



OREGON

Project Ability:

*Demystifying Disability in
Child Abuse Interviewing*



***Project Ability* was funded by Oregon's Children's Justice Act (CJA) Task Force.
The curriculum and training were developed by CARES Northwest.**

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CHAPTER 5: INTELLECTUAL DISABILITIES: THINKING AND REASONING

The National Dissemination Center for Children with Disabilities (NICHCY)

Down Syndrome Fact Sheet

www.nichcy.org/pubs/factshe/fs4txt.htm

ADHD “101”

www.nichcy.org/enews/foundations/ADHD101.asp

Mental Retardation Fact Sheet

www.nichcy.org/pubs/factshe/fs8txt.htm

The National Association for Down Syndrome

Down Syndrome Fact Sheet

www.nads.org/pages_new/facts.html

CHAPTER 6: SOCIAL AND EMOTIONAL DISABILITIES: SOCIALIZING, FEELING AND BEHAVING

National Dissemination Center for Children with Disabilities (NICHCY)

Emotional Disturbance Fact Sheet

www.nichcy.org/pubs/factshe/fs5txt.htm

CHAPTER 7: PHYSICAL DISABILITIES: HEARING, VISION, MOVEMENT, AND HEALTH

National Dissemination Center for Children with Disabilities (NICHCY)

ADHD Fact Sheet

www.Nichcy.org/pubs/factshe/fs19txt.htm

Centers for Disease Control and Prevention

National Center on Birth Defects and Developmental Disabilities

Cerebral Palsy Fact Sheet

www.cdc.gov/ncbddd/dd/documents/CerebralPalsyFactSheet.pdf

Hearing Loss

www.cdc.gov/ncbddd/dd/ddhi.htm

Vision Impairment

www.cdc.gov/ncbddd/dd/ddvi.htm

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LEAD AUTHOR

Kathleen Shelton, PNP, PhD, *Training Director,
LEND Project and CDRC Clinical Research Coordinator*

CO-AUTHORS

Holly Bridenbaugh, MSW, *CARES Northwest*
Marieka Farrenkopf, EdM, LCSW, *CARES Northwest*
Kathryn Kroeger, LCSW, *CARES Northwest*

PROJECT LEAD

Holly Bridenbaugh, LCSW, *CARES Northwest*

PROJECT COORDINATOR

Shelley O'Brian, *CARES Northwest*

**We are grateful for the time and expertise contributed by the following members of the
Project Ability: Demystifying Disability in Child Abuse Interviewing Advisory Committees.**

PROJECT ADVISORY GROUP

Shary Mason, *Community Outreach and Training Manager, Citizen Review Board,
Oregon Judicial Department*
Heather Mowry, *Grants Coordinator, Family Based Services,
Oregon Department of Human Services (DHS)*
Margaret Semple, *Deputy Director, Office of Investigations and Trainings,
Oregon Department of Human Services (DHS)*

LEGAL GROUP

Megan Johnson, *Deputy District Attorney, Washington County District Attorney's Office*
Jenni Jordan, *Deputy District Attorney, Columbia County District Attorney's Office*
Suzanne Isham, *Captain, Regional/Advanced Training Supervisor,
Department of Public Safety & Standards Training*
Stacy Liskey, *CAMI Program Coordinator, Crime Victim's Assistance Section,
Department of Justice*

CONTENT GROUP

Kirsten Brown, *Consultant, Oregon Department of Human Services (DHS)*
Kendra Farris, MD, *Developmental Pediatrician, Legacy Emanuel Hospital,
Department of Pediatric Development and Rehabilitation*
Sandra Leavitt, *Director, Mt. Emily Safe Center*
DeAnn Major, *Rights Advocate, Disability Rights Oregon (formerly Oregon Advocacy Center)*
Sue Skinner, MD, *Examiner and Regional Training & Consultation Center Trainer,
CARES Northwest*

INTRODUCTION

STATEMENT OF PURPOSE

Project Ability: Demystifying Disability in Child Abuse Interviewing provides a training curriculum for professionals throughout the State of Oregon who work with children with disabilities. The Oregon Children's Justice Act (CJA) Task Force commissioned the development of this work and specified a focus on strategies for interviewing children with disabilities about child abuse.

Professionals working in the fields of child welfare, law enforcement, emergency response, medicine, and mental health are well trained in their individual disciplines but often lack confidence in working with children with disabilities. Disabilities are numerous and complex. We have set out to demystify disabilities by identifying common problems that occur regardless of the root cause or diagnosis and by presenting a simple but systematic rubric or way of thinking to help professionals engage successfully with children with disabilities. In particular, we hope that by providing suggestions and strategies for interviewing children with disabilities about child abuse, we will be contributing to the future safety and protection of all children in Oregon.

COURSE OBJECTIVES AND COMPETENCIES

At the end of this training, participants will be able to

1. Define the term "disability"
2. Use the "Demystifying Disability" Rubric
3. Discuss characteristics and accommodations for interviewing a child who has difficulties with
 - a. Communication
 - b. Intelligence
 - c. Behavior
 - d. Physical functioning

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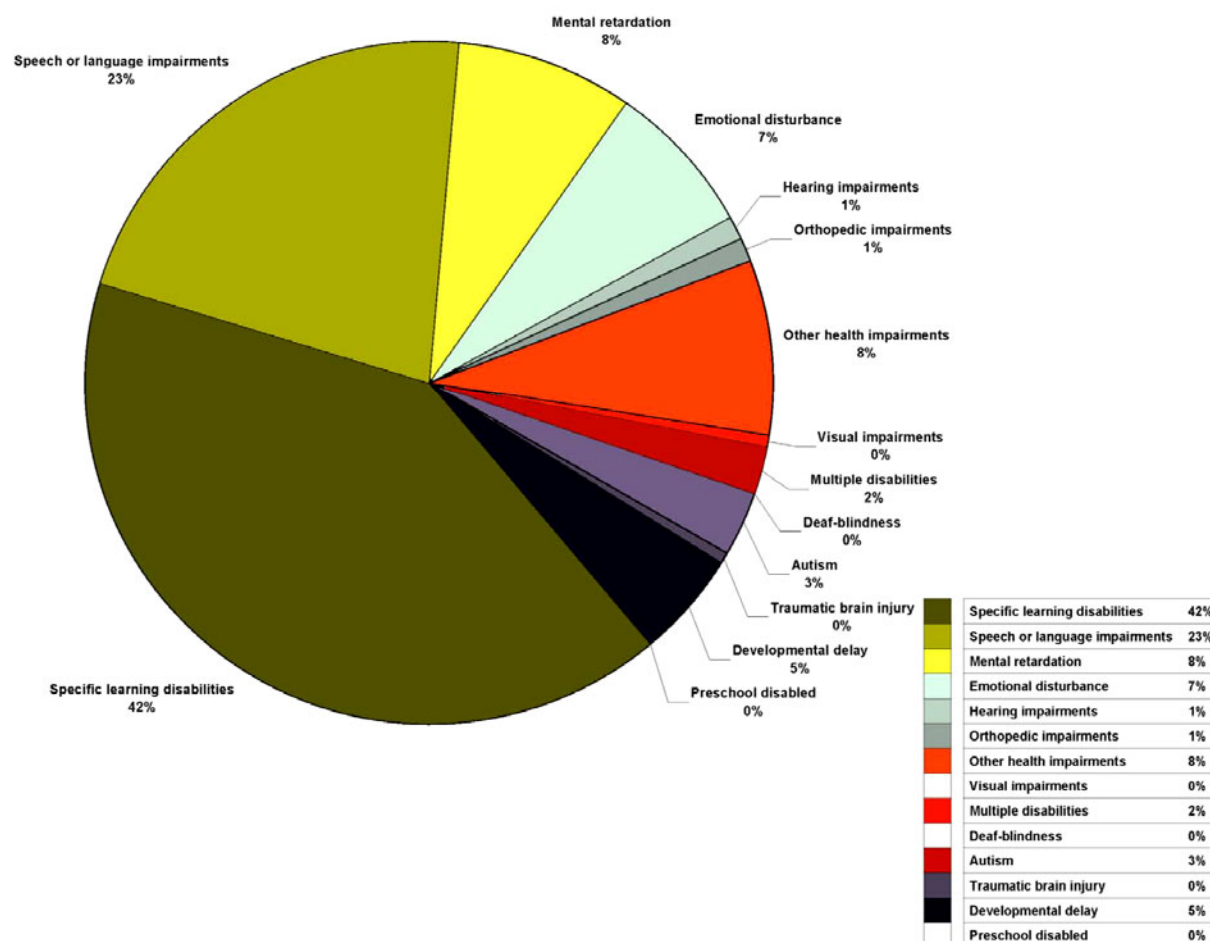
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DISABILITY STATISTICS

In 2006, 13.8 percent of all children enrolled in school had a disability. Of that group, 42 percent had a specific learning disability, 23 percent had speech or language impairments, 8 percent had mental retardation, and 1 percent had an emotional disturbance (National Center of Education Statistics, US Department of Education, 2006). Baladarian (1999) reported that of all sexually abused children, 15.2 percent had disabilities. Sullivan (2001) notes that children with disabilities are abused at almost four times the rate of peers without disabilities. Considering the range of abuse all children experience (physical, sexual, neglect, emotional, threat of harm), considering under-reporting of abuse in general, and considering the heightened vulnerability of children with disabilities, we must acknowledge these statistics and take appropriate action.

Distribution of Disabilities in Children Receiving Special Education



See **Appendix 6** for full-page version of pie chart above

This curriculum has been developed to help professionals working in the field of child welfare and child abuse to increase their knowledge about children with disabilities and to become confident in interviewing them. In this chapter, we provide basic information about definitions, laws, models of disability, and the increased vulnerability of children with disabilities to become victims of abuse.

DEFINITION OF DISABILITIES

When reading about disabilities, you may see the medical words diagnosis, disease, disorder, and disability used. For our purposes, we will dispense with the semantics and accept that each of these words mean there is some impairment or dysfunction of a body part, body system, or body function. Disability is the word that describes the condition of living with impairment or limited ability to do what a person without disabilities can do.

Definitions about disabilities come from a variety of sources, each with a specific purpose and population.

- The International Classification of Disease (ICD-10) is the sourcebook for medical diagnoses.
- The Diagnostic and Statistical Manual (DSM-IV TR) contains mental health diagnoses.
- The Individuals with Disabilities Education Act (IDEA, 2004) lists categories of disabilities that qualify a child for special education services.
- National Medical Committees such as the American Academy of Pediatrics
- Other federal laws and agencies

The names may vary slightly but usually can be used interchangeably. For example, IDEA uses the term “autism”. The DSM-IV TR uses the term “autistic disorder”, and the term “autism spectrum disorders” is an umbrella term that includes autism or Autistic Disorder, and variations such as Asperger’s Disorder, Rett’s Disorder, and Pervasive Developmental Disorder Not Otherwise Specified (PDD NOS). You will notice in future chapters that IDEA categories are used primarily but we have included a few specific medical and mental health diagnoses when indicated. Most of the disabilities experienced by children also qualify as developmental disabilities when there is failure to progress through the ages and stages of childhood.

Developmental disabilities

Children grow and develop into adults according to a predictable schedule. They meet developmental milestones as they learn new skills and move through the ages and stages of childhood. Sometimes things go awry, and children develop atypically. The process might be delayed or the milestones may not be met at all.

The Centers for Disease Control (www.cdc.gov/ncbddd) has defined developmental disabilities as follows:

- A group of severe chronic conditions that are due to mental and/or physical impairments that become apparent as a child grows
- Are usually detected when a child falls away from the trajectory of normal development
- Begin anytime during development up to 22 years of age
- Usually last throughout a person's lifetime
- Cause problems with major life activities such as language, mobility, learning, self-help, and independent living

DEFINITION OF DISABILITY FOR THIS TRAINING

There are many childhood disabilities with multiple causes and presentations. Professionals interviewing children about possible abuse need to know how to interview children with disabilities, but it is unrealistic to expect them to develop expertise in the many disabilities themselves. No matter what the label of the impairment or the cause or prognosis, disabilities can interfere with a child's ability in four basic areas: communication, intelligence, behavior, and physical functioning—sight, hearing, movement, and maintaining health.

For the purposes of this curriculum on *Project Ability: Demystifying Disability in Child Abuse Interviewing*, we define disability as a medical, educational, or psychological condition that interferes with a child's ability to

- Speak, understand, and use language
- Think and reason
- Behave appropriately, socially, and emotionally, in most settings
- See, hear, move, and health

This definition is broad and includes developmental disabilities, categories listed in the Individuals with Disabilities Education Act (IDEA), and many of the medical and mental health conditions that affect children.

We have organized a large amount of information about disabilities into a simple Demystifying Disability Rubric, i.e., a set of questions to help you think about what the disability's impact is and how to make appropriate accommodations. This Rubric can be used whenever you encounter a child with a disability. You do not need to be an expert in the disability. You do not need all of the child's medical history to understand his or her condition. By asking yourself five questions prior to interviewing a child with a disability, you can quickly organize what you know and what you need to know before proceeding to an interview.

