

**Title:** ‘I can’t forget’: Experiences of Violence and Disclosure in the Childhoods of Disabled Women

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**Abstract**

Violence against children is a human rights problem that cuts across gender, race, geographical, religious, socio-economic status and cultural boundaries. The risk of violence towards disabled children during their lifetime is 3-4 times greater than towards non-disabled children. It starts in early childhood, is more severe and linked to disablist structures in society. Violence is perpetrated by individuals and through institutional practices that are part of disabled children’s everyday life. Violence is often misdiagnosed as related to individual impairment, and not recognised by professionals or the victims themselves. Presenting disabled women’s reflections of childhood violence, help seeking and responses to disclosure, this article seeks to raise an awareness of violence towards disabled girls and the need for these to be recognised as a serious child protection issue to be included in official definitions of child abuse.

## **Introduction**

Nationally and internationally violence against children is recognised as one of the most serious violations of human rights (Pineiro, 2006; Etienne et al, 2002). Its associated consequences have been the subject of major global health concern for decades, prompted by the UN Convention on the Rights of the Child (UNCRC, 1989). The World Report on Violence Against Children (2006:4) defines violence drawing on article 19 of the UNCRC:

all forms of physical or mental violence, injury and violence, neglect or negligent treatment, maltreatment or exploitation, including sexual violence...

The UNCRC (1989) was the first human rights treaty to protect the rights of all children, including disabled children, under the age of 18. The 54 binding articles include the right to survival, protection against abuse, neglect and exploitation (Article 19). The UNCRC (1989) cites disability as grounds for protection against unfair treatment and discrimination, and addresses the rights of disabled children in Article 23, which states that:

State Parties recognise that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate to child's active participation in the community (UNCRC, Article 23.1)

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006) reinforces disabled children's rights, including their rights to express their views (Article 7) and to be protected from violence, exploitation and abuse (Article 16).

However, national and international evidence reveals that disabled children are at greater risk of violence than non-disabled children. Sullivan and Knutson's (2000) study in Nebraska and Jones et al's (2012) synthesis of 17 studies on prevalence and risk (conducted in the WHO regions of America and Europe), suggest that disabled children are three to four times more likely to experience violence than their non-disabled peers, and are more likely to experience different types of violence during their lifetimes, starting from an earlier age. Drawing on evidence from the Seattle Rape Relief Developmental Disabilities Project, Ryson (1984) revealed that 700 disabled children between the ages of 2-4 years experienced sexual violence in Seattle during 1977-1983, which continued for a period of 5-15 years. Further, violence and especially sexual violence is perpetrated more against disabled girls than against disabled boys (Sobsey et al, 1997).

Thus, although treaties recognise disabled children's rights to survival, support, protection and expression, the achievement of these are very often thwarted by disablist assumptions and restricted resource allocation (Priestley, 2003). Article 19 of the UNCRC states the protection of all children from abuse, neglect and exploitation within and outside the family; yet high levels of adult surveillance of disabled children increases their 'vulnerability' to violence and creates barriers to disclosure (Hernon et al, 2015; . For instance, disabled children who rely on others for personal care may find it difficult to resist or report inappropriate touching.

Further, Article 12 asserts that all children have the right to express their views on matters that affect them and these should be given due weight. However, this is open to adult interpretation and judgments about children's capability to expressing their views; especially in the cases of children with communication or cognitive impairments. As Westcott and Cross (1996) argue, little account is taken of disabled children's communication and information requirements, such as, when they cannot use traditional communication methods

and are forced to remain silent or depend on others to ‘talk’ for them. Even when assistive communication tools are used, these do not always include vocabulary to describe intimate and inappropriate acts. Further, materials developed for ‘prevention programmes’ are not always sensitive to the needs of children with different learning and communication styles.

