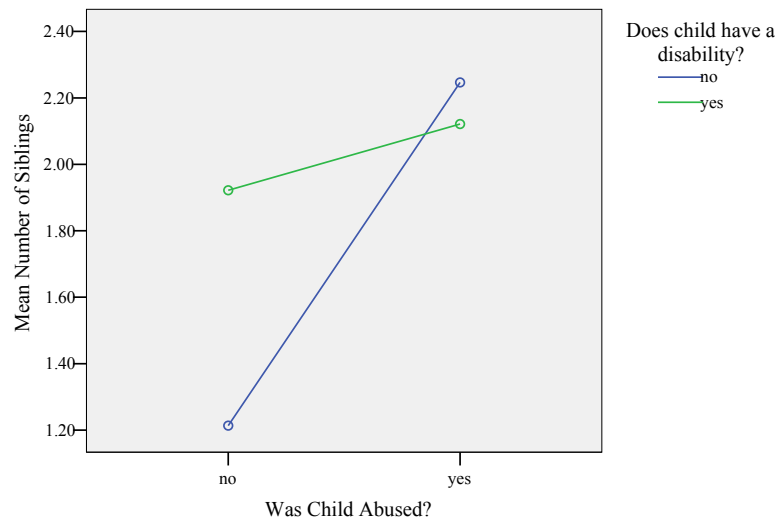


Figure 2. Interaction of Number of Siblings, If Child was Abused, and If Child had a Disability

*Research question 4: Among children seen at the COE, do children with particular disabilities differ in terms of abuse?*

While children with disabilities in general did not differ greatly from children without disabilities, it was thought that children with specific disabilities might differ more.

Therefore, specific disabilities were examined in terms of risk and abuse characteristics and compared to those without disabilities. The specific disabilities were combined into 4 main groups of disabilities. These groups consisted of: **behavior disorders** (autism and ADHD);

**communication disorders** (speech and language disorders, hearing impairments, learning disabilities); **mental retardation** (all degrees of mental retardation and developmental delay); and **orthopedic and health conditions** (visual and physical impairment, health related disabilities, such as diabetes, asthma). These categories were consistent with those used by Sullivan and Knutson (2000) and are often used in the school system.

The prevalence of various disability groups seen at the COE was first compared to the expected prevalence rates in the U.S. population. In essence, if children with specific disabilities are experiencing abuse at the same rates as they appear in the population, one would expect equal or near-equal representation at the two COE locations. For certain disabilities, however, Table 6 shows that this is not the case; that children with many different disability conditions are over-represented among the COE population. Specifically, mental retardation and behavior disorders seem particularly over-represented.

Next, the percentage of overall abuse was examined, as was each specific type of abuse experienced in each specific disability group. A significantly higher percentage of children with behavior disorders experienced abuse (75.4%) when compared to children without disabilities (65.0%),  $\chi^2 (1, N= 385) = 4.94, p < .05$ . On the other hand, a smaller percentage of children with mental retardation experienced physical abuse (26.7%) when compared to children without disabilities (39.9%),  $\chi^2 (1, N = 274) = 4.44, p < .05$ . There were no differences for children with communication disorders or health/orthopedic disorders when compared to children without disabilities.

Table 6

*Prevalence of disability groups seen at the COE as compared to the US population*

Disability	% of COE	% of US population
Behavior disorder	38.6	6.0
Communication disorder	9.3	6.0
Mental retardation	19.4	1.0-2.0
Orthopedic and health problem	17.4	5.0-6.0

Finally, fewer fathers abused their children if the child had mental retardation (17.4%) than if the child did not have a disability (33%),  $X^2 = 7.05, p < .01$ . On the other hand, mothers of children with health or orthopedic impairments more often abused their child (50.6%) than if the child did not have a disability (37.9%),  $X^2 = 3.83, p = .05$ .