The Demystifying Disability Rubric

- Does this child have a disability or difficulty with
 - Speaking, understanding, and using language?
 - Thinking and reasoning?
 - Socializing, feeling, and behaving?
 - Hearing, vision, movement and health?
- How does the disability affect *this* child?
- What strengths or abilities does the child have?
- What else do I need to know about the disability and the child?
 - Are there medical or educational records available for review?
 - Who might be available for a general consultation on this disability?
- How can I structure the setting and the questions for a successful interview?

In the following chapters, we will provide information about disabilities that contribute to each of the problem areas caused by disabilities, along with strategies for accommodating the child's disability. There will be case examples and group exercises to provide practice using the Rubric.

DISABILITY AND HEALTH

Ability versus disability

The International Classification of Function (ICF) is the World Health Organization's framework for measuring health and disability at both individual and population levels (www.who.int/classifications/icf/en). The ICF puts the notions of health and disability in a new light, acknowledges that every human being can experience a decrease in health and thereby experience some degree of disability. The ICF thus mainstreams the experience of disability and recognizes it as a universal human experience. By shifting the focus from cause to impact, the ICF places all health conditions on an equal footing. Furthermore, ICF takes into account the social aspects of disability and does not see disability only as medical or biological dysfunction. This project is named *Project Ability* to acknowledge the importance of recognizing that each child has abilities beyond his or her disability.

We will include several case examples demonstrating the importance of recognizing what abilities children have in addition to their disabilities. By identifying strengths and abilities in each child, you show respect for and interest in the child, thus opening up possibilities for a successful interview.

CULTURE AND MODELS OF DISABILITY

Definitions alone may not fully explain the context surrounding disabilities. Cultures have very different views of disability, its causes, its meaning, and how people with disabilities should be treated. When learning about a culture, it is also important to learn how disability is viewed. There are many ways to think about disabilities. In fact, there are four models of disability that define disability very differently within a social context: the medical model, the rehabilitation model, the moral model, and the social model. Cultural perspectives are embedded in these models. Often, elements of all four models can be identified in encounters with children and adults with disabilities.

- The **medical model** is a deficit model, focusing on what is wrong or what a person cannot do, and assumes that the deficit must be treated by medical interventions. In this model, disabilities arise from congenital conditions, developmental delays, illnesses, or injuries that lead to a medical diagnosis.
- The **rehabilitation model** is related to the medical model in that it focuses on the deficiencies to be addressed by therapeutic professionals such as physical therapists, occupational therapists, speech therapists, and audiologists.
- The **social model** assumes that disability is a normal aspect of life, not a defect or deviation from normal. In fact, the social model suggests that some disability is created when buildings are not accessible, or accommodations for low vision and hearing are not available, or when personal prejudices against people with disabilities exclude them solely because of the disabling condition.
- The **moral model** is historically the oldest model and is less prevalent today. However, there are still cultures that associate disability with sin, shame, and feelings of guilt, even if such feelings are not overtly based in religious doctrine. For the individual with a disability and his or family, this model can be particularly harmful.

Culture plays an important role in how professionals and families perceive disability. While it is not possible to address specific cultural accommodations in this training, it is important for professionals to recognize that one or more of these models may be influencing a conversation or interview. For example, when a family feels shame has been cast upon them because a member has a disability, family members may appear evasive or act guilty. Families may have hidden away the disabled family member, keeping him or her out of school and excluded from any chance at having a meaningful role in society. Even in less extreme circumstances, the moral model has resulted in general social ostracism or self-hatred. It is important for medical and social service professionals to know when family and community members hold this view of disability to better understand their statements and behaviors.

DISABILITY LAWS

Disability laws aim to provide children and adults with disabilities legal protections against discrimination based on a disability and to offer services beyond what non-disabled citizens require. The need for protection from discrimination may stem from the moral model of disability or simply from ignorance and misunderstanding. These laws provide the incentive and mandate for professionals to learn how to interview children with disabilities about abuse. Three federal laws are often cited when providing services and protections to children with disabilities: the Americans with Disabilities Act, the Rehabilitation Act, and the Individuals with Disabilities Education Act.

- The **Americans with Disabilities Act (ADA)** prohibits discrimination against individuals with disabilities in employment, housing, education, and access to public services. The ADA defines a disability as any of the following: (1) “a physical or mental impairment that substantially limits one or more of the major life activities of the individual”; (2) “a record of such impairment”; or (3) “being regarded as having such an impairment” (www.ada.gov).
- The **Rehabilitation Act, Section 504** requires schools to provide accommodations to children with disabilities who do not qualify under the Individuals with Disabilities Education Act (IDEA). The children who qualify under Section 504 have a documented disability and need accommodations to succeed, but their actual achievement and potential for achievement are not more than two standard deviations apart (www.ada.gov/cguide.htm#anchor65610).
- The **Individuals with Disabilities Education Act (IDEA)** requires public schools to make available to all eligible children with disabilities a free appropriate public education in the least restrictive environment, according to their needs. This is the law that established regulations for early intervention programs for infants and toddlers (birth to two years) and special education and related services for children aged three to 21. IDEA requires school districts to provide special education services for children who fall within one or more of the categories of disability identified in the act, and provides funding to assist with the additional costs of educating a child with a disabling condition. To find out if a child is eligible for services, a full individual initial evaluation of the child must first be conducted. This evaluation is free to the family. IDEA was first passed in 1975 and was recently reauthorized in 2004 (www.nichcy.org/idea.htm).

DISABILITIES INCREASE VULNERABILITY FOR CHILD ABUSE

Children and adults with disabilities are at higher risk for abuse and neglect. Of all types of disabilities, children with **emotional and behavioral disorders** showed the highest rate of abuse and neglect (Benedict, 1992). This may be, in part, because parents and communities have higher expectations for these children with “hidden” disabilities, whereas children with more

noticeable disabilities (physical, communication, intellectual) do not have such expectations placed upon them. As a result, parents and communities may become quickly frustrated with children who have emotional and behavioral disorders, increasing the risk for abuse.

Other factors that increase vulnerability children with disabilities include:

- The child is taught to follow the rules.
- The child is taught obedience/compliance.
- Impaired communication may limit a child's ability to disclose abuse.
- Many children have an absence of privacy (residential care) or are isolated (home care).
- The child has not received education on sexuality.
- The child has had a lack of education on self-protection.
- Some forms of therapy can be painful (injections, physical therapy), and the child may not be able to differentiate appropriate pain from inappropriate pain.
- The child may be accustomed to having his body touched by adults on a regular basis for dressing and hygiene due to increased number of caregivers.

Regarding absence of privacy and/or isolation, these can also be seen as types of segregation, further increasing a child's vulnerability. Sobsey (1994) adds that segregating children with disabilities tends to increase the perception of differences and suggests that “. . . group membership and social distance influence our attitudes about the acceptability of violence. Attitudes about individuals or groups that tend to depersonalize, dehumanize, or distance them appear to make violence against them more acceptable.” While seeing people with disabilities as subhuman, there can be an attitude of “Who would want to have sex with X?” This perception confuses sexuality with sexual assault, and leads to increased vulnerability (Baladarian, 1999).

Caregiver stressors

In all cases of abuse, (physical, sexual, neglect, emotional abuse) the most frequent abuser is the primary caregiver. The impact on caregivers can be stressful, especially for families of children who need more care. The degree of stress the parents feel may be influenced by psychosocial stressors, such as parental depression, financial stress, marital stress, employment stress, or housing problems (Orr, 1989).

Some of the stress points for caregivers of children with disabilities include:

- Lack of information and education on the disability resulting in unrealistic expectations
- Lack of respite care
- Daily care: bathing, dressing, eating, transporting, and providing medical care
- Behavioral management: coping with challenging behaviors such as temper tantrums, aggressiveness, and noncompliance
- Feelings of guilt over the child's disability

On the positive side, children with high numbers of caregivers may be at a lower rather than higher risk for abuse because there are many people looking at, caring for, and teaching them. Therefore, the likelihood of abuse being recognized may be higher.

Jamie Hoffman-Rosenfeld, MD, of the Child Protection Center at the Children's Hospital at Montefiore Medical Center in New York, also notes that children with disabilities may have "conditioned compliance" and are "rewarded with passivity." This makes them especially vulnerable to abuse because they want to please others and be accepted, and are easily influenced by others. This passivity can pose an even higher risk when coupled with impaired communication, as the child may not have the language to express sexuality, abuse, or other concerns. In this scenario, changes in behavior could be the indicator that a child has been mistreated, rather than the child using words to disclose the abuse (2004).

Statistics on disability and abuse

According to Sullivan and Knutson (2000) on the maltreatment of children with disabilities from the Washington, D.C. National Center on Child Abuse and Neglect, Department of Health and Human Services, children with disabilities are

- 1.7 times more likely to be abused
- 1.6 times more likely to be neglected
- 1.8 times more likely to be sexually abused
- 2.1 times more likely to be physically abused
- 2.8 times more likely to be emotionally abused

CASCADE OF INJUSTICES

In summary, children with disabilities are at higher risk for maltreatment. We are indebted to Mary Steinberg, MD, and Judith Hylton, M.Ed. (1998) for characterizing further increased risk for the aftermath of abuse as a "Cascade of Injustices." The risk extends to events that are associated with abuse for these children:

- Not having the abuse recognized as wrong
- Not being able to disclose the abuse
- Not having a disclosure understood or believed
- Not having the abuse reported
- Not having the reports investigated
- Not having investigations lead to trial
- Not being recognized by the courts as a competent witness
- Not receiving therapy for the effects of abuse
- Not having the therapy appropriate to their needs

Cascade of Injustices

People with disabilities are at greater risk for:



Abuse and neglect

Not recognizing abuse and neglect as wrong

Not having a disclosure understood or believed

Not having reports of abuse investigated

Not having investigations lead to trial

Not receiving therapy for the effects of the maltreatment

Not having the therapy appropriate to their needs

Disability itself places children at increased risk for maltreatment of all types. Disabilities also appear to place children at increased risk for a whole cascade of injustices related to the maltreatment.

Adapted from Steinberg & Hylton, 1997. Responding to Child Maltreatment.

CHAPTER 2: BASIC INTERVIEWING

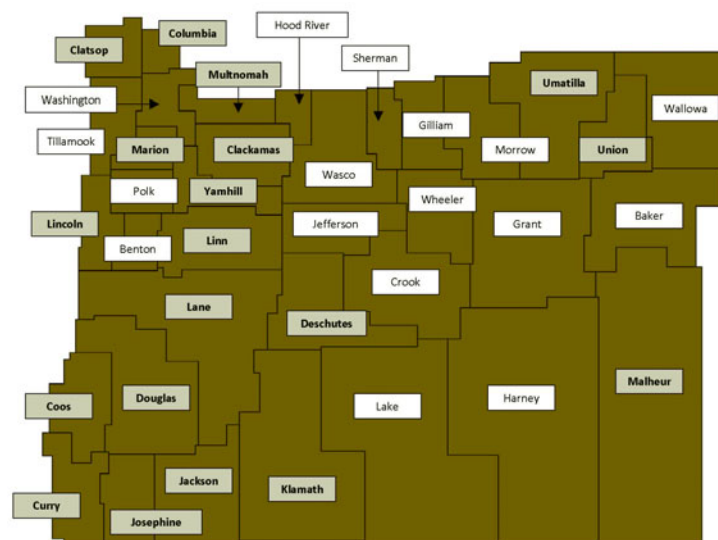
This training curriculum is about interviewing children with disabilities regarding abuse. The *Oregon Interviewing Guidelines* (OIG) apply to all children, including those with disabilities. In later chapters, we will discuss how various disabilities may affect a child's ability to report abusive events. Each chapter on disabilities will offer suggestions for accommodations that interviewers can make to address the specific needs of each child. Here we discuss, in brief, the basics of child interviewing and general accommodation strategies for children with disabilities. Keep in mind that many children with disabilities can be interviewed with no accommodations to the guidelines.

THE OREGON INTERVIEWING GUIDELINES

In a statewide effort to promote consistency in the quality of care provided to Oregon children who are interviewed for possible abuse, the OIG was written in 1998 and updated in 2004. These guidelines were written in collaboration with the Oregon Department of Human Services, child interviewers, pediatricians, law enforcement personnel, and mental health professionals, paired with a thorough literature review and a legal consultant.

The guidelines cover a myriad of topics including single vs. multiple interviews, neutral approaches, gathering history, posing developmentally appropriate questions, child development, anatomically detailed dolls, memory and suggestibility, false reports, and interviewing children with special needs, among other topics. Training on the OIG is offered several times a year in various locations throughout the state through Oregon's Regional Training and Consultation Centers (RTCCs).

More than 18 child abuse centers (located in counties whose names are shaded on the map below) have been established throughout Oregon with the goal of minimizing the number of interviews a child experiences and allowing full evaluations to occur at the local level, thus eliminating the need for children to travel outside their communities after making the initial disclosure.



First responders such as paramedics, child protective services workers, and law enforcement officers are trained to gather “minimal facts” at the scene and to determine whether or not a child will be referred to a center for a more in-depth forensic interview. With attention to safety and the best interest of the child, first responders must use their professional judgment in determining how much to ask during a field interview. In some cases, a minimal facts interview will be sufficient in creating a safety plan, and the child can be referred to the center; in other cases, the first responder may need to conduct a more thorough interview in order to determine whether the child is safe. In the latter case, professionals who conduct field interviews should be adequately trained in OIG use.

