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The physical and mental health consequences of bias victimization among people with disabilities

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Abstract

Aim: Research on the health consequences of violent victimization of people with disabilities is lacking. This study aims to identify the factors that are associated with physical and mental health impacts of anti-disability bias victimization.

Methods: The study drew on a unique sample of 331 self-identified people with disabilities, all over the age of 15, residing in Czechia. From this sample, 47 questionnaires were excluded. The respondents were asked about the most serious incident of anti-disability bias victimization in the last five years. A series of bivariate binary logistic regressions were performed – with the consequences of this incident as outcomes (mental health and physical health).

Results: 90 respondents (32%) reported experiencing the most serious incident of bias victimization in the last five years. 60% of victims reported anxiety and sadness, and 28% deterioration in physical health. The results suggest that victims experience physical and mental health consequences unequally. Age, perceived disability in specific areas, visibility of disability, presence of multiple disabilities, and number of offenders are associated with the experience of physical health deterioration. Education, perceived disability in specific areas, and visibility of disability are associated with the experience of mental health impacts.

Conclusion: Certain groups of people with disabilities who experience victimization report poorer physical and mental health outcomes. This differential experience should be considered in immediate responses and prevention programs.

Keywords: Bias violence; Disability; Hate crime; Mental health; People with disabilities; Physical health

Introduction

The victimization of people with disabilities constitutes a significant public health issue (Hughes et al., 2012). Systematic reviews published in the Lancet journal (Hughes et al., 2012; Jones et al., 2012) underscore the prevalence of violence against this demographic, indicating a substantially higher risk of victimization for people with disabilities compared to their non-disabled counterparts. Subsequent studies have largely corroborated these findings, revealing the persistent high rates of victimization among people with disabilities in general, and also the diversity of experiences of victimization within this population depending on a variety of factors, including gender, age, disability type, presence of multiple disabilities, etc. (Alemu et al., 2023; Codina et al., 2022; Emerson and Llewellyn, 2023; FRA, 2021; Krnjacki et al., 2016; Liasidou and Gregoriou, 2021; Snæfríðar-og Gunnarsdóttir et al., 2024).

Bias violence (or hate crime) has been recognized as a form of victimization that people with disabilities are more often exposed to than people without disabilities (Emerson and Roulstone, 2014). People with intellectual disabilities are a particularly vulnerable group (Díaz-Faes et al., 2023). Anti-disability bias victimization can be understood as an experience of verbal, physical, sexual, economic, or other violence that is motivated by prejudices about people with disabilities, or their perceived "otherness". The consequences of bias victimization have consistently been shown to be more severe than those of victimization with other motivations (Walach, 2024). This is primarily attributed to the greater emotional harm that stems from the interference with the identity of the victimized individual (Iganski and Lagou, 2014).

Existing research – primarily from the U.S. – offers limited insight into the repercussions of victimization on individuals with disabilities (Dembo et al., 2018, 2021). It predominantly focuses on specific subgroups such as women (Hayes and Powers, 2021), students (Scherer et al., 2013), and young people (Chiu et al., 2017; Dembo et al., 2021), and on specific types of crime such as identity theft (Irvin-Erickson, 2024; Maher et al., 2025), sex trafficking (Krushas and Kulig, 2024), or both, e.g., survivors of sexual victimization with intellectual disabilities (Byrne, 2018). Collectively, these studies suggest that people with disabilities who experience victimization often face more severe physical and mental health consequences than the general population – and that these consequences are not experienced equally in this demographic (Dembo et al., 2018; Hayes and Powers, 2021; Irvin-Erickson, 2024).

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In East-Central Europe, the subject of interpersonal violence against people with disabilities and its health impacts has received even less attention (Radkiewicz and Korzeniowski, 2017; Walach and Petruželka, 2024; Wołowicz et al., 2022). The present study aims to fill this gap by analyzing a unique dataset obtained through surveying people with disabilities in Czechia. The main objective is to identify factors associated with physical and mental health impacts for the most serious incident of anti-disability bias victimization that the study participant experienced in the last five years. In addition, the study seeks to ascertain the prevalence of this victimization in the group.

Materials and methods

Data and sampling

This study utilizes a unique sample of self-identified people with disabilities who live in Czechia and are over 15 years of age (for a detailed description of the research design, see Walach et al., 2024). Given the heterogeneity of the surveyed demographic, we developed two versions of the questionnaire to collect data: a default and an adjusted version. The adjusted version was prepared together with a relevant NGO to better suit the needs of people with intellectual disabilities. They also had the option to complete the default version, potentially with the assistance of a facilitator. Along with the language changes, some questions were discarded as they could be confusing for members of this group.