Official definitions of childhood violence within mainstream child protection fail to grasp the full range of disabled children’s experiences which often go beyond those experienced by non-disabled children. Hernon et al’s (2015) review reveals how disabled children are largely excluded from mainstream child protection policies, while their ‘voices’ on issues of violence and support are absent from research (Stalker and McCarther, 2012). Taylor et al’s (2015) study, one of the few in the field, recognised the need to consider disabled children’s subjective accounts of violence to uncover a host of abusive acts and practices that are regularly inflicted upon them. The social interpretation of disability (Oliver, 1990) can explain how violence towards disabled children is stimulated by the context in which they are placed and the disabling practices they are coerced to endure. These are often part and parcel of growing up as a disabled child; for example, regular medical interventions to ‘correct’ impairment, or placement in segregated respite/school institutions. Therefore, listening to and understanding disabled victim-survivors’ perspectives on childhood violence is essential to improve micro, meso and macro level relationships and practices that oppress and infringe their human rights (HM, 2011)

This paper reports findings from the U.K. strand of the E.C funded study on disabled women’s experiences of violence and support.. Drawing on the analysis of 15 life history interviews with disabled women reflecting on their childhood, this article discusses their memories of experiencing childhood violence perpetrated by different adults in different contexts, and their experiences of help seeking and disclosure. As such, it contributes to the

dearth of research foregrounding voices of disabled women who have experienced childhood violence.

For the sake of brevity the term ‘disabled children’ here refers to disabled children and teenagers between ages 0-18 years. This draws on the definition by UNCRC and the UK child protection guidance. In this regard, the term ‘childhood’ will describe generational locations when individuals are 0-18 years old.

## **Literature Review**

### *Disabled Children, Human Rights and Violence*

Disabled women and girls are at greater risk of systemic and individual violence across their life-course compared to their non-disabled counterparts (Thiara et al, 2011). Sullivan and Knutson (2000) and Kelly et al (1991) suggest that disabled girls are more prone to sexual violence than disabled boys while the opposite is true for physical violence. Violence against disabled children tends to be more severe than for non-disabled children (Akbas et al,2009), while severity is correlated with the impairment type (Stalker and McArther, 2010). For instance, children with speech and language impairments are three times more likely to experience violence compared to non-disabled children, while this could five times greater for children with cognitive and behavioural impairments. Assessing research on violence of deaf people and those with hearing impairments, Sullivan et al (1987:257) concludes:

[...] there appears to be more sexual abuse of deaf children than hearing children. Whereas 10% of hearing boys and 25% of hearing girls report sexual abuse, the rates are 54 and 50% respectively for deaf boys and girls

Several factors contribute to disabled children's increased risk to violence. Disabled children's exclusion from certain social spaces impacts on their exposure to sexual knowledge and opportunities while growing up. Shah (2005) and Morris (1997) suggest that disabled children are excluded from important social processes and socialisation by differential mechanisms of surveillance and segregation, and are consequently prevented from developing their social skills and self-confidence at the same level as non-disabled children. For instance, lack of awareness of their sexuality and of what is inappropriate sexual treatment or harassment may be the result of exclusionary socialisation that potentially increases their risk to violence (Mandl et al, 2014; Nosek et al, 2001; Shakespeare et al, 1996). Hence, even when heightened risks are evident the problem cannot always be communicated and often remains hidden, undetected, and unreported (Stalker et al, 2014).

### *Disablism, Violence and Disclosure*

Violence against disabled children and barriers to knowledge, disclosure and reporting are grounded in the devaluation of disabled people in society (Higgins & Swain, 2010). From infancy disabled people are continuously reminded of their 'difference' and 'otherness' through mechanisms of stereotyping, objectification and marginalisation reproduced through language, social structures, institutional practices and individual reactions (Shah et al, 2014). The objectification and manipulation of the disabled female body has been suggested to create opportunities for violence (Higgins and Swain, 2010;). Shah and Priestley's (2011:77) work illustrates disabled girls' experiences of objectification under the powerful, normalising gaze of medical services:

As a child all I remember is being poked and, you know, stripped off and made to walk across the room in your knickers...I feel the medical profession has experimented with me and my body trying to make it into something which is acceptable in the way that I eat, the way that I walk, the way that I sit... You

know, that's what the medical profession wants. It wants for you to look and act and be like the majority, and if you don't fit in then it has to try and bend your limbs, and twist your head, so it's all in the right direction.