## CHAPTER IV

### DISCUSSION

This study was among the first to explore abuse-risk characteristics within a special group of children in state custody. Not only were abused children with disabilities compared to abused children without disabilities, but the children were also compared to a group of children who were in state custody but did not experience abuse. The results of this study have practical and theoretical implications for future research and interventions.

This study had main findings among 4 different groups of children. The first main finding of this study related to children who were abused and seen at the COE compared to those who were not abused but seen at the COE. Children who were abused were different from those who were not abused in characteristics related to their time in custody, as well as to child and family characteristics.

First, children who were abused entered state custody at a younger age and were evaluated at the COE when they were younger compared to those who were not abused. Second, in the sample of children evaluated at the COE, a larger percentage of females were abused than not abused. Third, as past research supports (Baumrind, 1994), children who were abused were more likely to have a sibling than children who were not abused. These children were also likely to have more siblings than those who were not abused.

The differences among children who were and were not abused are similar to those reported in past research. Specifically, the finding that children were younger when entering custody is similar to findings that children are more likely to be abused when younger and

that the risk of abuse decreases with age (Crosse et al., 1993). If children are abused at younger ages, then it follows that they should be removed from the abusive situation at a younger age as well. The gender difference found among children who were and were not abuse is also supported by past findings that females are at increased risk of abuse (Sobsey et al., 1997).

The second main finding revealed that children seen at the COE who had a disability were not as different from those who did not have a disability as one would expect. Still, there were some differences. Children with disabilities were most often evaluated at the COE in the middle years. Comparatively, children without disabilities were more often evaluated when they were very young, or when they were older.

This finding may relate to the difference in abuse rates found in previous studies. Specifically, children without disabilities are found to experience abuse at younger (rather than older) ages (Crosse et al., 1993, Sullivan & Knutson, 2000; U.S. Department of Health and Human Services, Administration on Children, Youth and Families, 2005). It should follow, then, that children would be evaluated at the COE at younger ages as well. In contrast, Sullivan and Knutson found that children with disabilities were more susceptible to abuse at varying ages. Following this path, then, children with disabilities should be evaluated at the COE at varying (or later) ages as well.

Another explanation, however, could be that children with disabilities were evaluated in the middle years because the disability was diagnosed late or the child was sent to the COE specifically for a diagnosis. Or children with disabilities may not have disclosed abuse until later, because they did not know it was wrong, or were too afraid to tell. Finally, the

children without disabilities, who were evaluated above age 16, were most likely children who were close to exiting state custody or children in state custody due to juvenile justice.

The third main finding was the interaction between children with and without disabilities who were and were not abused. The main interaction was between the number of siblings the child had and if the child had a disability or if the child was abused. Interestingly, children with disabilities had close to the same number of siblings, regardless of if the child was abused. Children without disabilities, however, had many more siblings if the child was abused. In essence, the number of siblings did not relate to abuse in children with disabilities, but the number of siblings was greatly related to abuse in children without disabilities. The question, then, is why are children without disabilities who have more siblings more susceptible to abuse? And why aren't children with disabilities who have more siblings more susceptible to abuse?

As stated earlier, larger families are more susceptible to child abuse (Baumrind, 1994), which could be the result of the stress from raising so many children. In families with disabilities, however, perhaps the other children are seen as helpful, and not stressful. If mothers are stressed caring for a child with a disability, perhaps the mother can count on another sibling to help with child care, or with chores around the house. On the other hand, the siblings of children with disabilities may just be overlooked, or may not matter as much within the family.

The last main area of results related to children with specific disabilities. Two main findings stood out. First, when compared to U.S. prevalence rates, the prevalence of disabilities at the COE was extremely elevated, ranging from 1.5 to 19 times what one would expect. As shown in Table 6, rates of children with mental retardation and behavior

disorders were particularly high, with the over-representation of children with communication disorders present (1.5 times more likely), but less so.