Both questionnaire versions were available online via Google Forms. Dissemination efforts included extensive outreach to numerous organizations (disabled people's organizations, counselling services for victims), social media platforms, and community media. A peer-led video campaign was also organized to motivate people to participate in the survey.

Between May 2021 and January 2022, a total of 331 respondents completed the default and adjusted versions of the questionnaire. However, this study only works with data from 284 default questionnaires. 47 adjusted questionnaires were excluded, mainly due to differences in the measurement of the victimization period in the default and adjusted questionnaires. While the default questionnaire asked about the most serious incident of bias victimization in the last five years, the adjusted questionnaire covered the entire lifespan.

Measures

Two groups of variables were used: socio-demographic characteristics and bias victimization characteristics. Socio-demographic characteristics consist of the following categories. In terms of gender, respondents could identify themselves as male, female or other. We collapsed the latter two into one category because of the similar victimization experiences of these respondents and due to the low occurrences of the "other" option (11 cases). Age was categorized using the following intervals: 15–25; 26–33; 34–48; 49–65; 66–85. The different education categories were also collapsed to create categories such as: elementary and high school without diploma; high school with diploma; post-secondary vocational school or university. All employment statuses were dichotomized into employment (including part-time jobs) and unemployment. We also collected information about the residence in one of the 14 regions of Czechia. For the bivariate analysis, the variable of structurally disadvantaged region was created using the official definition; the Czech state defines the Moravian-Silesian, Ústí nad Labem and Karlovy Vary regions as structurally disadvantaged (Regional Development Strategy of the Czech Republic, n.d.). Other sociodemographic variables are municipality size (up to 999 inhabitants; 1,000–4,999 inhabitants; 5,000–19,999 inhabitants; 20,000–49,999 inhabitants; 50,000–99,999 inhabitants; over 100,000 inhabitants), and several measures of disability.

Following the Czech Statistical Office (2019), we applied both objective (disability pension status: yes; no) and three subjective measures of disability. The first subjective measure concerns perceived disability in specific areas (physical mobility; intellect, psychological condition, and behavioral disorders; hearing; vision; internal organs and skin; voice and speech). The second subjective measure is the presence of multiple disabilities (yes; no); the positive answer captures the situation where a respondent indicated perceived disability in two or more areas. The final subjective measure is the visibility of disability at first glance, which respondents were asked to assess according to their opinion (yes; not sure; no).

Bias victimization primarily refers to the experience of an incident of bias victimization that occurred in the last five years and that respondents considered to be the most serious. To avoid terminological confusion, the questionnaire asked about "being attacked because of their disability" rather than using the term "bias violence" (yes; no). The bias victimization characteristics also include variables such as the mode of victimization incident (internet or telephone; physical environment), location (home, excluding the residential social service; public spaces, including means of transport; at school or workplace; shop or restaurant; other). In addition, we asked about the number of offenders involved in the incident (one offender; two or more offenders; four "I don't know" responses were excluded from the analysis), and the degree of familiarity of the offender to the respondent (I knew the offender well; sometimes we exchanged a few words; I knew the offender by sight; I did not know the offender at all). In the case of multiple offenders, the question focused on the one the respondent was most familiar with. For the bivariate analysis, however, the variables for a sole offender and multiple offenders were collapsed.

Consequences of victimization refers to the impact of the most serious incident on the physical and mental health of the victim. The questionnaire contained 17 possible consequences as multiple-choice answers, including the option to indicate an answer other than the ones given. Based on these items – and building on prior work (Dembo et al., 2021) – two outcomes were created: anxiety and sadness (as an indicator of mental health), and deterioration in physical health (as an indicator of physical health). These outcomes were used in logistic regression analysis as dichotomous variables.

Data analysis

Analysis was conducted in R studio software. Data were continuously extracted from Google Forms utilizing the read sheet function from googlesheets4 package directly into R studio. The assessed level of statistical significance is alfa 5%. A series of bivariate binary logistic regression models with odds ratios were performed using the tbl_uvregression function from gtsummary package. The outcomes in these models were the consequences of bias victimization in two areas: mental health and physical health. For models which included more than two categories of independent variables, we also provide the overall p-value of the model.