Shah and Priestley (2011) suggest that the birth of a disabled child is often conveyed as a personal tragedy, as a life lacking in social value or a wrongful life that would be an economic and social burden to family and society. This societal view impacts on the interaction and quality of attachment between parent and child. Howe (2006) argues that it is actually the quality of attachment that determines children's risk to violence, rather than disability. Marshall and Marshall (2000) and Howe (2006) assert how secure early attachment allows growth in self-confidence and time to explore, while insecure parent-child attachments may result in weak and sporadic exploration, lack of self-confidence and increased vulnerability to violence later in life.

Disabled children's constant exposure to negative scripts coupled with the absence of positive role models undermines their self-esteem and confidence to disclose the violence experienced. Moreover, it leaves them feeling disempowered and doubting their right to protection and support. Thomas (2007) refers to this cumulative damaging impact as 'psycho-emotional disablism' and suggests that it creates long-term 'barriers to being'. However, it is worth pointing out that this may not be the case for all survivors of violence. As Shah (2005) and Taylor et al (2015) indicate, early trauma can also induce survivorship skills that benefit future pathways.

Various myths play part in professionals' views towards violence against disabled children. Kennedy (1996) argues that there is a notion, among professionals, that violence experienced by disabled children less significant than that experienced by non-disabled children. Views such as 'sexual abuse of disabled children is OK, or at least not as harmful as sexual abuse of other children' (Marchant, 1991: 22) or that 'these children won't understand

what's happened, therefore won't be damaged by it' (Kennedy, 1992: 186) influence the extent to which disabled children are listened to and believed when attempting to disclose. Furthermore, diagnostic overshadowing by health services (namely, the tendency to attribute signs of violence to the person's impairment) is likely to undermine child protection concerns (Murry and Osbourne, 2009). All these factors contribute to the unfortunate reality that violence towards disabled children is likely to go unchallenged. Thus disabled children and adults live without protection but with the long-term psycho-emotional impacts of violence.

Westcott and Cross (1996) argue that the disablist beliefs and power systems that oppress disabled children and constrain their agency at a micro level are the same ones that shape systems of protection and processes of prevention at a macro level:

Just as the abuse of girls is part of the overall pattern of sexism, so that abuse of disabled children must be understood as part of the position of disabled adults in society; that is part of the overall pattern of disablism (cited in Westcott and Cross, 1996: 2)

Disabled children are likely to encounter potentially risky practices, specific to being disabled. For instance, their placement in segregated services and institutional facilities coupled with dependency on others for basic personal and social needs increases their vulnerability and risk to violence. However, because such practices are a normalised part of a disabled child's life, they are unlikely to be considered as unsafe. Therefore without undoing fundamental structural inequalities, disabled children will not be empowered to act against the perpetrators, and professionals will continue to misrecognise signs of maltreatment and abuse.

## **Research design and methods**

This paper is draws on a four-country comparative study conducted by teams in Austria, Germany, Iceland and the U.K. between 2013 and 2015. All teams adopted a mixed methods approach to cover four phases of empirical fieldwork: a national online survey of specialist violence support services, 15 semi-structured interviews with key representatives from these support services, four focus group discussions with women with different impairments (i.e. sensory, mobility and learning disability) and 15 life story interviews with disabled women who voluntarily identified as having experienced violence during their lifetimes. These were conducted in different parts of the country. This paper focuses on the life histories of 15 disabled women across the UK.

Recently, life stories or biographical methods have contributed to the field of disability studies and, in particular, to uncovering the hidden childhood histories of disabled people (Shah and Priestley, 2009). Bringing victim-survivors' self-told histories into light is considered paramount for service providers and planners to ensure that policies and practices are developed to protect and support disabled children. As Jenny Morris (1997:257) pointed out:

We need to know much more about the experiences of disabled children and young people, and such research must offer an opportunity for their accounts to be heard. Only when this happens will policy and practice be driven more clearly by the interests of disabled children themselves.

Life history methods not only generate personal narratives but have the potential to offer a unique insight to development across time (both biographical and historical) and space (Chase, 1995), and to the interplay between the individual and the broader social structures and interdependent relationships (Bertaux, 1981). Life histories favour a social model lens and allow space for non-medicalised narratives to be voiced. They allow research to move beyond the 'life experiences of disabled people' towards the 'experiences of disability in

people's lives' responding to Finkelstein's reminder that 'disabled people are not the subject matter of social interpretation of disability' (Finkelstein, 2001: 1). Disabled people's experiences can provide unique evidence of the ways disability manifests itself. This approach can also reveal the network of social relations, institutions and practices that, while being part of disabled children's lives, increase their 'vulnerability' to violence and barriers to support.