Such over-representation of these particular disability types is partially supportive—and partly not supportive— of prior studies. Specifically, virtually all studies show that children with behavior disorders are vastly more likely to be abused (Cross et al., 1993; Sullivan & Knutson, 2000). This over-representation also held true in this study. Similarly, in most studies children with mental retardation are more likely to be abused.

In contrast, COE findings did not support the extreme over-representation of children with communication disorders. Specifically, prior studies have found that children with communication disorders are at increased risk of abuse. This risk, however, was most often when the children were younger; 44.3% of the sample from Sullivan and Knutson (2000) were 0 to 3 years old. The children with communication disorders in the current study, however, were much older ( $M = 10.36$ ) when entering custody. This age difference could explain the discrepancy in findings. Another possible explanation could be the disabilities comprising the communication disorders group. While the groups for this study followed those created by Sullivan and Knutson (2000), perhaps different combinations of disabilities—based on different common characteristics of the children—might better relate to whether the child was abused.

The second finding was that the perpetrator of abuse was related to the child's type of disability. While fathers with a child with mental retardation were less likely to commit abuse compared to fathers of children without disabilities, mothers of children with health and orthopedic conditions were more likely to abuse their child than were mothers of



children without disabilities. Unfortunately, it is still unclear what interacting factors were involved in the abuse. Some speculation, however, can be posed.

First, fathers could consider their child with mental retardation to have a severe disability. Because children with more severe disabilities are less likely to be abused (Zirpoli et al., 1987; Verdugo et al., 1995), then fathers may not often abuse their child with mental retardation because they view the disability as severe. Mothers, on the other hand, may experience caring for a child with health and orthopedic problems as very stressful. Increased hospital visits, medication management, and the need for child support could escalate the mother's stress. The stress could be because increased expenses may be difficult for mothers of low SES. Also, a mother caring for a child with a health and orthopedic problem may spend more time in hospitals, making her less likely to have a job. All of these factors, combined may increase the risk of abuse.

Taken together, these findings raise a host of interesting issues and questions. First, why do children in the two COE's differ? Specifically, children in Memphis who were not abused were found earlier, had fewer disabilities, and the number of siblings did not relate to the child's abuse. Children in Nashville, on the other hand, experienced more types of abuse by more people and they were older than the children in Memphis when they entered custody for the first time.

Perhaps it is the difference in the demographics between the two cities. While the COE in Nashville serves 39 counties throughout Middle Tennessee, the COE in Memphis serves only 21 counties throughout West Tennessee. This difference in the number of counties, as well as the demographics of the counties could make the children vastly different. Also, among the 544,765 people living in Nashville, 65.9% of the residents are

Caucasian. On the other hand, among the 645,978 residents in Memphis, only 34.4% are Caucasian. This racial difference could account for the differences in children seen at the COE. Finally, it is possible that the way DCS evaluates at-risk cases in the two regions is different and could account for the difference in cases among children evaluated in Memphis and in Nashville. Referrals could also vary, with more cases being reported earlier in Memphis versus Nashville. Further research, however, is needed to determine the cause of these differences. Such research should not only explore the differing demographics of the two cities, but also explore the different practices of DCS within the cities.

Another interesting finding concerned the general lack of differences in whether the child had a disability and was abused. When beginning this research, it was expected that children with disabilities would present with different or heightened risk characteristics compared to those without disabilities. The children with disabilities, however, were similar to those without disabilities in most respects. Understanding why these children were more similar, however, is a big question.

One possible explanation could be that children with and without disabilities have the same risk factors overall, but that children with disabilities have these factors to an exacerbated extent (Sellinger, Hodapp, & Dykens, in press). Thus, compared to parents of children without disabilities, parents of children with disabilities are more likely to be divorced or single-parents, families are more likely to be of lower socio-economic status, and children are more likely to be born prematurely, to have difficult temperaments, and to show behavior problems. Yet because most COE children were already abused, these risk factors were probably present in children with and without disabilities. For example, while there were not enough data to evaluate statistically, most families in this study were divorced or

separated, regardless of whether the child had a disability. This risk factor, along with the low level of education and occupation status of most families, could have greatly increased the risk of abuse among all children within the sample. Unfortunately, because the intensity of the risk factors was not measured in this study, it is not possible to know if children with and without disabilities differed on other characteristics.