Minimal facts interviewers aim to obtain the following information from children:

- What happened, including whether force and/or coercion were used
- Who did it and his or her age
- Where (jurisdiction)
- When (first and last time)
- Other victims or witnesses
- Necessity for urgent medical attention

Criteria for taking a child to interview

For both field-based and center-based interviewers, recognizing whether or not a child can participate in an interview is essential. In general, if a child is younger than six years old (or acts developmentally younger) and has already made a disclosure to a responsible adult, a field interview is not necessary and the child can be referred directly to a center. If the child is older than six and has made a vague disclosure, further questioning in the field may be necessary to determine the nature of the concern.

In either case, and also for children with disabilities, *do not* proceed with an interview if

- Child appears too emotionally fragile to proceed with a structured interview.
- Child does not have adequate language development.
- Child is too emotionally distractible to attend to a structured interview.
- Appropriate communication assistance, e.g., language interpreter, is not available to the interviewer.

Prior to the interview

In preparing for the interview, it is important to gather history regarding information about prior interviews or conversations about the abuse, child’s developmental stage and abilities, potential sources of contamination.

When the family is from another culture, e.g., deaf or non-English speaking cultures, the family may require extra reassurance regarding the interview process and its potential impact on the

child and family. As well, the interviewer should approach the family with cultural sensitivity and assure that he or she will be sensitive to the child's needs.

History about a child with disabilities is extremely important and will pave the way to a better interview and an outcome of obtaining more accurate information. Spend extra time gathering history about the child with the parent or guardian who often best knows the child's difficulties and abilities. Pertinent information to be obtained includes how the child is impacted by the disability, when the disability first became apparent, what services or interventions the child has received, and details about how the child communicates. Also important to ask is whether any conversations about the abuse concerns have taken place in the child's presence. For example, first responders and others in the child's environment may engage in conversations without realizing that the child understands the content of the discussion, which may be a source of contamination (OIG, 2004). With background information on *this* child, the interviewer will be able to modify the criteria for not only the interview format, but also the type of questions asked and the manner of communication.

Establishing rapport during the interview

Even in a brief field interview, establishing rapport with all children is essential in creating a sense of familiarity and to screen for developmental levels (see below). Simple conversation, such as introducing yourself and explaining your role and asking the child to do the same, can help alleviate a child's stress. Sit at the same level as the child or crouch down to his level. Be genuine. Smile if it is appropriate, especially with younger children. By establishing rapport, you will not only achieve the goal of reducing the child's stress level, but you will also gather information on the child's comprehension of your questions and whether additional adaptations are needed.

Examples of neutral rapport-building questions are

- Where do you live? Who do you live with? Tell me about them.
- Do you have siblings? Pets?
- Tell me about your house/apartment.
- Do you have a favorite book/TV show? Tell me about it.
- What are some things you like to do?

During this conversation, you want to determine if the child had difficulty with any questions you asked. Is there a pattern with the child's responses? If so, adapt your interview to best meet the child's needs. In future chapters we will address specific accommodations for children with disabilities.

Basic developmental screening exercises

In order to determine whether or not a child is developmentally able to attend to a structured interview, whether or not the child has a disability, the interviewer can employ several basic

developmental screening exercises. Even if the child is not able to engage in these activities, it will guide the interviewer on what types of questions to ask and how accurate the child may be in answering those questions.

After the interviewer has introduced him or herself and established basic rapport, the interviewer can have the child

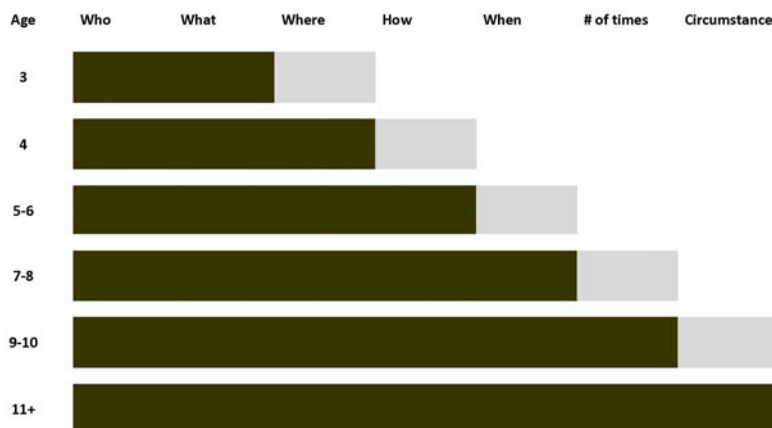
- Spell/write his or her name
- Sing the ABCs
- Give his or her birth date and/or recall details from last birthday
- Name colors
- Distinguish between first and last
- Name prepositions (on, under, behind, in, over, on top of)

These exercises will differ depending on whether or not the child has a disability. Children with intellectual disorders, for example, may not be able to engage in some or all of the above-mentioned exercises.

Age-appropriate interview questions

A child's developmental level is the most important factor in determining what questions to ask, how much to ask, and how much information the child will be able to relay. Think about how you talk to an adult; now think about how you talk to a six year old, or a 16 year old. Your style with each of these age groups will be very different, not only with your grammar and inflection, but also with your vocabulary and manner. The same is true for interviewing children with disabilities; tailor your approach to the child's age and developmental stage. For example, some older school age or teenage children with intellectual disabilities possess skills levels equivalent to a child age seven or older and, thus, can have most of the requisite cognitive skills needed for an interview. Consider the following graph as a guide:

Guidelines for Age-Appropriate Interview Questions



Each child's capacity will vary depending on his or her unique circumstances and developmental level

Contamination

As interviewers, it is our job to cue children's memories without tainting the memories or adversely impacting the way they are reported. **Contamination** is the potential for a child's memory of a life event to be impacted by things other than the actual event. In order to avoid contaminating a child's memory or his statements of an event, interviewers can take a neutral yet friendly approach to children, and pay attention to other potentially contaminating factors that might influence a case.

Potential sources of contamination in the home:

- Child is repeatedly questioned by a parent or other family member.
- Child overhears others talking about the concerns.
- Child is exposed to pornography or sexual activity.
- After making a disclosure of abuse, child sees family members upset.
- Child or other family members are removed from the home.
- Child has continued contact with the alleged offender or a nonsupportive caregiver prior to an evaluation or forensic interview.

Potential sources of contamination during a field interview:

- Child is interviewed in front of a parent or other family member.
- Child is interviewed with another potential victim present.
- Child is interviewed with a suspect present.
- Child is interviewed in the room where the abuse occurred.
- Interviewer uses leading questions or coercion.
- Interviewer is not neutral or has a bias.
- Interviewer repeats questions after a child has already answered.
- Child undergoes multiple interviews.

INTERVIEWING CHILDREN WITH DISABILITIES

It is not possible to create an exact recipe for interviewing children with disabilities about child abuse. What follows, however, is an extrapolation of how interviewing guidelines for typically developing children can be modified when interviewing children with disabilities. Many times a child with a disability will be described as functioning at a younger age. However, there may be unevenness across developmental domains. For example, a child may exhibit good self-care, social skills, and vocabulary, but may lack age-appropriate abilities to reason and abstract. Even without details of the disability, the interviewer can revise the interviewing protocol by using guidelines for younger typically developing children. While the interviewer's language might be simplified, often children can understand more than they can verbalize. The interviewer should treat children in an age-appropriate manner and not be condescending (OIG, 2004).

General guidelines for interviewing typically developing children about abuse also apply for interviewing children with disabilities:

- Use short sentences with only one idea per sentence.
- Ask yes/no questions as a last resort.
- Avoid using double negatives.
- Avoid asking “why” or “if”; instead, ask concrete questions such as who, what, where, how.
- Clarify terms the child uses.
- Use the child’s words for body parts.
- Allow the child to express feelings, or to express no emotions at all.
- Allow for long silences.
- Interview in a comfortable room with minimal distractions.
- Avoid infantilizing the child, e.g., “baby talk.”

There is no perfect interview, nor is there only one way to conduct an interview. With training and experience, an interviewer can increase his or her comfort level and skill set in working with children with disabilities, and this will enhance the quality of information yielded during the interview.

Interviewing children with disabilities often takes more time. However, a general guideline for the length of the initial interview is one hour. Decide thoughtfully about whether to lengthen the time of the interview or schedule a second interview. Multiple interviews may yield more information, as the child and interviewer become familiar with each other’s particular communication style (Baladarian, 1992).

If you do write a report summarizing the interview, it is critical to document any information you have about the child’s disability. You also want to document the child’s presentation, as well as any accommodations you made for the child during the interview.

In the following chapters, we will discuss a variety of childhood disabilities and how child interviewers can modify the interview to accommodate the child’s abilities and disabilities.

The basis of understanding disabling conditions in children is rooted in typical child development. By learning “what went wrong” during typical development, it is easier to be able to see what did not go wrong—that is, see what children with disabilities *can* do—and to combine those strengths with adaptations and accommodations we can incorporate into our work to still serve these children well. This chapter reviews typical child development with a goal of demystifying labels and stereotypes that have developed around disabling conditions.

TYPICAL CHILD DEVELOPMENT

Almost everyone has some formal and/or informal knowledge about children. Even when we cannot discuss child development in a systematic way, we “know” about child development informally because we grew up with siblings, went to school with all kinds of children, and observed how children share similarities and differences. Now as adults, maybe even watching the predictability of child development in our offspring, we see the developmental process unfold from a “front row seat” as it were.

From each of these perspectives, we are aware that all children start small and grow larger, know very little at first and learn many things very rapidly, and are often ahead or behind another child the same age in one way or another. So the *process* of child development is sequential and predictable. The *speed* through which the process unfolds varies from child to child, but the general *sequence* through which children pass is similar. When the process and speed of development varies little, we call that “typical development,” which may be referred to as ages and stages of child development.

Child development is a formal academic discipline with applications in many professions such as education, medicine, recreation, social services, law enforcement, and the legal/judicial systems. There are three basic principles of child development. It proceeds from

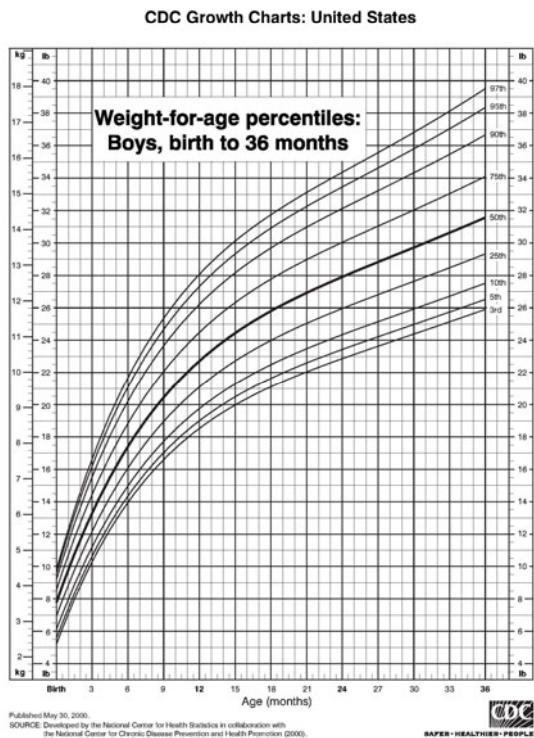
- Head to toe
- Midline to extremity
- Simple to complex

Domains of Child Development

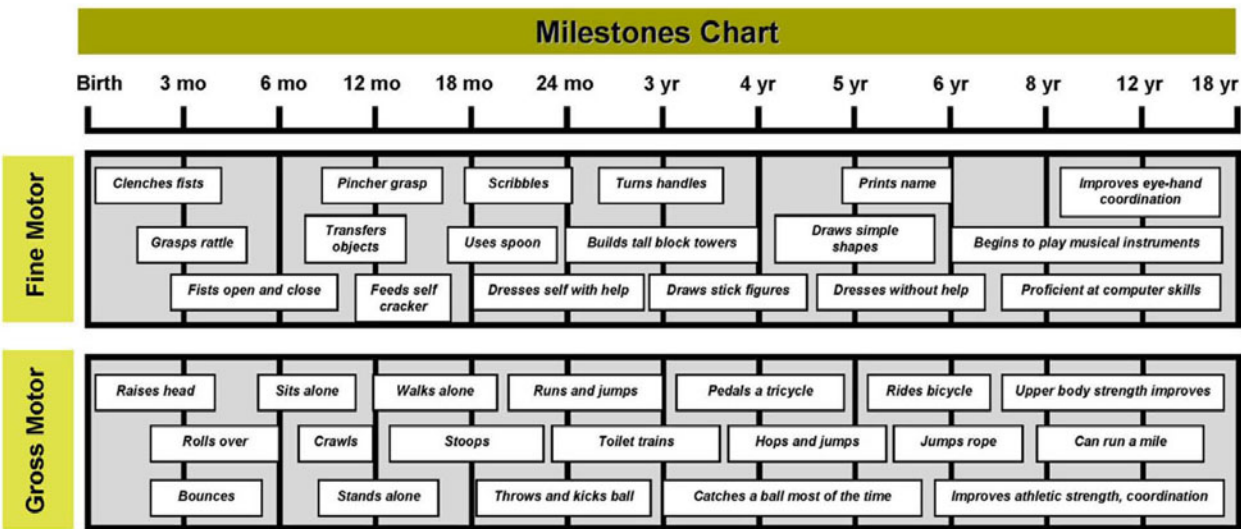
Child development is usually described in terms of **domains**, e.g., physical development, cognitive development, and by ages and stages, i.e., the predictable process of growing from infancy to adulthood. We will emphasize the domains, which will aid our understanding of the most common types of developmental problems. Whenever we talk about variation or deviation, we refer implicitly or explicitly to some standard or central tendency. When talking about a child’s ability and disability, we use the process of typical child development as such a standard.