### *Sampling and Recruitment*

The target sample included women with different impairments between 18-65, stipulated in the original proposal for reasons relating to ethics and funding. These women from different social class and minority ethnic backgrounds grew up in different geographical areas across the U.K. All women identified themselves as being survivors, and had experienced violence and accessing support at different points in their lives. Details of the participants are summarised in table 1 below. Women's names have been replaced by self-selected pseudonyms. All women became involved in the project through a process of self-selection. Disch (2001) asserts the importance of research participants being able to freely volunteer for involvement in research. Disabled women in this sample considered they were in the right place in terms of their personal healing and were confident about sharing their realities.

Short recruitment notifications were published on the project website, on Facebook, and in newsletters of disabled people's organisations across the U.K. A number of disabled women responded to these, while others were recruited through snowballing and their association with some of the expert service providers involved in the previous phases of the project. The final sample was made up of women based in different parts of England and Scotland.

**Table 1: Characteristics of Disabled Women**

<i>Pseudonym</i>	<i>Age</i>	<i>Ethnicity</i>	<i>Impairment</i>	<i>Area / Country</i>
Sarah	56	White British	Mobility	Ayrshire, Scotland
Barb	47	White British	Visual	Glasgow, Scotland
Lois	22	Black British	Genetic fluctuating mobility	West Midlands, England
Alison	47	White British	Mobility	Ayrshire, Scotland
Zara	37	Pakistani	Deaf	Glasgow, Scotland
Sam	47	White British	Speech, Mobility	Edinburgh, Scotland
Freya	33	White British	Deaf	London, England
Elma	39	White British	Mobility	Leeds, England
Adele	34	White British	Mobility	Leeds, England
Samantha	48	Hindu Punjabi	Arthritis, hearing and mobility	Leeds, England
Shirley	48	White British	Mobility, Hearing	Glasgow, Scotland
Malika	41	Palestinian	Mobility	Edinburgh, Scotland
Betty	40	White British	Learning Difficulty	Leeds, England
Lucy	48	White British	Learning difficulty	Leeds, England
Saima	29	Asian British	Mobility, Mental Health	Yorkshire

***The Interview***

Once the women expressed interest in participating in the research, they were sent the aims and objectives of the research, information about how their stories would be used, and a *Consent Form* to give written consent for their stories to be used in publications and seminars. Higgins and Swain (2010) propose that the process of explanation is important as it influences the acquisition of informed consent.

The women were presented with options as to the format of interview so that it would be most accessible for them, such as face-to-face, via e-mail, via skype, and telephone. All women expressed a preference for face-to-face interviews in a location of their choice. Most interviews took place in their own home which was considered safe and accessible. In some cases this was not appropriate, so interviews were held in local women's support services which were familiar to them. Service providers also offered support these women, in case they were re-traumatised by the interview. One of the interviews was conducted in a public place (bar/restaurant) as it was convenient for the participant. The possible problems of discussing such a private and sensitive topic in a public place were noted but did not deter the participant. All interviews ran on for 60-120 minutes. Interviews were analysed using thematic analysis and N-Vivo software was used to supplement the manual analysis of interviews. Themes were also shaped by the interview guide.

Most interviews were conducted by the first author, who is herself a disabled woman. researcher and participants identified as a disabled female and shared the experience of simultaneous oppression it engenders. This was helpful in terms of recruiting building rapport and encouraging women to be more open. Nosek et al (2001) argues that non-disabled interviewers may create a psychological divide when interviewing disabled women. However, a non-disabled member of the research team interviewed two participants, as it made logical sense in terms of geography and time.

The researchers guided participants through the interview with a very open topic guide, but gave women ultimate control over how and whether they responded to questions. The women interviewed determined if/when they wanted a break or to resume the conversation. This was especially important given the sensitive nature of the topic.