It is important to remember, however, that children with disabilities were still found to experience abuse at higher-than-expected rates. Even more concerning is that most children with disabilities are probably not even reported to be abused. Prevalence of abuse among children with disabilities has often been considered an underestimate of the true rates. This underestimate could be due to a low rate of reporting of abuse among children with disabilities. Many children with disabilities may not know that the abuse is wrong, and therefore may not disclose the abuse. Nonverbal children, furthermore, cannot tell others they are being abused (Westcott & Jones, 1999). Also, those who work with these children may attribute certain behaviors or markings, usually indicative of abuse, to be a consequence instead of the child's disability (Zigler & Hall, 1990). To see such a high rate of abuse, therefore, and to know that these children are only the tip of the iceberg, leads to the need for increased screening and recognition of abuse.

Unfortunately, studies of child abuse prevention among families with children with disabilities are incredibly lacking in the field. In fact, most child abuse prevention studies exclude from participation families of children with disabilities. A child's disability status is often viewed as a special circumstance, which is thus treated as a confounding variable. As such, the most vulnerable families, families of children with disabilities, are the same families that are left without help.

The findings from the present study indicate the children with disabilities are not as different from other children in state custody. Perhaps then, the same prevention programs that are effective for at-risk families with typically developing children can be effective with families of children with disabilities. Until we allow families of children with disabilities into studies of child abuse prevention, however, we will never know how to approach these families.

### Limitations

As stated earlier, record reviews must be considered with caution. Within this study, not all records contained the same information, or even the same type of evaluations and forms. Some contained much more detail than others. Every step was taken to ensure accurate data collection and reliability rates reflect that data was collected carefully. Another limitation relates to the sample. Because data were collected from two locations, a very diverse sample of children was examined. The differences in these children were taken into consideration whenever possible.

Regardless of the limitations, this study was one of the first to examine characteristics of a special sample of children in state custody. In comparing children with and without disabilities who were and were not abused, I was able to better understand the differences between the groups. When children need to be evaluated by a special team within DCS, the children do not differ in as many ways as one would think. Specifically, children with disabilities are not as different from those without disabilities.

Future research should move beyond a record review in order to examine specific personality characteristics within a sample of children in state custody. If the child

characteristics are better measured we might be able to determine if children have similar risk factors present at different levels of severity. Also, more information about conditions prior to abuse would be helpful. Interviews with family members or case managers could help fill in the missing pieces to this special population. Still, while we try to answer the question of why children with disabilities are at increased risk of abuse, it is just as important to move toward finding what we can do to help families of children with disabilities.

APPENDIX A  
COE Coding Sheet

Name \_\_\_\_\_ COE# \_\_\_\_\_ MR# \_\_\_\_\_ SSN \_\_\_\_\_

Date of review \_\_\_\_\_ Reviewer \_\_\_\_\_ Data entered? \_\_\_\_\_

DOB \_\_\_\_\_ Date of Evaluation \_\_\_\_\_ M/F \_\_\_\_\_ Race \_\_\_\_\_

Custody \_\_\_\_ ( D/N or JJ ) Non-Custodial \_\_\_\_ Region: MC D UC SS

Current Placement \_\_\_\_\_ Level \_\_\_\_\_ Therapeutic Y/N

Type: BP AP FH GH PTC RTC DT L4 OTHER

Referral Agency \_\_\_\_\_

Reason For Referral: Dx TX Med TC PR PS ED MD CO \_\_\_\_ \_\_\_\_

Presenting Problem: Agg Mood SI HI PF POLY SD PD TF HYP IMP A&D PS SB Def \_\_\_\_\_