Ethical considerations

The study was conducted in accordance with the Helsinki Declaration of 1964 (amended 2024). Since this study is not based

on clinical research, formal approval of the ethical committee was not sought. The study design ensured that no potential harm would befall participants, anonymity was maintained throughout the questionnaire process, and contact details for social and legal support for participants were provided. Prior to completing the questionnaire, participants were provided with detailed information regarding the study's objectives and its method, and informed consent was obtained as participation could not commence without it. To ensure the questionnaire was understandable, we consulted with community members and incorporated their suggestions.

Results

Basic socio-demographic characteristics of the sample

As Table 1 shows, over half of the sample population is female and other. The overall demographic profile of the sample skews younger, though older individuals are also represented. Most respondents resided in Prague. All categories of municipalities are represented, with a significant proportion of participants coming from municipalities with more than 100,000 inhabitants. Over half of the sample reported physical mobility disabilities. 28% of respondents reported experiencing multiple disabilities. 40% indicated that their disability was visibly apparent at first glance.

Characteristics of the most serious incident of bias victimization

90 respondents (32% of the sample) reported experiencing the most serious incident of bias victimization in the last five years. 23% of respondents indicated that they were subjected to attacks via the Internet, telephone, or written correspondence. Among the remaining 77% who experienced victimization in physical environments, further inquiries were made regarding the locations where these incidents occurred. The most frequently reported locations included the victim's residence and public areas. In most incidents, there was a sole offender. A minority of incidents were committed by offenders unknown to the respondents. As a result of the victimization incident, 60% of respondents reported experiencing anxiety and sadness, while 28% noted a decline in their physical health (Table 2).

Correlates of mental and physical health consequences of victimization

Table 3 and Table 4 present the results of the bivariate logistic regression models. The analysis did not identify any statistically significant difference based on gender, employment status, disability pension, and mode of victimization incident.

The following variables were found to be statistically significant in one or both models. Starting with age, in the physical health deterioration model, the analysis showed that people in the age groups 34–48 and 49 and over had statistically significantly higher odds than the reference group. In the anxiety and sadness model, the model p-valued showed no significant association with the outcome. Despite this, a closer look at the comparison between age groups reveals that participants aged 49 years and over had significantly lower odds of deteriorating health compared to the reference group.

In terms of perceived disability in certain areas, respondents with intellectual, psychological, and behavioral disorder disabilities had higher odds of both outcomes compared to the other respondents. Respondents with internal organ and skin disabilities had higher odds of physical health deterioration compared to other respondents. People with physical mobility disabilities had lower odds of anxiety and sadness.

Respondents without multiple disabilities had statistically significantly lower odds of experiencing physical health deterioration than people with multiple disabilities. Visibility of

Table 1. Characteristics of the sample

Variables	*N* (%)
Gender	
Female and other	167 (59%)
Male	128 (45%)
Age	
15–25	72 (25%)
26–33	67 (24%)
34–48	75 (26%)
49–65	50 (18%)
66–85	20 (7%)
Education	
Elementary and high school without diploma	53 (18%)
High school with diploma	121 (43%)
Post-secondary vocational school or university	110 (39%)
Employment status	
Employed, including part-time jobs	170 (60%)
Unemployed	114 (40%)
Regional residence	
Prague	81 (29%)
South Moravian	34 (12%)
Moravian-Silesian	31 (11%)
Central Bohemian	27 (10%)
Vysočina	9 (3%)
South Bohemian	16 (6%)
Ústí nad Labem	17 (6%)
Pardubice	13 (5%)
Hradec Králové	12 (4%)
Olomouc	12 (4%)
Liberec	10 (4%)
Plzeň	10 (4%)
Zlín	6 (2%)
Karlovy Vary	6 (2%)
Size of the municipality	
Up to 999 inhabitants	25 (9%)
1,000–4,999 inhabitants	35 (12%)
5,000–19,999 inhabitants	39 (14%)
20,000–49,999 inhabitants	30 (11%)
50,000–99,999 inhabitants	33 (12%)
Over 100,000 inhabitants	122 (43%)
Disability pension status	
Yes	190 (67%)
No	94 (33%)
Perceived disability in specific areas	
Physical mobility	145 (51%)
Intellect, psychological condition and behavioral disorders	91 (32%)
Hearing	60 (21%)
Vision	42 (15%)
Internal organs and skin	37 (13%)
Voice and speech	22 (8%)
Presence of multiple disabilities	
Yes	79 (28%)
No	205 (72%)
Visibility of disability at first glance	
Yes	115 (40%)
Not sure	54 (19%)
No	115 (40%)