### **Limitations**

As our sample depended on voluntary participation it was difficult to get representation from different parts of the U.K. Despite sending out recruitment materials across the country the women who responded lived in England or Scotland. Therefore women from Wales and Northern Ireland were not included. Another limitation relates to relying on recovered memories of childhood violence. This has been criticised for being unreliable and clouded by subsequent experiences (Stafford et al, 2015; Nelson and Hampson, 2008)). However the topic guide was divided into generational categories across the lifecourse (such as childhood, youth and adulthood), and a timeline was used to focus responses on particular time periods. Asking questions about a fixed time window of time limits recall bias and provides ‘more accurate estimates of lifetime abuse’ (Yoshihama & Gillespie, 2002:215)

### **Results**

This section presents disabled women’s reflections on the types of violence they experienced during their childhood, and responses to help seeking and disclosure.

#### *Theme 1: Violence experienced in Childhood*

The women recalled a range of experiences of childhood violence including physical and sexual. This was perpetrated by different individuals and in different contexts. There was much evidence of violence perpetrated by family members, usually male. For instance,

Shirley recalled on-going physical violence by her father, since she was three years old and escalating over time; when she was 14, he threatened her life:

My father was violent towards me so yes it was an ongoing thing. My mother has a learning difficulty so she allowed it to happen...The violence with my father escalated to a point where he did actually threaten my life...

Shirley also experienced neglect by her mother. She attributes this to her mother's learning difficulty, and reflects how lack of parental care impeded her childhood, resulting in her being bullied at school and being perceived as an outcast:

I was severely neglected in terms of my dress, my appearance, how often I washed; the basic things that you associate with looking after a child and as a result of this neglect, I went to school having not washed in several days and not knowing I was supposed to wash everyday...I was severely bullied.

Sarah also had a disabled mother and a violent father. She described her father as a 'predator', who treated his children as play toys:

My dad was a very brainy man but he was an alcoholic. My mum was a very timid lady, she'd been in a – she had a disability herself...With alcoholism and that our house was not a very nice house to live in. It was very violent. He was a predator as well. We were his playthings [...]

It was not only fathers who were perpetrators. Samantha, a Hindu Punjabi woman and the youngest of five children, experienced physical violence from her brothers since she was two years old. She reflects on how the violence she experienced was about control. When her mother died, Samantha was made to adopt a housewife role, taking care of her sick father and the household chores. When she was 16 her father died and her brothers sent her to marry an older man in India. Thus she was prevented from engaging in normal childhood activities and getting an education:

I went to school...but I stopped at an early age because my dad got really ill. My sisters had got married so it was only me and my other brother looking after my dad...I didn't have much education or

nothing...So really they just put me to one corner...just clean, iron, all the housework...when I was sixteen I ran away from home so my family didn't want to know me, so they said I need to get married to this guy - he was an old man.

Saima was also a young bride. At the age of 16, she got married to an older man who was 'clingy' and abusive:

I was such an immature sixteen year old...into my studying and my dolls and my friends,. I still had a dolls' house at sixteen...He was always clinging on to me...I felt sorry for him and accepted it. But then it got worse, he got even more clingy and then the clinginess turned into abuse – I couldn't have a life of my own... my life was still to develop and I was actually put on anti-depressants at that very early age because of him.

Lois was a victim of childhood sexual violence. The perpetrators were older male members of her extended family. From the age of six, she was coerced into oral sex during sleepovers with relatives. This continued until she was 13. She was then raped by another man:

when I was about 14 or 15, I was raped...That information went to the sort of church board of trustees as a safeguarding issue and my father sits on that board

Other women recollected experiencing violent acts more specific to being disabled. For example, Adele's impairment meant that she was always dependent on others to support her with intimate personal care such as dressing, bathing and going to the toilet. She recalls how, when she was a young teenager (age 13) she had a sexual relationship with her support worker (over age 20) for a decade. Reflecting back, she realised it was an exploitative and uneven relationship as he manipulated her medication, controlled the level of her engagement with others, and isolated her. However, at the time she did not recognise it as violence:

I was in a relationship with someone who I believed at the time was trying to be protective of me... now I realise it was just someone trying to control what I was doing. But at the time they used all that to abuse me really...He would tell friends that I was poorly when he'd zonked me out. If you've had very strong painkillers you're very dosey. He would purposefully give me the strongest painkillers when my friends were coming, and they couldn't come then, obviously because I was asleep

Some women recalled their experience of violence within education. For instance, Lucy was sexually violated during her teens at a specialist college for people with learning difficulties. The perpetrator was in the college and was well known to Lucy. She reported that she was one of several victims:

I was raped when I was eighteen...he physically and mentally abused me. I hated it. It also happened not just to me, it happened to four, three other people; it was one of my mates.