CHAPTER 3: IDENTIFYING ABILITY AND DEMYSTIFYING DISABILITY:
CHILD DEVELOPMENT, ASSESSMENT, AND DEVELOPMENTAL DISABILITIES

Physical development includes increases in height, weight, and head circumference along a predictable trajectory called a growth chart. Physical development is dependent on adequate nutrition and calories; vitamins, minerals, and hydration; and genetic coding; it is also influenced by health and illness, acquired infection and injury.

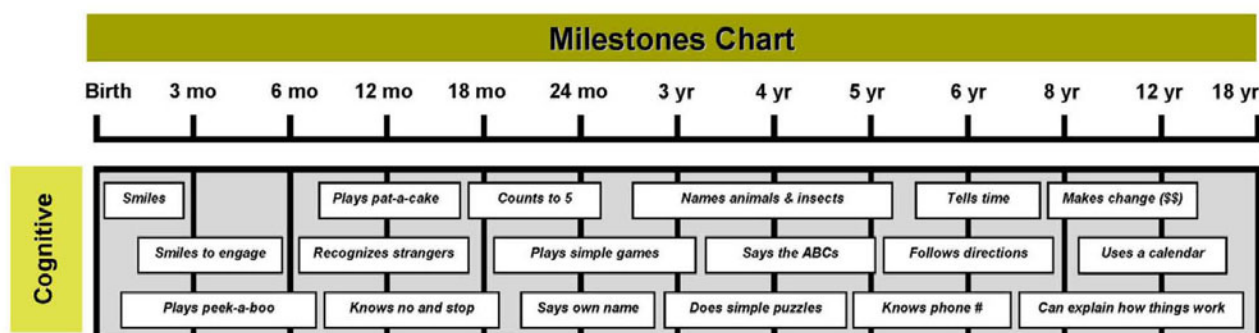


Motor development includes the acquisition of gross motor and fine motor skills. Reflexes and voluntary coordination of muscles and the nervous system improve with adequate stimulation and opportunities to practice.

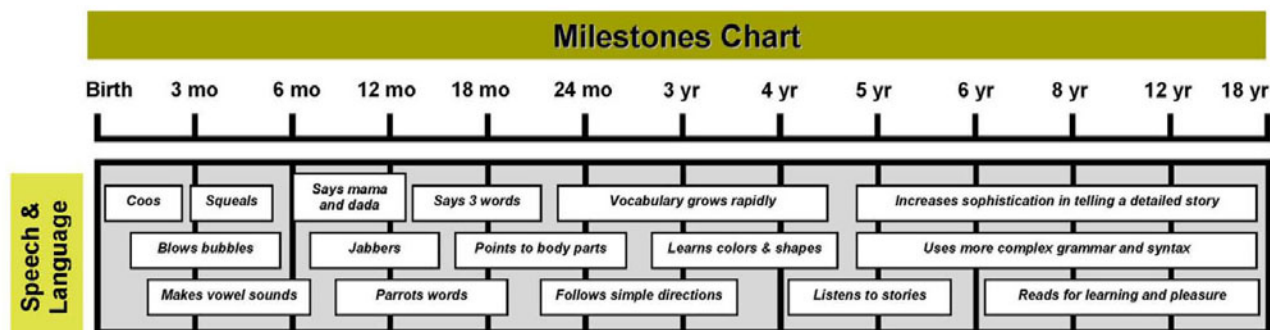


CHAPTER 3: IDENTIFYING ABILITY AND DEMYSTIFYING DISABILITY: CHILD DEVELOPMENT, ASSESSMENT, AND DEVELOPMENTAL DISABILITIES

Cognitive development refers to how our brain takes in, processes, and uses information. It involves both the accumulation of information (learning) and the process of doing so. In addition, cognitive development includes the development and use of reasoning and judgment. Cognitive development may be measured using intelligence testing as well as tests for processing and learning styles.

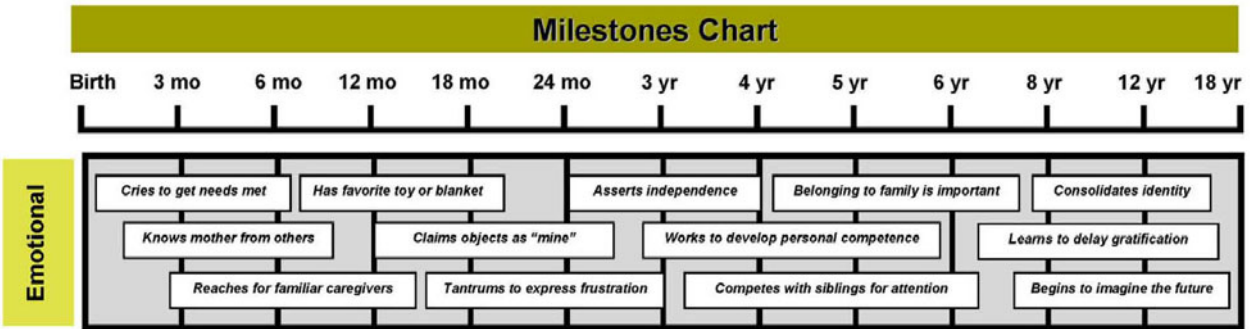


Speech and language development involves the production of speech sounds and the use of language for communication and comprehension. Speech is talking and language is a set of rules for sharing thoughts, ideas, and feelings. Speech begins in infancy and proper articulation of all speech sounds is usually mastered by age eight or nine. Language includes expressive language (messages sent) and receptive language (messages received). Speech and language development varies somewhat across specific languages and is certainly more complex for children growing up in bilingual homes and communities.

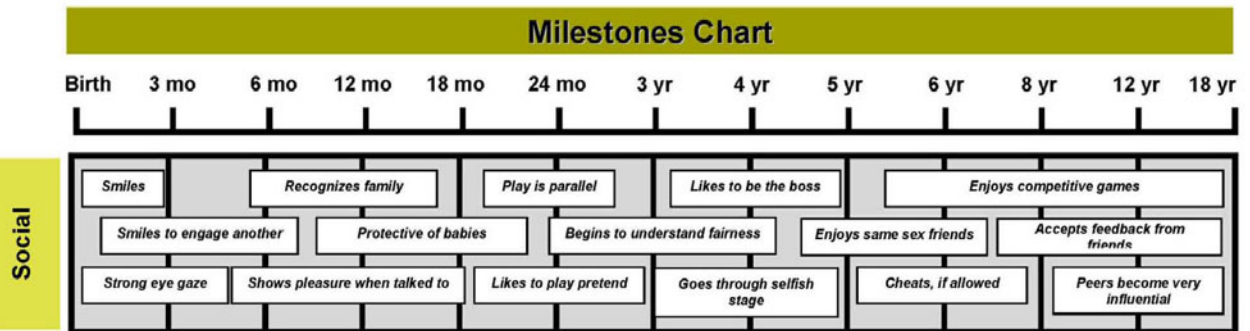


CHAPTER 3: IDENTIFYING ABILITY AND DEMYSTIFYING DISABILITY:
CHILD DEVELOPMENT, ASSESSMENT, AND DEVELOPMENTAL DISABILITIES

Emotional development has to do with psychological development—personal identity, meeting personal needs, and finding one’s place in relationships within family, school, work, and community. The acquisition of self-esteem and self-regulation are part of emotional development.



Social development involves developing skills for interactions and implementing emotional development in a social setting. Social development helps us learn how to select behaviors appropriate to the setting and situation. While all of the ages and stages of childhood are influenced by environment, social development and emotional development are very much an interactional process. Social development is evidenced in part by one’s behavior. Behavior is an observable manifestation of cognitive processes directing and sometimes overriding emotional wants and needs.



VARIATION IN CHILD DEVELOPMENT

In daily life, as we come into contact with children, we all perform informal assessments. At the very least, we notice when children do not “act their age,” or are taller or shorter than other children their age, or look overweight. We notice when a child is outside our expectations of how children should appear and behave at particular ages and stages.

During the last 50 to 60 years, the process of child development has been well studied and norms have been established. Norms for child development indicate typical behaviors at certain ages. A chart of typical development is frequently used to show how close to the “age line” a particular child is. In cases where the variation is wider around the age line for a single domain, sometimes it can be explained as an *individual difference*, and the child often catches up. When the process and/or speed of a child’s development are significantly different from most other children, it may be called a *developmental delay*. When this is noted, the next step would be a formal assessment.

During a formal assessment, variation in typical development, including individual differences, is evaluated. Developmental delay is defined as less than one standard deviation from the mean. When a child falls below one standard deviation in two or more areas, a child is said to demonstrate a developmental delay. A developmental delay is not a diagnosis; it is a label indicating the need for a developmental evaluation to determine a cause for the delay and to identify services to mitigate or reverse the delay. Developmental delays usually occur in one or more domains of child development.

Ideally, the assessment for developmental delays should be done by an experienced health care provider or team of multidisciplinary providers using standardized developmental assessment tools. Older children may be evaluated at school, and testing results may be summarized in an Individualized Educational Plan (IEP), the required process specified in the Individuals with Disabilities Education Act (IDEA).

CATEGORIES OF DISABILITY

In order to understand the wide range of disabilities and chronic conditions, we have chosen to use categories of disability that are familiar to most professionals who work with children—those included in special education laws (IDEA) and disability legislation related to children. Thus, we are not reinventing categories here for our own use, but building on the work of others in the field and the existing knowledge base of our colleagues.

CHAPTER 3: IDENTIFYING ABILITY AND DEMYSTIFYING DISABILITY: CHILD DEVELOPMENT, ASSESSMENT, AND DEVELOPMENTAL DISABILITIES

The categories from IDEA are

- Autism
- Deaf-blindness
- Emotional disturbance
- Hearing impairment, including deafness
- Mental retardation
- Multiple disabilities
- Orthopedic impairment
- Other health impairment
- Specific learning disability
- Speech or language impairment
- Traumatic brain injury
- Visual impairment, including blindness

Distribution of Difficulties Across IDEA Categories of Disability

	Speaking, Understanding, and Using Language	Thinking and Reasoning	Socializing, Feeling, and Behaving	Hearing, Vision, Movement, and Health
<i>Autism</i>	X	X	X	
<i>Deaf-blindness</i>				X
<i>Emotional disturbance</i>			X	
<i>Hearing impairment & deafness</i>	MAYBE			X
<i>Mental retardation</i>	X	X	X	
<i>Multiple disabilities</i>	X	X	X	X
<i>Orthopedic impairment</i>	MAYBE			X
<i>Other health impairment: ADHD</i>		X	X	
<i>Specific learning disability</i>	X			
<i>Speech or language impairment</i>	X			
<i>Traumatic brain injury</i>	X	X	X	X
<i>Visual impairment & blindness</i>	X			X

VARIATION IN DISABILITIES

We stated earlier that typically developing children vary less than one standard deviation from peers. Children with disabilities demonstrate greater variation than typically developing peers. It is said that if you have seen one child with a particular disability, you have seen one child with that disability.

There is variation in the **severity** of a condition for a particular child. For example, one child with cerebral palsy may walk with an unsteady gait but in all other ways is like other children his or her age. Another child might not be able to walk at all. Severity of a disability can also refer to the overall impact on daily functioning. Deafness and blindness are considered severe impairments in contrast to a visual or hearing impairment that can be corrected with glasses or a hearing aid.

There are differences in the **frequency** of occurrence of disabilities. Generally speaking, genetic disabilities occur least often but can be the most involved and lifelong, in contrast to speech articulation problems that occur frequently and can be treated.

Disabilities vary in **complexity**. One child with attention deficit/hyperactivity disorder (ADHD) might only struggle with paying attention in school; another might be very hyperactive and inattentive, demonstrating difficulties with time management and social behaviors.

Disabilities vary according to **co-occurring conditions**. This means that there are clusters of disabilities that may occur together frequently enough for a statistical correlation but not occurring in all children all the time.

There is variation among children in the **number of disabilities** they have. One third of children with disabilities have one type, another third have two disabilities, and another third have three or more disabilities.

Severity and incidence of disabilities

Disabilities can be ranked according to severity and incidence of each condition. These rankings are often put into a chart to illustrate how disabling conditions compare in severity and incidence. This categorization can be useful when trying to determine how to plan for providing services and for professional training.