Table 2. Most serious incident of bias victimization in the last five years

Variables	*N* (%)
Incident experience	
Yes	90 (32%)
No	194 (68%)
Mode of victimization	
Internet or telephone	21 (23%)
Physical environment	69 (77%)
Location (in physical environment)	
Home (excluding the residential social service)	22 (32%)
Public spaces (including means of transport)	21 (30%)
At school or workplace	12 (17%)
Shop or restaurant	9 (13%)
Other	5 (7.2%)
Number of offenders	
One offender	56 (62%)
Two or more offenders	30 (33%)
I don't know	4 (4%)
Familiarity of the sole offender	
I knew him well	24 (43%)
Sometimes we exchanged a few words here	7 (12%)
I knew him by sight	6 (11%)
I did not know him at all	19 (34%)
Most familiar offender in the group	
I knew him well	9 (30%)
Sometimes we exchanged a few words here	8 (27%)
I knew him by sight	4 (13%)
I did not know him at all	7 (23%)
Did not respond to the question	2 (7%)
Consequences of the victimization	
I was anxious or sad	53 (60%)
I was afraid	46 (52%)
I felt less confident in everyday life	45 (51%)
I felt inferior	44 (50%)
I was angry	41 (47%)
I became more withdrawn	36 (41%)
I started blaming myself	30 (34%)
I was ashamed	30 (34%)
I had trouble falling asleep or didn't sleep at all	28 (32%)
My physical health has deteriorated	25 (28%)
I was afraid to go to some places alone	24 (27%)
I suffered from anorexia or overeating	21 (24%)
It has negatively affected my sex life	16 (18%)
I started to self-harm	12 (14%)

disability showed some statistical significance in both models. Respondents who were unsure of the visibility of their disability and those who thought that their disability is not visible had higher odds of experiencing anxiety and sadness. In the physical health deterioration model, the model p-value showed no significant association with the outcome. Despite the non-significant model p-value, a closer look at the comparison between age groups showed that participants who were unsure of visibility had significantly higher odds of experiencing physical health deterioration compared to the reference group. Victimization by two or more offenders increased the odds of deterioration in physical health compared to victimization by one offender.

Table 3. Bivariate binary logistic regressions with the outcome of anxiety and sadness

Variable	*P*-value	OR	95% CI (Lower, Upper)
Gender			
Female and other (ref. male)	0.41	1.48	0.58, 3.77
Age			
Model *p*-value	0.21		
26–33 (ref. 15–25)	0.70	0.80	0.25, 2.51
34–48 (ref. 15–25)	0.35	0.56	0.16, 1.91
49 and more (ref. 15–25)	**0.047**	0.29	0.08, 0.96
Education			
Model *p*-value	**0.014**		
High school with diploma (ref. elementary and high school without diploma)	**0.033**	3.58	1.13, 11.9
Post-secondary vocational school or university (ref. elementary and high school without diploma)	0.89	0.93	0.30, 2.90
Employment status			
Unemployed (ref. employed, including part-time jobs	0.16	1.92	0.79, 4.89
Structurally disadvantaged region			
Yes (ref. no)	0.47	1,43	0.54, 3.98
Disability pension status			
No (ref. yes)	0.33	1.60	0.63, 4.24
Perceived disability in specific areas			
Physical mobility (ref. other disability types)	**<0.001**	0.17	0.07, 0.43
Intellect, psychological condition, and behavioral disorders (ref. other disability types)	**0.002**	4.45	1.73, 12.6
Hearing (ref. other disability types)	0.67	1.25	0.45, 3.72
Vision (ref. other disability types)	0.67	1.25	0.45, 3.72
Internal organs and skin (ref. other disability types)	0.11	0.40	0.12, 1.22
Voice and speech (ref. other disability types)	0.94	1.05	0.28, 4.39
Presence of multiple disabilities			
No combined disability (ref. yes)	0.88	0.93	0.38, 2.27