Service type provided: RR CR MD PhD ED PS Peds Out Consult

Accompanied by: CM PARENT FOSTER OTHER

Age Entering Custody(T1)\_\_\_\_ (T2)\_\_\_\_ Number of Times in Custody \_\_\_\_\_

Number of Placements (T1)\_\_\_\_ (T2)\_\_\_\_ Length of time in custody (T1)\_\_\_\_ (T2)\_\_\_\_

Types of placement (all times): BP AP FH GH PTC RTC DT L4 REL OTHER \_\_\_\_\_

Detachment Hx from mother: 0-2 2-6 6-10 10+ Detachment Hx from other: 0-2 2-6 6-10 10+

Maltreatment Hx: SEX PHYS NEG DV

Previous Dx	Previous meds trials	Current Medications	COE Dx
			Axis I
			Axis II

IQ 1 Date \_\_\_\_\_ <50 50-70 70-80 80-90 90-110 110-120 >120 Which IQ test? \_\_\_\_\_

IQ 2 Date \_\_\_\_\_ <50 50-70 70-80 80-90 90-110 110-120 >120 Which IQ test? \_\_\_\_\_

IQ 3 Date \_\_\_\_\_ <50 50-70 70-80 80-90 90-110 110-120 >120 Which IQ test? \_\_\_\_\_

Current Servs: IT FT GT A&D IH BM SEXOFF IP OP L4 MEDS Ed PL MF/U

COE Recs: IT FT GT A&D IH BM SEXOFF IP OP L4 MEDS Ed PL MF/U CCT

**Family information**

COE # \_\_\_\_\_

Mother: DOB \_\_\_\_\_ Occupation \_\_\_\_\_ Education years: \_\_\_\_\_

Mother Education Category						
			Degree			
Some HS	HS degree	Some College	2 YR	College	Graduate	Unknown

Father: DOB \_\_\_\_\_ Occupation \_\_\_\_\_ Education years: \_\_\_\_\_

Father Education Category						
			Degree			
Some HS	HS degree	Some College	2 YR	College	Graduate	Unknown

Marital Status: married divorced separated dating live-in widowed unmarried Zip code (of primary parent): \_\_\_\_\_

Siblings: age \_\_\_\_\_ M/F age \_\_\_\_\_ M/F age \_\_\_\_\_ M/F age \_\_\_\_\_ M/F age \_\_\_\_\_ M/F age \_\_\_\_\_ M/F age \_\_\_\_\_ M/F

Who else was in the house at the time of abuse? \_\_\_\_\_

**Abuse information**

Type of Abuse: (Check all that apply):

	Physical	Sexual	Emotional	Neglect	Not specified	Confirmed
Mother <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other family member <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outside family _____ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Number of times abuse occurred (1x multiple times unknown) and Age of child when abuse occurred**

Mother		Father		Other family		Outside family		Other		Other	
times	age	times	age	times	age	times	age	times	age	times	age

What happened to child? Stayed at home Taken into state custody other: \_\_\_\_\_

Who reported abuse? \_\_\_\_\_ Were siblings abused as well? Yes No

Specific Disabilities: ICD 9 codes (from TPG form): \_\_\_\_\_ Axis V GAF score: \_\_\_\_\_

TPG Form: 13 Y/N 14 Y/N 15 Y/N 16 Y/N 17 Y/N 18 Y/N 19 Y/N 20 Y/N

Category: check all that apply: Autism  Cystic Fibrosis  Down Syndrome  Hearing impaired  Motor Impaired

Visually impaired  PDDNOS  Spina Bifida  ADHD  Chronic medical conditions: Asthma  Diabetes

Other  \_\_\_\_\_ Mental retardation: Yes  No  Severity: Mild  Moderate  Severe

Axis III: \_\_\_\_\_ Axis IV: \_\_\_\_\_

School Placement: Grade \_\_\_\_\_ Placement: Regular education  regular education with aide  resource room