For the initial phase of this training curriculum, we will focus on higher frequency, low intensity conditions since they are the most likely conditions our training audience will encounter. Future work will concentrate on lower frequency conditions.

Frequency and Intensity of Disabilities

FREQUENCY	
HIGH	LOW
INTENSITY	HIGH
	LOW
Autism (in Oregon)	Visual impairment Hearing impairment Mental retardation Autism Chronic illness Genetic disorders
Learning problems Speech & language problems Conduct disorders Childhood obesity School failure Teen pregnancy Drug abuse	

In the next section, we begin discussing four basic problem areas experienced by children with disabilities: communication, intelligence, behavior, and physical functioning.

INTRODUCTION

The Demystifying Disability Rubric (Appendix 1) identifies four basic areas of difficulty: communication, intelligence, behavior, and physical functioning. This chapter is about communication disabilities, the group of developmental disabilities that interfere with the ability to speak, use, and/or understand language. Specific learning disabilities interfere with reading, writing, and understanding spoken and written language. Speech and language disorders and specific learning disabilities are among the categories in the Individuals with Disabilities Education Act (IDEA) that make children eligible to receive special education services. In this chapter, you will learn about speech and language disorders and learning disabilities that interfere with a child's ability to communicate and ways to make accommodations for a successful interview.

Difficulties with communication fall into two main categories—speech and language. **Speech** is the production of understandable sounds used for communication. All speech sounds in the English language are usually mastered by age eight to nine. **Language** difficulties involve problems with sharing thoughts, ideas, feelings, and information. *Expressive* language refers to what and how the child speaks; *receptive* language refers to what the child hears and understands. A child can have difficulty with one or both of these areas of language development. Most learning disabilities fall in the language category.

Speech and language problems range from mild to severe, from simple mispronunciations of certain sounds, to not understanding spoken or written language, to damage of the oral-motor muscles and nerves that allow for speech and feeding. Many times the actual cause of speech and language problems is unknown. However, hearing loss, brain injury, mental retardation, or birth defects such as cleft lip and palate are associated with speech and language problems. Please see the Fact Sheet published by the National Dissemination Center for Children with Disabilities (NICHCY) at www.nichcy.org/pubs/factshe/fs11txt.htm for an overview of speech and language problems.

Children growing up in bilingual families often are slightly behind children learning only one language, but the delay is mild and involves primarily speech rather than language problems. Usually the delay diminishes by early elementary school age.

Communication difficulties are complex, because they involve at least a four-way interaction: what the child says, what we say, what the child understands about what we say, and what we understand about what the child says. With or without specific information about a child's ability to communicate, the interviewer can listen and observe a child to identify problems with:

- Articulation (pronunciation)
- Fluency (rate, flow, and repetitions in speech, e.g., stuttering)

CHAPTER 4: COMMUNICATION DISABILITIES: SPEAKING, UNDERSTANDING, AND USING LANGUAGE

- Voice quality, pitch, loudness, and resonance
- Phonology (full range of speech sounds expected for age)
- Comprehension of spoken and/or written language
- Semantics (meanings of words)
- Syntax (grammatical construction of phrases and sentences)
- Pragmatics (use of conversational speech)
- Reading and writing

PROBLEMS WITH SPEAKING

In typically developing speech, infants hear speech, attempt to imitate it, and discover how to coordinate lips and tongue with breath to make sound. Through practice and feedback from others who delight in infants' early speech development, infants learn to make intelligible (or at least interpretable) sounds. The repetition of the words and phrases form "speech motor plans and programs" that can be easily retrieved when needed. The sounds become associated with people and objects (dad, mom, bottle, blanket) as speech development is integrated with language development.

Human speech is a series of distinct and complex parts that ends in an understandable verbal message:

- Intention to communicate is generated.
- An idea develops about what to communicate.
- Words of the message are put in grammatically correct order.
- Each word contains a specifically ordered combination of sounds and syllables.
- Highly coordinated muscle movements of the lips, tongue, jaw, and palate synchronize with air and pressure through the vocal cords to produce speech sounds.

Children learn vocabulary quickly. By 18 months, typically developing children have up to 20 words in their vocabulary, at 24 months up to 300 words, and by age three children can have mastered as many as 1,000 words. As preschoolers, children continue to expand their vocabulary, but the greatest development occurs in the language area—grappling with grammar, syntax, and the abstraction and utility of language for communicating ideas, thoughts, and feelings.

SPECIFIC PROBLEMS WITH SPEECH

Articulation problems

All speech sounds are not mastered until age eight to nine. Vowels are mastered during infancy and consonants and diphthongs emerge in clusters in a predictable order. Articulation

problems are not the same as mispronunciations made when children learn new words. There are three main types of articulation problems: omissions, substitutions, and distortions. A typical omission occurs when a child deletes the first sound of a word such as “at” for “hat.” Substitutions are regular uses of one sound for another, such as “wabbit” for “rabbit.” Distortions in articulation are usually unique to individual children and often become part of family lore. Articulation problems often fade as children grow and are able to master the correct sounds of vowels and consonants. Many children and adults can tune their ear to understand the child despite the articulation problems.

Stuttering

Stuttering is a speech problem that is an interruption in the normal flow of speech, also known as a fluency disorder. It is usually characterized by a repetition of a sound or part of a word like “W-w-w-what should I do?” or “S-s-s-see you later.” In other cases, children use interjections such as “um, you know, like ____” until they can smoothly transition to the next word or phrase. Stuttering sometimes occurs in young children as speech emerges in toddlers and preschoolers; most outgrow it without treatment. More serious and persistent forms of stuttering often are unique in presentation. For example, some may have difficulty with performing, others using a telephone. Sometimes children who stutter tend to withdraw for fear of teasing or feelings of embarrassment. Frequently there is a family history of stuttering.

DIAGNOSES ASSOCIATED WITH SPEECH PROBLEMS

Apraxia

Apraxia, sometimes called dyspraxia, is a motor disorder where children have trouble planning and making the very precise movements of the lips and tongue, jaw and palate that produce understandable speech sounds. Five characteristics of apraxia are

- Difficulty with making and maintaining sounds
- Vowel distortions
- Limited repertoire of consonants and vowels
- Simplistic syllable shapes
- Problems completing certain sounds in both short and long words in the beginning, middle, and end of a word

Children with apraxia do not “just talk late”; late talkers do not demonstrate the other hallmarks associated with apraxia. Children with apraxia may rely on gestures to communicate and, in some cases, even develop a private set of signs for communication. Children with apraxia often have normal intelligence and meet other developmental milestones on time. They usually need intensive therapy; careful diagnosis and early intervention are essential for the best outcomes. They may also require augmentative communication devices. For more information, please refer to the information published by the National Institute of Deafness and

Other Communication Disorders, The National Institutes of Health at www.nidcd.nih.gov/health/voice/apraxia.htm.

Dysarthria

Dysarthria is a more involved articulation problem caused by oral and facial muscle weakness or paralysis. Children with this type of articulation problem often have a history of feeding problems and may have other medical conditions as well. The required therapy is more involved and may last into the elementary school years or beyond. Dysarthria is often associated with apraxia of childhood and is differentiated by the presence of underlying anatomical causes, such as cerebral palsy.

Case example of a child with severe dysarthria

An adolescent girl with severe dysarthria told her special education teacher that she was sexually assaulted while on the school ground after lunch. She was brought by school police for an evaluation at a child abuse center. Records that school provided to interviewers included notes about her being an honest and hard working student with an IQ between 65 and 70. She had a verbal vocabulary of about 20 understandable words but a much greater receptive language capacity; she was able to answer yes/no questions to communicate and participate in conversation.

Her physical examination was abnormal, consistent with sexual assault. The evaluators learned from talking with her that she did not know the name of her assailant, but he was an adult male. She had seen him before that day on the school grounds. She said several times, “O hot” and she would toss her head back each time she used the phrase. She repeated the information during a videotaped interview but the evaluators were unable to understand the meaning of her communication at the time. During the follow-up investigation, detectives interviewed a man who later confessed to the assault. He was wearing a green ball cap emblazoned with the team logo of University of Oregon—a large capital “O.” This explained the verbalization of “O hot [hat]” the girl had described to interviewers.

This example illustrates that often the child’s communication can be accurate even when it is not readily understood by professionals. Thorough investigation eventually enlightened the multi-disciplinary team about the meaning of the girl’s important statement and led to successful prosecution.

Cleft lip and/or palate

Cleft lip and cleft palate are conditions that occur before birth when there is incomplete closing of structures in the lip and/or roof of the mouth. Clefts can be unilateral or bilateral (location) and complete or incomplete (severity). Cleft lips are repaired with surgery around three months of age and clefts in palates are repaired between nine and 18 months. An

interdisciplinary team is needed to help manage the feeding and nutrition problems, speech and developmental concerns, surgical corrections and specialized dental care.

The anatomical abnormalities even after surgical correction may still affect speech production. Speech problems usually are mild when only a cleft lip is involved. When the palate is involved, the child often has a hypernasal (stuffy nose) quality to speech sounds and may consistently mispronounce consonants. Even with the mispronunciations, usually children with a cleft lip and/or palate are understandable. Children often require speech therapy during preschool and early elementary school.

PROBLEMS WITH LANGUAGE

Language is complex. The use of language involves the intent to communicate. There are building blocks of language—words, phrases, sentences, paragraphs—and rules of language—grammar, syntax, and semantics. Educators often refer to types of language—expressive and receptive. **Expressive language** is about how we put words together to express thoughts verbally. It involves retrieving words, correctly naming things, organizing words with the intended meaning according to rules of grammar with correct tense. **Receptive language** involves attending to, processing, understanding, retaining, and integrating a spoken message into a context. Given the complexity of language, it follows that there are numerous opportunities for problems to develop in one or more areas of language.

Case example of expressive and receptive language

A fifth-grade boy who has severe difficulties with expressive language went to interview after the evaluation team was able to understand part of what the boy was saying. His receptive language was excellent and he had developed a combination of gestures to assist others to understand his words.

As the interviewer was establishing rapport with the child, she noticed he was drawing very detailed objects. Later, when asking questions about the alleged abuse, he raised a finger, indicating he wanted her to wait. He drew his answers: male figures—one with a ponytail, another with a tattoo, and a third with a hairy chest; a wooded area; and a truck. To emphasize details, he would tap on the drawings.

Detectives went out to the location and interviewed the adults there. Indeed, one had a long ponytail, another had the same tattoo the boy had drawn, and a third had his shirt unbuttoned, displaying an abundance of curly hair on his chest. The truck at the residence had the same markings as those the boy had drawn.

In this case, the interviewer was not sure about the importance of the details contained in the drawings. However, following the interview those details were very instrumental

in assisting the detectives in their investigation. Despite this boy's severe expressive language disability, he was able to communicate clearly what happened to him once the interviewer capitalized on his other abilities and made accommodations for him to use them.

DIAGNOSES AND PRESENTATIONS IN COMMUNICATION DISABILITIES

Learning disabilities

Learning disabilities are problems that children have with age-appropriate reading, spelling, and/or writing. The Individuals with Disabilities Education Act (IDEA) uses the phrase “specific learning disability” while others refer to the same cluster of difficulties simply as a learning disability. A learning disability is caused by a difference in how the brain is “wired.” Learning disabilities are lifelong conditions, but children with learning disabilities can master strategies for success.

Learning disabilities are often identified when a gap is noticed between a child's potential for achievement and the actual level of performance. By definition, these difficulties are not a result of low intelligence but rather of how the brain receives, processes, and responds to information it perceives. Children with mental retardation may also have language difficulties, but their potential for achievement will be different from children with normal intelligence.

Learning disabilities are often grouped into five categories:

- Dyslexia—trouble understanding written words; sometimes called a reading disability
- Dysgraphia—trouble forming letters or writing in a defined space
- Dyscalculia—difficulty with arithmetic and mathematical concepts
- Auditory and visual processing disorders—trouble understanding written or spoken language despite normal vision and hearing
- Nonverbal learning disabilities—difficulties with right-brain activities such as organization, evaluation, and visual-spatial abilities

You are likely to observe a child with a learning disability struggling with

- Learning new vocabulary through reading or listening
- Understanding questions
- Following directions
- Using filler words—“um,” “thing,” or “stuff”—while searching for correct words
- Repeating numbers in sequence, such as phone numbers or addresses
- Understanding the plot of a story
- Knowing right from left
- Confusing the order of words, numbers, or sequence in a story
- Telling time and having a concept of time

CHAPTER 4: COMMUNICATION DISABILITIES: SPEAKING, UNDERSTANDING, AND USING LANGUAGE

Autism Spectrum Disorders

Autism Spectrum Disorders (ASD) are a complex set of disorders that affect a child's ability to communicate, understand language, play, and relate to others. Autism Spectrum Disorders are a group of medical diagnoses that fall under the umbrella category of Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS). The ASDs are developmental disabilities with the following signs and symptoms:

- Impaired social interaction and impaired verbal and non-verbal communication
- Evident before age three
- Adversely affected learning and educational performance
- Engagement in repetitive activities and stereotyped movements
- Resistance to environmental change or change in daily routines
- Unusual responses to sensory experiences

There are several diagnoses that fall within the Autism Spectrum Disorders (ASD) category: Autistic Disorder, Asperger's Disorder, Rett's Disorder, and Childhood Disintegrative Disorder. Classic autism affects more boys than girls while Rett's Disorder affects girls almost exclusively. Asperger's Disorder is a more mild form of the autism spectrum diagnoses; intelligence is normal or above normal, speech is present, and social impairments are subtler. In contrast, Childhood Disintegrative Disorder symptoms are usually quite severe. Each disorder affects a child's communication in a different way. Often children with the same autism diagnosis will manifest unique differences in their speech and language. Please see the fact sheets published by the National Dissemination Center for Children with Disabilities (NICHY) for Autism, Asperger's Disorder, Rett's Disorder, and Pervasive Developmental Disorder for an overview of these disorders.