Table 3. ***(continued)***

Variable	*P*-value	OR	95% CI (Lower, Upper)
Visibility of disability at first glance			
Model *p*-value	**<0.001**		
Not sure (ref. yes)	**<0.001**	10.5	3.04, 43.8
No (ref. yes)	**0.003**	4.80	1.76, 14.0
Mode of victimization			
Internet or telephone (ref. physical environment)	0.49	0.71	0.26, 1.91
Number of offenders			
Two or more (ref. one)	0.48	1.39	0.57, 3.54
Familiarity of the offender			
Model *p*-value	**0.004**		
I knew him by sight (ref. I did not know him at all)	0.76	1.26	0.26, 5.64
Sometimes we exchanged a few words here (ref. I did not know him at all)	**0.008**	7.56	1.85, 40.0
I knew him well (ref. I did not know him at all)	**0.004**	5.04	1.71, 16.1

Table 4. Bivariate binary logistic regressions with the outcome of deteriorating physical health

Variable	*P*-value	OR	95% CI (Lower, Upper)
Gender			
Female and other (ref. male)	0.31	1.78	0.62, 5.94
Age			
Model *p*-value	**0.009**		
26–33 (ref. 15–25)	0.59	0.65	0.12, 2.99
34–48 (ref. 15–25)	**0.049**	3.84	1.03, 15.6
49 and more (ref. 15–25)	**0.021**	4.80	1.31, 19.6
Education			
Model *p*-value	0.27		
High school with diploma (ref. elementary and high school without diploma)	0.69	0.79	0.25, 2.59
Post-secondary vocational school or university (ref. elementary and high school without diploma)	0.14	0.38	0.10, 1.38
Employment status			
Unemployed (ref. employed, including part-time jobs)	0.13	2.08	0.80, 5.39
Disability pension status			
No (ref. yes)	0.44	0.66	0.22, 1.83
Structurally disadvantaged region			
Yes (ref. no)	0.18	0.46	0.12, 1.41
Perceived disability in specific areas			
Physical mobility (ref. other disability types)	0.71	1.19	0.47, 3.02
Intellect, psychological condition, and behavioral disorders (ref. other disability types)	**0.008**	3.63	1.41, 9.78
Hearing (ref. other disability types)	0.45	0.63	0.17, 2.00
Vision (ref. other disability types)	0.87	0.91	0.27, 2.74
Internal organs and skin (ref. other disability types)	**0.004**	5.53	1.75, 18.8
Voice and speech (ref. other disability types)	0.87	1.13	0.23, 4.47
Presence of multiple disabilities			
No combined disability (ref. yes)	**0.006**	0.26	0.09, 0.67
Visibility of disability at first glance			
Model *p*-value	0.073		
Not sure (ref. yes)	**0.027**	4.15	1.22, 15.8
No (ref. yes)	0.21	2.16	0.67, 7.75
Mode of victimization			
Internet or telephone (ref. physical environment)	0.93	1.05	0.33, 3.02
Number of offenders			
Two or more (ref. one)	**0.036**	2.80	1.07, 7.48
Familiarity of the offender			
Model *p*-value	**0.001**		
I knew him by sight (ref. I did not know him at all)	>0.99	–	–
Sometimes we exchanged a few words here (ref. I did not know him at all)	**0.044**	5.11	1.11, 28.7
I knew him well (ref. I did not know him at all)	**0.009**	6.39	1.78, 30.7

Discussion

The results suggest that victims of anti-disability bias violence suffer mental and physical health consequences unequally. This is consistent with the findings of studies focused on general violence (Dembo et al., 2018, 2021; Hayes and Powers, 2021). In our analysis, the factors that make some respondents more affected following bias victimization are as follows: First, age over 34, intellectual, psychological, and behavioral disorder disabilities and internal organs and skin disabilities, presence of multiple disabilities, lower visibility of disability, and victimization by two or more offenders increase the odds of physical health deterioration compared to reference categories. Second, higher education, intellectual, psychological, and behavioral disorder disabilities, and lower visibility of disability offender increase the chance of reporting anxiety and sadness compared to reference categories. Meanwhile, physical mobility disabilities decrease the odds of experiencing anxiety and sadness.

Comparing the results is difficult due to the lack of similarly focused studies. Based on studies examining non-bias victimization (Dembo et al., 2018; Hayes and Powers, 2021), we can state the following: Gender did not show a statistically significant relationship with outcomes in our study, which is in line with the results of other studies (Hayes and Powers, 2021) – no significant association on the overall injury among people with disabilities was ascertained (although they found a positive association between gender and the severity of the overall injury). Gender has been shown as significantly related to psychological distress in previous studies (Dembo et al., 2018; Hayes and Powers, 2021).