Special education classroom  Special education school/facility  other special services: \_\_\_\_\_

CBCL: Total \_\_\_\_\_; Anxious/Depressed \_\_\_\_\_; Withdrawn \_\_\_\_\_; Somatic \_\_\_\_\_; Social Problems \_\_\_\_\_; Thought Problems \_\_\_\_\_; Attention Problems \_\_\_\_\_; Delinquent Behavior \_\_\_\_\_; Aggressive Behavior \_\_\_\_\_

TRF: Total \_\_\_\_\_; Anxious/Depressed \_\_\_\_\_; Withdrawn \_\_\_\_\_; Somatic \_\_\_\_\_; Social Problems \_\_\_\_\_; Thought Problems \_\_\_\_\_; Attention Problems \_\_\_\_\_; Delinquent Behavior \_\_\_\_\_; Aggressive Behavior \_\_\_\_\_



**Custody**

D/N = Child adjudicated Dependent Neglect  
JJ = Child adjudicated Juvenile Justice  
Attachment Hx: Was Primary Caretaker  
same?

**Region**

MC = Mid-Cumberland  
D = Davidson  
UC = Upper Cumberland  
SS = South Central

**Reason For Referral**

Dx = diagnosis  
TX = treatment  
Med = medication review/2<sup>nd</sup> opinion  
TC = No TennCare  
PR = Placement recs  
PS = psychosexual  
MD= Psychiatric Eval  
CO= Court Ordered

**Presenting Problem**

Agg = aggression  
Mood = depression, anxiety, mood lability  
SI = suicidal  
HI = homicidal  
PF = psychotic symptoms  
POLY = review of medications  
SD = school disruption  
PD = placement disruption  
TF = treatment failure  
HYP = Hyperactivity  
IMP = Impulsivity  
A&D = Alcohol and drugs  
SB= Sexualized Behavior  
Def= Defiance

**Service type provided**

RR = Record Review  
CR = Case Review or Staffing  
MD = Psychiatric Eval  
PhD = Psychological Testing  
ED = Educational testing  
PS = psychosexual  
Peds = Pediatric Eval  
Out = Referral from triage to outside agency

**Placement**

BP = Biological Parent(s)  
AP = Adoptive Parent(s)  
FH = Foster Home  
GH = Group Home  
PTC = Primary Treatment Center  
RTC = Residential Treatment Center  
DT = Detention

L4 = Hospital or other level 4 placement  
REL= Relative placement

**Maltreatment Hx**

SEX = sexual abuse  
PHYS = physical abuse  
NEG = neglect  
DV = domestic violence

**Current Services**

IT = Individual Therapy  
FT = Family Therapy  
GT = Group Therapy  
A&D = Alcohol and Drug Treatment  
IH = In-home (CCFT, CTT, Intercept)  
Bm = Behavior Mangement  
SEXOFF = Sex offender (Hermitage Hall,  
Cedar Grove)  
IP = Inpatient  
OP = Outpatient  
L4 = Hospital or other level 4 placement  
MEDS = psychiatry follow-up/med  
management  
Ed = Educational follow-up  
PL = placement change  
MF/U = medical follow-up

**COE Recs**

IT = Individual Therapy  
FT = Family Therapy  
GT = Group Therapy  
A&D = Alcohol and Drug Treatment  
IH = In-home (CCFT, CTT, Intercept)  
Bm = Behavior Mangement  
SEXOFF = Sex offender (Hermitage Hall,  
Cedar Grove)  
IP = Inpatient  
OP = Outpatient  
L4 = Hospital or other level 4 placement  
MEDS = psychiatry follow-up/med  
management  
Ed = Educational follow-up  
PL = placement change  
MF/U = medical follow-up  
CCT= Continue Current Treatment

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