Autism is a complex disorder that can cause difficulties in all four areas of the Demystifying Disability Rubric, as illustrated in the table below. In this section, we will focus on the communication aspects of autism, and later chapters will highlight problems in the other areas.

	Speaking, Understanding, and Using Language	Thinking and Reasoning	Socializing, Feeling, and Behaving	Hearing, Vision, Movement, and Health
Autism	<ul style="list-style-type: none">• May or may not speak• Have unusual flow, intonation• Use of language is limited usually because of relationships• May repeat others' words, use echolalia; limited topics• May substitute sounds or gestures for words to communicate	<ul style="list-style-type: none">• May have depth of knowledge about certain things• Difficulty with abstract concepts• May have low or high IQ• Use habit rather than decision making to solve problems or new situations	<ul style="list-style-type: none">• Problem relating to people, especially unfamiliar people• Play is solitary, repetitive• Inflexible about changes in routine	<ul style="list-style-type: none">• Often employs rocking or other repetitive motions• Unusual responses to sensory information

Difficulties with communicating for children with Autistic Spectrum Disorders

The hallmark of ASD is pervasiveness, in that it affects several domains of development at once. With other diagnoses, such as stuttering, the child can have normal intelligence, good social skills, and no underlying physical abnormalities that contribute to the stuttering. Hence, the child has a problem with communicating—speaking—but the problem is limited to a single domain of child development. In contrast, the diagnostic criteria for ASD require impairments in both domains of communication and social interaction. There is frequently a qualitative relationship among impairments: the social and emotional difficulties interfere with communication with others, and the child's problems with communicating then interfere with their social interactions. When a child with ASD also has a low IQ, it too contributes to problems with communicating and with social behaviors. This is important because approximately 80 percent of children with Autistic Disorder have mental retardation in intelligence and problems with adaptive functioning. Sometimes, despite low scores in intelligence, these children have unusual talent in one or two areas such as music, mathematics, or artistic ability.

While problems with communication in children with ASD can be grouped, use of words, gestures, and non-verbal communications are unique to each child. We will discuss the groups of communication problems associated with ASD below; however, we emphasize that to discuss communication problems apart from social and intellectual difficulties is an artificial distinction because of the interrelationships among the various domains of child development.

Use of words and speech. Children with ASD may or may not use speech to get their needs met. Usually speech is not used for social interaction or the pleasure associated with talking, playing, or engaging in mutual activity. These children may use non-verbal gestures to replace words, and they often misinterpret or miss altogether the non-verbal social cues of others. In response to words and speech from others, many children will turn away or physically withdraw from the person trying to talk with them.

Use of echolalia. Another form of autistic “language” includes echolalia, both immediate and delayed. The child may repeat back to you immediately what you or the child just said or you may hear the repetitious words or phrases later, long after the interaction in which it occurred. Children with autism may use echolalia when they do not understand what has been said to them and/or when they are unable to make a response using more appropriate speech.

Eye contact. Many children with ASD actively avoid eye contact or other physical contact during communication.

Some examples of communication difficulties that may be associated with ASD include:

- Very limited vocabulary or vocabulary that does not fit with the conversation or situation

- Exaggerated focus on only one topic of interest to the child, regardless of others' interest
- Inability to “read” body language or to understand social situations and adjust accordingly

Attention Deficit Hyperactivity Disorder (ADHD) and problems with communicating

Attention Deficit Hyperactivity Disorder is covered in IDEA under the category “other health impairments” (see Chapter 7). The hyperactivity aspect of ADHD is described in detail in Chapter 6 in which behavioral features are the focus. In this chapter, we will focus on the communication difficulties associated with ADHD.

Attention deficit and hyperactivity can certainly interfere with communication when a child is unable to focus on a sentence, paragraph, or conversation long enough to hear the entire message, keep the message in mind long enough to develop a response, send a meaningful reply, and then await the next message. Children with ADHD often have one or two kinds of attentional problems. On one hand, they are very distractible so their ability to engage in a long conversation may be dependent on what else is competing for their attention at a given moment. On the other hand, a child may begin to answer a question but then begin to digress because his or her train of thought has been interrupted by a competing thought or an external distraction.

Another form of attentional problem involves “getting stuck” on a topic or activity (hyperfocus) to the exclusion of all other stimuli. With hyperfocus, children also have difficulty changing their focus from one topic or activity to another. A child may talk on and on about minute details on a specific topic and not be able to move smoothly to another question or different aspect of the topic. Sometimes an interviewer proceeds to the next question and the child is not able to converse in a “give and take” way with the interviewer.

Children with ADHD also struggle with the saliency of a detail. This can be described as a “figure-ground” problem. The interviewer may ask an open-ended question, and many responses might occur to the child. However, a child who struggles with saliency has difficulty knowing what the topic at hand is (foreground) and what is less relevant (background).

ADHD also is mentioned here because of the frequent co-morbidity of ADHD and learning disabilities. The general characteristics of learning disabilities mentioned above are frequently seen in children with ADHD, resulting from both the inattention feature of ADHD and the associated learning disabilities. These children struggle when answering complex or vague questions. They may use filler words such as “um,” “thing,” or “stuff” while searching for the correct word, and they may provide confusing order of words, numbers, or sequence in a story. However, these children can give a detailed account of their experiences.

**ACCOMMODATIONS AND INTERVIEWING STRATEGIES FOR CHILDREN
WITH DIFFICULTIES WITH COMMUNICATION**

The interview approach for children with communication disorders will depend on the type and extent of the disorder. Use of the Demystifying Disability Rubric (Appendix 1) below will help identify what difficulties the child experiences and what additional information may be helpful when interviewing the child. A review of the **Demystifying Communication Disabilities Checklist (Appendix 2)** may provide specific guidance for preparing and conducting the interview.

The Demystifying Disability Rubric

- Does this child have a disability or difficulty with
 - ***Speaking, understanding, and using language?***
 - Thinking and reasoning?
 - Socializing, feeling, and behaving?
 - Hearing, vision, movement and health?
- How does the disability affect *this* child?
- What strengths or abilities does the child have?
- What else do I need to know about the disability and the child?
 - Are there medical or educational records available for review?
 - Who might be available for a general consultation on this disability?
- How can I structure the setting and the questions for a successful interview?

Once you have identified that a child has difficulty with speech, understanding, and/or using language, refer to the following information regarding accommodations for children with communication disabilities, so you can prepare for and successfully interview the child.

Prior to the interview

The main question before beginning an interview is “What ***type of communication*** does this child use?” When children have complex communication problems and you have the luxury of time, it is important to gather information from schools, speech and language professionals, and family members to learn how the child communicates and how best to converse with the child. If the child uses anything other than verbal communication, such as an augmentative communication device, the interviewer should spend time becoming familiar with the device the child uses prior to meeting the child.

Augmentation refers to the use of a communication tool or aid. There are various augmentative communication devices. Examples include:

- Computer keyboard
- A to Z spelling board
- Picture board

CHAPTER 4: COMMUNICATION DISABILITIES: SPEAKING, UNDERSTANDING, AND USING LANGUAGE

Each of these augmentative communication devices can be individually tailored to the needs of the child. Interviewing with these augmentative communication devices may require an interpreter who fully understands the aid and the child's ability to use it. Statements from children using augmentative communication devices should not be treated any differently from verbal statements (OIG, 2004).

Facilitated communication is also a form of augmentation for a child. Facilitated communication requires direct assistance from another person to use a keyboard, picture board, or spelling board. The child's facilitator assists the child by stabilizing his or her motor movements. Facilitated communication is quite controversial because of the concern that the facilitator may influence or control the child's response.

During the interview

Children with communication difficulties may simply need more time to receive, process, and respond to questions, so **allow for long silences**. If the child has difficulty in articulation and phonology, the interviewer will need to **listen carefully** and **stop to ascertain what the word means**. As with all interviews, the interviewer should take care to **speak clearly and distinctly**.

It is sometimes helpful to **acknowledge communication challenges in the beginning of the interview**, perhaps as part of rapport building. This will give both the child and the interviewer permission to correct themselves or each other and more comfort in communicating. For example, the interviewer can say, "You are new to me. Sometimes it's hard for me to understand new people. I may have to ask you to repeat some things." Or, "I will have to learn what words you use for things. Probably I'll ask you to make drawings to help me understand what happened" (adapted from Baladarian, 1992). During the interview, do not be reluctant to say, "I didn't understand what you said, please repeat it."

If the child uses an augmentative communication device, the interviewer and child should demonstrate use of the device during the rapport building section of a videotaped interview to also acquaint the observer of the videotape with the equipment.

General strategies for many types of communication difficulties

If receptive communication is a concern, the interviewer can

- Minimize distractions in the interview room
- Pay attention to eye contact, body language, and other cues the child provides to indicate that he does not understand (such as squirming, grimacing, or long pauses)
- Stop periodically to ask the child if he understands or has any questions

If expressive language is a concern, the interviewer can

- Use tools to enhance communication (such as drawings, anatomically detailed dolls, mapping)
- Reflect back to the child what you understood, to assure accurate understanding
- Clarify pronouns and use identifiers whenever possible (e.g., “your uncle,” “John,” “the man with the yellow hat”; rather than “he,” “she,” “him”)
- Resist the temptation to fill in the blanks, but be aware that not all children will speak in full sentences

Strategies for specific diagnoses

Autism Spectrum Disorders (ASD). Many children with an ASD will not be able to participate at all in a structured interview. For those who use words to communicate, the interviewer should proceed slowly and take as much time as necessary to establish rapport. If the child answers questions and does not seem too taxed emotionally, the interviewer should proceed. The child’s presentation might be different from a child without ASD, but do not assume the child is not engaged in the conversation.

When interviewing children who have adequate language skills, be prepared for the child to give an inordinate amount of detail with each answer and not be able to discern what is important. Sometimes an interviewer might be tempted to “move on” to another section of the interview; however, patience may be rewarded with a piece of information that becomes extremely useful in understanding the child’s disclosure.

Children with autism usually understand word meanings very literally. For that reason, the interviewer should avoid colloquialisms, e.g., “Don’t let me put words in your mouth,” “What do you have up your sleeve?” “Are you pulling my leg?” or “by the skin of his teeth.” These sayings can be very confusing for such children. Jokes, sarcasm, slang, and innuendo are difficult for children with ASD to understand and should be avoided.

Attention Deficit Hyperactivity Disorder (ADHD). When interviewing children with ADHD, the interviewer can observe how well the child is able to attend to the flow of conversation and questions. You can often identify the level of attention during rapport building. Be ready to repeat a question if the answer given by the child suggests the child’s mind drifted or the interviewer observes the child seeming distracted. It is appropriate to comment on distractibility when repeating a question so that the child does not think his or her answer was not a “right” answer.

When asking open-ended questions to children with ADHD who struggle with saliency, consider asking more focused question to cue the child about what information you are seeking. For example, after asking a child to tell you about what happened with a person mentioned by the child, you might say, “I would like to hear about where you were and what you did with ____.”

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This helps the child distinguish what is important for you to know from the hundreds of details the child might share.

Children with ADHD are often fidgety during conversation. Allowing the child to wiggle some in the chair or walk around the room while talking can often help with focusing on the discussion. However, the interviewer will have to “check in” periodically with the child if his or her responses do not seem to be relevant answers to the questions.

CONCLUSION

Each child with a communication disability is unique in his or her abilities and limitations. The information in this chapter will guide you in understanding the child’s disability and in making accommodations to tailor your interview to capitalize on the child’s abilities. Best practice would dictate that this information is used in tandem with case consultation through ongoing training and peer review sessions.

INTRODUCTION

The second area addressed by the Demystifying Disability Rubric (Appendix 1) is intellectual disabilities—difficulties with thinking and reasoning. **Intellectual disability** is the preferred term for describing children with below average intelligence. Intellectual disabilities are either congenital (a condition present at birth, though perhaps not diagnosed at birth) or acquired, e.g., a severe infection such as meningitis or a traumatic brain injury. Other terms that have been used previously for intellectual disability include cognitive disability or cognitive impairment.

Infants and children with intellectual disabilities usually develop more slowly than peers and soon fail to achieve developmental milestones in some or all of the developmental domains (gross motor, fine motor, social, and emotional). School age children with intellectual disabilities may struggle with memory, problem solving, attention, reading, language, math, and visual comprehension.