Regarding age, another study found a positive association between age, injuries, and mental distress (Hayes and Powers, 2021). This corresponds with our finding that age is related to deterioration in physical health (but not mental health). Older age may be associated with greater physical fragility and more difficult healing. Also, in line with another study (Hayes and Powers, 2021), we did not find a significant association with employment status. However, another study found that employed respondents reported less severe distress and anxiety than unemployed respondents (Dembo et al., 2018).

The relationship found between each of the two types of perceived disability (intellectual, psychological, and behavioral disorder disabilities; internal organs and skin disabilities) and increased vulnerability to physical health deterioration is partially compatible with Hayes and Powers (2021) conclusion that people with cognitive and physical disability suffer greater physical health consequences. In our study, people with intellectual, psychological, and behavioral disorder disabilities were also found to be at greater risk of anxiety and sadness as a result of the victimization. At the same time, people with physical mobility disabilities were found to be less at risk. Similarly, another study revealed that mental distress was more prominent in people with cognitive and physical disabilities, but less pronounced in deaf people (Hayes and Powers, 2021). According to the authors, worse consequences of victimization can stem from the dependence on care providers among people with cognitive or developmental disabilities. People with intellectual disabilities are generally more likely to be exposed to violence, and this frequency may also influence the worse physical and mental effects of victimization (Codina et al., 2022; Díaz-Faes et al., 2023; Walach and Petruželka, 2024).

Some studies have suggested that the presence of multiple disabilities and the visibility of disability at first glance can predict victimization experiences among people with disabilities (Bones, 2013; Snæfríðar-og Gunnarsdóttir et al., 2024). However, little is known about their relationship to health outcomes. While this study revealed that these factors are associated with worse health consequences, more research is needed to clarify these associations.

Offenders' characteristics, specifically multiple offenders, have also shown to be important (Hayes and Powers, 2021). Again, this is consistent with our results.

The present study revealed the differences between specific groups and that social workers should be educated in the specifics of both bias victimization and different groups of people with disabilities; including the ability to not confuse the effects of victimization with disability-related behaviors (cf. Klint et al., 2024). In addition, researchers should focus on understanding the barriers that may further exacerbate the challenges faced by those who are victimized (Hayes and Powers, 2021), and the role of protective factors against physical injuries and poor mental health – such as social support (Dembo et al., 2018).

The study has several limitations, mainly related to data construction. People with disabilities in Czechia represent a hard-to-survey population, and for various reasons we could only use non-representative sampling. This makes it impossible to generalize our findings to the whole population of people with disabilities. Our sample is relatively small, and it is also possible that we were unable to recruit respondents from all groups of people with disabilities. However, this is typical in this field of research. The size of the sample and relatively lower number of cases in individual categories of some variables leads to the wider confidence intervals. Therefore, it is important to interpret the results with caution. Furthermore, some groups may be underrepresented due to the use of the online questionnaire and its insufficient adaptation to the needs of certain groups; namely people with more profound intellectual disabilities, people primarily using Czech sign language, and people in residential institutions with more limited access to the Internet. Similarly, the lack of consideration of the intersectionality of bias victimization may be perceived as a limitation. We only asked about anti-disability bias, but people with disabilities may also be attacked for being part of another identity group (minority sexual orientation, non-white skin colour, etc.). Finally, the fact that the questionnaire did not include questions on possible factors at the household level or the wider socio-spatial environment may also be seen as a limitation.

Conclusion

Despite the above-described limitations, this study adds to the knowledge on the prevalence of anti-disability bias victimization among people with disabilities and its health consequences. At the same time, the study contributes to the identification of factors of differential experiences of the physical and mental health impacts of bias victimization. The results of the study demonstrate that there are significant differences in this regard, which can be used to identify groups of persons with disabilities who are more affected by the consequences of victimization than others. Immediate responses to harm, as well as prevention programs, should recognize this diversity of experience and tailor interventions to the specific needs of each group.

Certainly, more research is needed, especially in the East-Central European context, where various forms of vic-

timization of people with disabilities and their consequences is a marginal topic. Factors that were not found to be significant in this study should also be further investigated using representative samples. For example, living in a structurally deprived region – such as that of Moravian-Silesian – may exacerbate the harm caused by a lack of resources.

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Ethical aspects and conflict of interest
The authors have no conflict of interest to declare.

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