Betty recalled how she and other disabled girls, in her mainstream school, were targeted by the assistant art teacher or the 'arts janitor', who would be 'extra kind' to them. Her narrative conveys her misunderstanding of the perpetrator's actions at the time:

I remember in the summer, I was about 14/15 I was quite shy, quite naive...But this art janitor who used to work with my art teacher used to be really nice to me but some of my class members had noticed that and I remember it going to my head masters office. And years later I ended up finding out this guy had taken his own life... he'd segregated some of the other girls with disabilities but when you're young, 14/15 you don't always click straight away what's happening

Malika, who went to a residential school for disabled children in the 1980s, gave examples of male care staff exploiting their power and objectifying the girls rather than respecting their privacy and sexuality.

A male staff member would barge into your room and, you know, take off the duvet. You know, this was – you know, he never dared harm us or anything but this lack of privacy. You know, that would

not be at all tolerated today... it was just the characteristic of these kind of people, that they just feel that, I don't know, that it's part of their work.

Alison recalls being “thrown in the dark room” at a day-centre she attended as a young child - also an example of the exploitative power of ‘caring’ professionals over disabled children.

### *Theme 2: Attempts and responses to disclosure*

Disabled women described their attempts to seek help and disclose their experiences of violence during r childhood. Adele recalls how, for a number of years, she did not disclose for fear she would be left without support :

if that person has been doing your care for ages or they're the only person who knows the kind of care you need...trying to get that sorted that takes a lot of energy

However this was not the only barrier to disclosure. Adele recalls how the perpetrator was seen to be “someone who cared” for her and ‘he was respectable...he had his own business’.

Therefore when she tried to tell her GP:

They spent all the time blaming it on my meds, implying I was a bit paranoid. I wasn't really. But you know they were saying ‘these are all the symptoms of this’ ...trying to find a medical reason for it.

As mentioned earlier, the perpetrator would overmedicate Adele and isolated her from her friends and family. However, they were unaware of this .Even when Adele tried to disclose, they would excuse his behaviour:

...it's a strong painkiller and it does leave you spaced...but he'd give you so much that you don't know what you've done...He's the sort of person that has a very public face...being very respectable - being very nice, being like ‘can I help you with this?’. But it was all false. But at the time you just believe it.

And all my friends did...even when you did convince someone that something was wrong they'd make excuses like 'oh, he gets frustrated because it's difficult being someone's carer'.

Shirley spent her childhood in the USA and described how the abuse she experienced in childhood escalated and prompted a suicide attempt when she was 13. She believes that, in 1970s America, children's rights and protection legislation and systems of support were not as strong as today in the U.K.:

I probably thought at the time that the laws were not strong enough to protect me...I thought parents do whatever they want with their children and it never occurred to me that I could press charges against my own father or that I can show them evidence of physical scars... had I been born in the 1980's or 1990's I would have been in child protection and I would have a right to go as a child. Social services would have been more proactive, they were non-existent in the 70's, I hadn't heard of social services or child protection.

At age 14, Shirley feared for her life and contacted child protection services in the city she grew up. However she felt she did not receive adequate support against her father so she decided to move away:

When I was 14, I called something called Child Protection Services in America. I was told I would be entitled to family counselling...I was still pretty much fobbed off. The family counsellor said that until he did something quite nasty that would put me in hospital they did not have grounds to do something...So I moved away from home and I cut him from my life.

Other women described family responses to disclosures of childhood violence, including how it was "swept under the carpet" to avoid a family scandal. Barb was sexually assaulted while walking home from school when she was seven but her disclosure was dismissed, leaving her to deal with the psycho-emotional effects :

I think the thing that sticks with me most is, in part a reflection of the times then that these things weren't as widely spoken about as now. I remember hearing my parents talking trying to figure out what to do...I think the thing that hurts me the most was probably my parent's reaction – my mum particularly, I think they must have been thinking do they phone the police, if they do, you know, it'd be a big scandal; it would be in the paper - all this kind of thing. A sort of shameful situation and I remember hearing my mum saying "she's young, she'll just forget about it if we don't mention it". And it was just swept under the carpet.