The major consequence of an intellectual disability is a limited ability or inability to function in areas of daily living such as self-care, independent living, communication, and social/interpersonal skills. Called “adaptive behavior,” this set of behaviors indicates how well children (and adults) can function to maintain age-appropriate independence and meet the personal and social demands expected of them. Adaptive skills include dressing, toileting, feeding, and learning.

Despite gains made in the societal acceptance of intellectual disabilities, families often struggle a great deal with fears of acceptance and understanding of the child, regardless of the severity of the disability.

When a child has an intellectual disability, you may observe some of the following:

- Conversational style that seems immature for the child’s age
- Social behaviors that seem immature for the child’s age
- Slower mastery of speech compared with age mates
- Ability to converse about concrete topics but difficulty with abstraction
- Literal interpretation of words and gestures
- Later development of problem solving skills, which are less sophisticated compared with age mates
- Difficulties integrating knowledge (new or stored information) into problem solving or established behavioral patterns
- Impulsivity in decision making due to the impaired thought processes related to intelligence (unlike ADHD, which is unrelated to intelligence)
- Inability to perceive danger when danger presents as an abstraction
- Limited thinking and reasoning abilities but normal sexual development

DIAGNOSES AND PRESENTATIONS IN INTELLECTUAL DISABILITIES

Mental Retardation

Mental Retardation is a diagnosis for children who have Intelligence Quotient (IQ) scores below 70 to 75 *and* delays in at least two of three areas of adaptive behavior—daily living skills (dressing, toileting, feeding), communication skills, and social/interpersonal skills. Many young children diagnosed with mental retardation can learn to do many things but do so more slowly than typically developing children. Formal assessment includes age-appropriate intelligence testing and evaluation of adaptive functioning and is necessary to establish eligibility for services. However, it also provides families a realistic prognosis and interventions that maximize the child’s potential. Also important is the testing of hearing and vision, cardiac function, chromosomal anomalies, and associated conditions such as thyroid disease.

Mental retardation is a category of disability in the Individuals with Disabilities Education Act (IDEA, 2004) and is often addressed through early intervention and special education programs. So that children with this disability can live as independently as possible, they receive special training on adaptive behavior skills, such as the following:

- Learning job skills in an area of interest and ability
- Preparing nutritious meals
- Dressing, hygiene, and housekeeping
- Using transportation, shopping, banking, recreational activities
- Taking medication, making appointments, giving a medical history
- Protecting self from exploitation
- Managing money
- Maintaining a social network with friends and family

The degree of mental retardation varies in severity and has been classified historically according to IQ scores and the potential for learning and adaptation:

- Mild (educable mental retardation)
 - IQ score from 55 to 70
- Moderate (trainable mental retardation)
 - IQ score from 40 to 55
- Severe
 - IQ score from 25 to 40
- Profound
 - IQ score lower than 25

Approximately 85 percent of children with mental retardation are classified in the “mild” category, with an IQ score ranging from 55 to 70. This means that the child may be slower in

achieving developmental milestones in speech than his or her age mates but will usually show typical development in gross motor and fine motor domains.

The American Association on Intellectual and Developmental Disabilities (AAIDD), formerly known as the American Association on Mental Retardation (AAMR), prefers to describe severity by the level of support needed in the activities of daily living:

- Intermittent
 - Focused, short-term need for support usually associated with transitory events such as job loss or a medical crisis
- Limited
 - Time-limited events but more intense level of support than intermittent
- Extensive
 - Daily support needed across the lifespan in one or more settings
- Pervasive
 - Consistent, high level of care needed in all settings

A child can be affected with mental retardation and have no other impairments. Other children have mental retardation with an array of other problems that may worsen the child's level of adaptive functioning. Mental retardation can be caused by an inheritable genetic condition such as Down syndrome or fragile X; by complications during pregnancy or birth; by severe illness or head injury during the early developmental years; or by exposure to certain toxins.

Down Syndrome

Down Syndrome is a genetic condition that results in an individual with 47 rather than 46 chromosomes, with an additional copy of chromosome 21. Physical characteristics that are noticeable at birth may include low muscle tone, flat nose, small mouth and ears, slanted eyes, short arms, and a large head. Down syndrome may cause delays in physical development and intellectual attainment; however, many people with Down syndrome can live independently. According to the National Association on Down Syndrome, "The most important fact to know about individuals with Down Syndrome is that they are more like others than they are different." (www.nads.org/pages_new/facts.html)

Down Syndrome is usually diagnosed at birth and confirmed by chromosomal testing. Parents are connected with early intervention services intended to maximize the child's potential. Coordinated interdisciplinary care is best because the children often have increased infections, problems with vision and/or hearing, heart problems, and musculoskeletal instability.

Autistic Disorder

Most children with autism have an associated low IQ. Children with autism described as "high functioning" have an IQ score above 70; children diagnosed with Asperger's Disorder usually have no intellectual impairment but may have nonverbal learning disabilities. Often the low IQ

score does not determine the potential of a child with autism, because the impairments in communication and social interactions may have far more impact on a child's ability to function well in daily living.

Communication and social interaction difficulties experienced by children with autism are discussed in more detail in chapters 4 and 6, respectively. The National Institute of Neurological Disorders and Stroke (part of National Institutes of Health) offers a fact sheet on autism at www.cdc.gov/ncbddd/autism/ActEarly/autism.html_Autism. See also the National Center on Birth Defects and Developmental Disabilities website, www.ninds.nih.gov/disorders/autism/detail_autism.

Case example of a child with autism and mild mental retardation

A 6-year-old twin girl named "V" visiting her grandparents in Oregon was brought in for an evaluation after making allegations of physical and sexual abuse at her mother's house in Arizona. She had been diagnosed with autism and mild mental retardation. Her twin without autism and mental retardation did not report abuse but said that her mother and boyfriend picked on her sister a lot, and told the grandparents that V always tells the truth—"she doesn't know how to lie." The child's caregivers were not available to provide history.

V presented as a much younger child, functioning at about the level of a 3- to 4-year-old child. She had limited vocabulary that was understandable, she used gestures, and she shrunk away from eye contact. V allowed the interviewer to sit near her, but not too close. She often made a guttural sound after each question, and then paused before responding. Her attention focused on a small wand filled with floating objects that she spun around. However, she was able to answer yes/no questions.

When asked where she was when the alleged abuse took place, she initially put her hands behind her body, rocked back and forth, then put her hands to her ears and shrieked. She stomped on the floor. Throughout the interview, the interviewer followed up on each communication offered, subsequently learning that V's hands were tied behind her back, V was sexually assaulted in a chair, and loud noises were under the floor. V did not appear to be suggestible, correcting the interviewer when necessary. When the interviewer ended the session she had obtained the who (mom's boyfriend), what (sexual abuse), where (chair in the back room), and how (hands bound, boyfriend's hands touching her front private) details related to the abuse.

Given the interstate issues involved, detectives called local authorities in Arizona. Law enforcement personnel obtained a confession from the mother and boyfriend, and discovered a cache of weapons, firecrackers, and explosives under the floorboards in the back room. V and her sister were placed in the care of their grandparents.

ACCOMMODATIONS AND INTERVIEW STRATEGIES FOR CHILDREN WITH INTELLECTUAL DISABILITIES

The interview approach for children with intellectual disabilities will depend on the type and extent of the disability; use of the Demystifying Disability Rubric (Appendix 1) below will help identify what difficulties the child experiences and what additional information may be helpful when interviewing the child. A review of the **Demystifying Intellectual Disorders Checklist (Appendix 3)** may provide specific guidance for preparing and conducting the interview.

The Demystifying Disability Rubric

- Does this child have a disability or difficulty with
 - Speaking, understanding, and using language?
 - **Thinking and reasoning?**
 - Socializing, feeling, and behaving?
 - Hearing, vision, movement and health?
- How does the disability affect *this* child?
- What strengths or abilities does the child have?
- What else do I need to know about the disability and the child?
 - Are there medical or educational records available for review?
 - Who might be available for a general consultation on this disability?
- How can I structure the setting and the questions for a successful interview?

Once you have identified that a child has difficulty with thinking and reasoning, refer to the following information regarding accommodations for children with intellectual disabilities, so you can prepare for and successfully interview the child.

Prior to the interview

As with other disabilities, the interview strategies when working with children with intellectual disabilities will depend on the extent of the disability. If possible, gather this information beforehand. If the interviewer has time and access to the child's Individualized Education Plan (IEP), review this for tips on how to best communicate with the child. If you can discuss the child's abilities with caregivers or therapists beforehand, do so, and ask for the child's most current medical diagnoses and psychological records. If you cannot get such information beforehand, proceed with your interview as you would with any child. It is important not to "talk down" to the child but to be respectful while adapting the interview to the child's abilities and level of functioning.

If you do have historical documents on the child's functioning, use them as a guide for planning the structure of your interview and for setting realistic expectations for the child's abilities to communicate. However, be aware that your experience with the child may differ, sometimes dramatically, from what you might have expected upon reading past reports of school and/or

developmental testing. As we know, children's development can vary across the developmental domains. For example, you may have records indicating that a 12-year-old girl who has been referred for an interview "functions at the level of a five year old." When in the interview, it is clear that her language skills are much better than those of a typically developing five year old. However, she cannot read. Therefore, you may not need to make as many accommodations when interviewing this girl as you had anticipated.

The interview

Introduction. In the beginning, spend time on your introduction.

- Introduce yourself and explain what will happen during the interview.
- Tell the child where you will be taking him or her, and how long you expect to be there.
- Explain your interview room.
- Review who is observing and that you are videotaping, if applicable.
- Tell the child where the restroom is and that he or she can take a break if needed.
- Advise the child of answer options, including
 - Correcting the interviewer's mistakes
 - Importance of not guessing; it is okay to say "I don't know"
 - Talk about real things, no pretending
 - Option of not talking about a particular topic
 - Let interviewer know you do not understand the question

Rapport building. Spend extra time establishing rapport to become familiar with the child's abilities and language. As the interviewer, it is your responsibility to understand what the child is saying, not the child's responsibility to understand what you are saying.

During rapport building, assess the child's ability to respond to abstract questions. For example, if asked "What brings you here today?" the abstract response would be, "I'm here because someone hurt me." For the child without this ability to abstract, the concrete response would be, "Bus number 7." Again, it is important to tailor your questions to the language and intellectual abilities of the child.

Children with a diagnosis of Mental Retardation might have limited language skills. However, they may be able to understand more than they can express with words. Therefore, changes in the child's behavior, such as preoccupation with activities or subjects or an increase in anxiety, may indicate that the child is struggling with expressive communication. In such cases, the use of yes or no questions may help ease communication, although they should be used sparingly.

Comfort. Once in the room, ask if the child is comfortable. The offer of a beverage or snack often will help put a child at ease. By beginning with a familiar activity, snacking, the child may more easily transition from a familiar social situation to one that is not so familiar, an interview.

Language. Spend time familiarizing yourself with the child's language, vocabulary, syntax, and grammar. This will greatly increase your ability to pose appropriate questions and understand the answers. Do not spend too much time on this, as some children may become fatigued.

- Use plain language, not "baby talk"
- Ask one question at a time.
- Use "when" questions in the context of the child's daily or weekly activities.
- Match the child's language.
- Avoid compound questions and sentences. Use one idea per sentence.
- Avoid using "why" questions.
- Do not rush; allow the child to speak at his or her own pace.
- Use open-ended questions and invitational prompts to initiate narrative.

The interviewer may have to resort to beginning the discussion with direct, yes/no, or multiple choice questions if the child is unable or unwilling to provide a running narrative. The interviewer can use phrases such as, "And then what happened?" OR "Tell me more about that" OR "What was that like?"

Children with intellectual disabilities may not tell you when they do not comprehend your questions. The interviewer should remain cognizant of this and continue posing neutral questions as well as clarifying answers. Frequently, ask the child if she or he understands the question. If you cannot understand the child's speech or statement, ask for clarification. Sometimes saying, "I didn't understand that part; please say it again" is the best way to clarify a statement. Other times, the interviewer may need to pose the question again, allowing the child time to process and answer the question. Allow a pause before posing questions in order to avoid confusion. As well, remember to avoid the use of "why" questions, especially with children with intellectual disabilities. The child likely does not know the answer, and may feel badly about not being able to provide an answer to you.

Breaks. During the interview, watch the child for signs of stress, fatigue, or discomfort. If the child demonstrates any signs of stress, it may be time for a break. In many cases, the child may not ask for a break when needed, even if you have given him or her permission to do so. Therefore, pay attention to the child's body language as well as the following:

- Withdrawal
- Distraction (looking around)
- Fidgeting, hand wringing
- Humming, groaning
- Not answering the questions

When these characteristics are present, there are two options: (1) take a break from the topic by introducing another topic or (2) take a break from the interview. Rather than asking the

child if he or she needs a break, say, “I’d like a quick break. Would you also like one?” This will give the child a chance to relax, use the bathroom, take a drink, and/or take respite from the intensity of the interview. During the child’s break, the interviewer should remain on camera, if videotaping. When the child re-enters the room, assess his or her level of comfort before continuing.

Multiple interviews

For children with intellectual disabilities, several short interviews may be more productive and less stressful than one long interview. Use your judgment in deciding whether or not to schedule multiple interviews. If you do bring the child back for additional interviews, take care to discuss contamination with the caregiver and other community partners (see Chapter 2).