Similarly, Lois' family knew that she had been sexually abused by her cousin but were concerned with the potential scandal caused within their community, thus failed to adequately report it to the police at the time. When she was 18 she went to the police herself, but felt she was not fully believed because her parents "were in denial" and had "skipped over what was important" in the reports they gave.

However not all disclosures were denied or ignored. Lucy's disclosure of sexual violence at her college resulted in the perpetrator being convicted:

...Somebody, a friend, whose house I went to, she told her dad, a copper, and he got arrested...We all spoke up.

For some women, disclosures were triggered by violence escalation, as in Shirley's case. For others it was a consequence of recognising that the behaviour towards them was abusive. Adele became aware of her situation when she started attending a local health support group for disabled women, led by a disabled woman:

I met her [leader] through another group that she came to. Initially we didn't really speak a lot...I just listened and after a while it started to sink in that it happened to me...she started talking about this: domestic violence towards women, and it just sort of clicked into place that I've got to go, he's got to go. Even if I had to go back to my parents he's got to go.

Adele eventually disclosed her decade of experiences to the group leader and, age 23, broke ties with the perpetrator.

## **Discussion**

This paper draws on part of a qualitative EC study on disabled women's experiences of violence across their lifecourse. It presents disabled women's reflections of childhood violence, help seeking and disclosure, bringing out the 'hidden voices' of some survivors to inform the development of child protection policies and practices. The paper discusses how disabled girls are likely to experience specific types of violence, different from and in addition to that experienced by non-disabled children. These acts of maltreatment usually perpetrated by institutional practices and individuals play a prominent role in disabled children's lives (Cosser et al, 2013).

The paper suggests how disabled child -survivors may not always recognise signs of violence, and abuse. Cosser et al (2013) argues that recognition is often gradual and operates along a spectrum from 'no recognition' to 'clear recognition'. Barriers to recognition include limited access to social networks and opportunities for disabled children to compare life stories with friends and family; inadequate education on sexual relationships and sexual health and exclusion from informal social spaces where sexual exchanges and boundaries are explored (Nosek et al, 2001; Watson et al, 1999). Thus, it is critical for schools to provide the same level of sex/relationship education to disabled children as to non-disabled children, through accessible learning materials and resources suitable for children's individual needs.

Professionals often do not recognise scars of abuse and misdiagnose them as impairment related (Brandon et al, 2011; Hibbard and Desch, 2007). This diagnostic overshadowing can thwart child protection and support, and cause disbelief when disabled victims seek help and disclose their experiences of violence. Being silenced and unsupported has psycho-emotional consequences that the victims can carry with them for the rest of their lives. Hence it is paramount that violence against disabled children is recognised as such and included in the official definitions of child abuse used by child protection systems.

Although disabled children have an equal right to help, this paper reveals how victim-survivors' attempts to disclose to professionals and family are often met with negative responses. There was little evidence of good practice, except for the case of Adele who accessed a local health support group, run by and tailored to the needs of disabled women. Such examples need to be universally applied to improve support and safeguarding practices at different levels. Services providing child protection need to be aware of the support and communication needs of victim-survivors and regularly reviewed to ensure provisions are accessible. Moreover, prevention programmes and child protection training materials need to include real-life case studies of disabled survivors. We concur with Taylor et al (2015) that future child protection strategies need to be designed and implemented to raise awareness among the public and professionals, and encourage them to listen to the concerns of disabled children and adults.

## **Conclusion**

Disabled children are at a greater risk of experiencing violence than non-disabled children, yet this is less often recognized. They are more likely to encounter barriers to support and protection connected to disablism in society. The evidence suggests that scars of violence can

be overlooked by practitioners who see the disability first. Therefore child protection and criminal justice systems need to do more to recognise and prevent acts of maltreatment towards disabled children. Practitioners need to have knowledge and an understanding of how to communicate with disabled children and empower them to act against the perpetrators. This requires listening to their views and giving their accounts due weight.

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