CONCLUSION

Each child with an intellectual disability is unique in his or her abilities and limitations. The information in this chapter will guide you in understanding the child’s disability and in making accommodations to tailor your interview to capitalize on the child’s abilities. Best practice would dictate that this information is used in tandem with case consultation through ongoing training and peer review sessions.

INTRODUCTION

The Demystifying Disability Rubric (Appendix 1) asks about difficulties with demonstrating appropriate social-emotional behaviors. Social and emotional needs drive human behavior; children may have problems in one or both areas. In typical child development we see infants using immature but, often, effective behaviors to get their needs met. The feedback from those behavioral attempts begins to shape the child's learning of social and emotional skills, which later become modified to meet societal expectations for behaviors.

Social behaviors determine how we integrate ourselves and our personal needs and desires with the desires and needs of the group, which may vary and at times be in conflict with our own. Such behaviors include how we greet and treat people, how we take our place in a social order, and how we respond to authority. Children learn social behaviors through imitation, instruction, trial and error, and, occasionally, through traumatic events. Acceptable social behavior is somewhat dependent on intellectual ability and communication skill.

Social behaviors develop throughout childhood. These basic social behaviors include behaviors that demonstrate:

- Respect for authority
- Respect for others
- Understanding that the needs of a group are at times more important than the needs of an individual
- Ability to delay immediate gratification for a greater gain in the future
- Acceptance that there are rules to maintain social order so that individual needs can be met within a social context

Clearly, the message learned and the nature of the social order will vary by culture. However, the above social guidelines exist in most cultures.

Some children demonstrate atypical development in social and emotional domains. They grow up without learning appropriate social behaviors and are quickly labeled as children with behavioral problems. They may see and imitate socially unacceptable behavior, or lack instruction about getting their needs met within a social context. They may also grow up experiencing trauma or loss, creating feelings and needs that override their ability to moderate their behavior. They may also have medical or mental health problems that interfere with their ability to behave in socially appropriate ways.

Emotions or feelings are demonstrated through behavior in private or in social situations. Typically developing children experience consequences for certain behaviors and modify their behaviors in the future to get their needs met. They learn that acting out certain feelings, such

as love, generally produces a positive response in others. Conversely, acting out of feelings of selfishness or hate usually creates a negative response in others. Young children are taught that even when one “feels” a certain way they should still “behave” in a socially acceptable way. The lesson to be learned is that feelings can be controlled by thinking before acting.

Children with emotional problems are unable to manage feelings to control their behaviors. These emotional problems often stem from three sources: a lack of guidance about managing one’s emotions, a disturbance in brain biochemistry, and/or a traumatic event. Negative behaviors caused by imbalances in brain chemistry can often be mitigated with medication, psychotherapy, and/or cognitive-behavioral therapies. Other useful techniques for assisting children in managing their emotions include life skill and behavior management classes.

Behaviors that suggest difficulties in social and emotional domains include

- Persistent sad or unhappy mood
- Wide mood swings
- Withdrawal or avoidance
- Argumentative
- Angry outbursts
- Atypical behavior for age (acting much older or younger than age)
- Failure to make and maintain eye contact
- Impulsive
- Fidgety and unable to be still

See also the National Dissemination Center for Children with Disabilities (NICHCY) website at www.nichcy.org/pubs/factshe/fs5txt.htm.

DIAGNOSES AND PRESENTATIONS IN SOCIAL AND EMOTIONAL DISABILITIES

Anxiety Disorders

Symptoms of anxiety disorders may include an elevated state of worry or tension even when there is little or nothing to trigger it. Children with these symptoms may not be able to “not think about it.” The anxiety may also be accompanied by physical manifestations, including fatigue, muscle tension, headaches, insomnia, irritability, trembling, twitching, and sweating.

There are several diagnoses included in the broader category of anxiety disorders. The most common for children include

- Generalized anxiety disorder
- Panic disorder
- Post traumatic stress disorder

- Social anxiety disorder
- Obsessive-compulsive disorder

Children with **generalized anxiety disorder** present as overly concerned about school, their health, family members, and often imagine impending disaster. **Panic disorder** is characterized by physical symptoms that accompany feelings of terror: sweating or chills, tingling or numbness, dizziness or fainting. **Posttraumatic stress disorder** (PTSD) develops after children experience or witness terrifying ordeals or threats of harm. Children with PTSD relive the trauma through re-experiencing the images, sounds, odors, or feelings associated with the original incidents. **Social anxiety disorder** is diagnosed when a child has a persistent fear of being watched or judged by others and/or doing things that will invite embarrassment or shame. Children with **Obsessive-compulsive disorder** (OCD) use rituals to control their anxiety, but, in time, the rituals end up controlling the children. Examples of rituals (compulsions) include counting things, insisting on a particular sequence or order for certain activities, and washing hands over and over. Unfortunately, performing rituals does not alleviate the underlying obsession for the child.

Children who experience or witness child abuse, neglect, and/or domestic violence often exhibit signs of one form of anxiety or another. Effective treatments are available for anxiety including medication, individual and/or group psychotherapy, and non-pharmacological adjunct therapies such as exercise and/or stress management techniques. Cognitive-behavioral therapy and behavioral therapies can be very successful treatments.

Case example of an adolescent with mental health and behavioral difficulties

A young adolescent from a residential setting was interviewed for possible abuse after disclosing to house staff that she had been raped by a neighbor. “J” had been in foster care for many years and was moved to a group home when her foster parents could no longer manage her behavior. She had threatened suicide and was involved in multiple high-risk behaviors—running away, truancy, and shoplifting. She was diagnosed with PTSD, bipolar disorder, and received special education services because of an emotional disturbance and learning disabilities; she refused to take medications.

She completed a physical examination (with positive physical findings) and interview. She presented as angry, uncooperative, and sullen. She was sarcastic throughout the interview but did answer questions and provided peripheral detail.

Her case went to trial and ended in a mistrial before she testified. During the second trial, she had testified, but the district attorney said her sullen presentation was “not helpful” and the judge was clearly frustrated with her behavior. That trial ended in a hung jury. At a third trial, six years after her initial interview, she testified once again, this time answering questions with a more appropriate demeanor. However, she then began to lose control when the defendant sat up, leaned forward, and stared at her. She

then shouted obscenities at the him and his attorney, told the judge that the entire system of justice was “anything but just” because the courts had failed her two times before, and left the courtroom accompanied by the bailiff, still screaming at the judge. The defendant was found not guilty.

Her behavior in court had not been explained in the context of her disability, and her medical and mental health history had been ruled inadmissible in court.

Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder, or ADHD, is the most commonly diagnosed mental health disorder in childhood. As with most conditions, ADHD can present on a continuum of mild to severe. The more severe the presentation, the more behavior problems a child will develop. Children with ADHD may qualify for special education services under more than one category of disability in Individuals with Disabilities Education Act (IDEA). ADHD is one diagnosis specifically identified in the IDEA section “other health impairment.” In this chapter, we concentrate on the behavioral aspects of ADHD. ADHD is also covered in Chapters 4 and 7, in which attention-specific learning disabilities and physical disabilities (medication side effects) are addressed.

The three major characteristics of ADHD affecting children’s behaviors include impulsivity (acting before thinking), hyperactivity, and inattention:

Impulsivity in children leads to behavior problems when a child cannot wait his or her turn, blurts out and interrupts instead of following social rules in conversation, and becomes impatient or aggressive when things do not go how the child wishes.

Hyperactivity and impulsivity usually occur together and present as restlessness, fidgeting, running, climbing, and staying seated or quiet when the social situation calls for that.

Inattention in children with ADHD is displayed by distractions to irrelevant sights and sounds, making careless mistakes, daydreaming, difficulty following instructions, difficulty completing one activity before moving to another, and constantly losing belongings.

Case example for a child with ADHD

A five-year-old girl diagnosed with attention deficit hyperactivity disorder, reported that her stepfather had molested her. She presented as a bright child with a good vocabulary; she could not stay still and she was easily distracted by sounds outside the room and thoughts that popped into her head. She was prescribed stimulant medication and had taken the medication prior to her evaluation.

Her physical examination was normal, and she completed a videotaped interview. During the interview, the interviewer allowed the child to move about the room, walk on

the furniture, and hide under the table. The girl answered questions about the abuse and gave details including new information that had not been reported prior to the interview. Eventually, the interview was ended when the child was no longer attending to the interviewer's questions. There was no documentation included in the report about the child's behavior being related to her disability.

The case proceeded to trial and a competency hearing was held to see if she could participate as a witness. She sat up in the witness box but soon began to fidget. She answered questions remarkably well with compelling consistency but occasionally had to be reminded of the question. However, when the defense attorney asked her a question, she told him that she had already answered that question and perhaps he should pay closer attention. She had come out of the witness box so that she could make eye contact with the defense attorney. She was scolded by the judge and asked to get back in her seat. She did so, for only a short time. She began chattering about sounds outside the courtroom and asked to go to the bathroom—each of her behaviors clearly demonstrating her diagnosis of ADHD. The judge ruled that she did not meet the competencies required by the court.

The trial proceeded without her; the videotaped interview was shown to the jury. During cross examination and closing statements, the defense attorney criticized the interviewer's conduct in the interview and raised doubt about the credibility of the child abuse program and the skills of the interviewer. The defendant was acquitted.

This example demonstrates that there had been no opportunity to educate the court about the child's disability and how it might affect her ability to testify in court.

Autism Spectrum Disorders

Autism is defined by IDEA as a developmental disability that significantly affects verbal and nonverbal communication and social interaction, was evident by age three, and adversely affects a child's educational performance. IDEA includes a caveat that indicates the term does not apply if the child's educational performance is primarily affected because the child has a serious emotional disturbance. In this section we will address the behavioral aspects of autistic disorder that interfere with social interactions. See chapter 4 for details about difficulties with communication that are associated with autism and chapter 5 for detail about intellectual disabilities.

The diagnostic criteria for autistic disorder relating to a "qualitative impairment in social interaction" must be manifested by at least two of the following:

- Marked impairment in the use of multiple nonverbal behaviors such as eye gaze, facial expression, body postures, and gestures to regulate social interaction
- Failure to develop peer relationships appropriate to developmental level

- A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people by a lack of showing, bringing, or pointing to objects of interest
- A lack of social or emotional reciprocity

Children with autism spectrum disorders display emotions in a variety of ways. When overwhelmed, they may howl or shriek; when frightened, they may hide or run away. It may appear that they have a limited repertoire and range of emotions.

Bipolar Disorders

Pediatric bipolar disorders in children are characterized by rapid cycling between depression and mania. Children also frequently display mixed cycling, that is the existence of both depressive and manic symptoms at the same time. Due to this emotional cycling, these children can exhibit extremely negative and challenging behaviors. They have little insight into the consequences of these negative behaviors.

Though controversial, a diagnosis of bipolar disorder in children must be carefully made in order to determine appropriate treatments to include medications and psychotherapy.

Conduct Disorder

Conduct disorder is a serious disorder that is characterized by aggression to animals and people, bullying, destruction of property, serious violation of rules, lying, stealing, and deceitfulness, often resulting in police involvement. Brain damage, child abuse and neglect, school failure, and exposure to trauma and violence are common precursors to conduct disorder.

There are two types of conduct disorder that are distinguished by age of onset. Childhood onset often is diagnosed after aggressive behavior escalates before age 10. These children, more commonly male, are involved with serious harm to humans, animals, and property; they are likely to develop adult antisocial personality disorder. Adolescent onset conduct disorder is characterized by less aggression than childhood onset. Mild conduct disorder describes behavior that causes relatively minor harm to people or property but involves misbehaviors such as lying, truancy, and breaking rules.

Depression

Depression is a medical condition characterized by feelings of sadness, isolation, hopelessness, pessimism, guilt, and/or worthlessness to the point of interrupting enjoyable activities and interests. Other symptoms include overeating or loss of appetite, fatigue, insomnia, and difficulty with concentration, attention, and decision making. Children with depression may demonstrate mood swings, resist going to school, irritability, aggressive behavior, or feign illness.

Emotional Disturbance

Emotional Disturbance is a category within the Individuals with Disabilities Education Act (IDEA) to describe students whose academic performance is compromised because of social, emotional, and behavioral problems. Emotional Disturbance is not a medical or mental health diagnosis; rather it is an educational label that allows children with a variety of mental health diagnoses to be eligible for special education services. Approximately 7 percent of school-age children receiving special education services do so because of an emotional disturbance. To qualify, a child must have a condition exhibiting one or more of the following characteristics, displayed over a long period of time and to a marked degree that adversely affects a child's educational performance:

- An inability to learn that cannot be explained by intellectual, sensory, or health factors
- An inability to build or maintain satisfactory interpersonal relationships with peers or teachers
- Inappropriate types of behavior or feelings under normal circumstances
- A general pervasive mood of unhappiness or depression
- A tendency to develop physical symptoms or fears associated with personal or school problems

Oppositional Defiant Disorder

Oppositional Defiant Disorder is described as “a pattern of negativistic, hostile, and defiant behavior lasting at least six months” (DSM-IV TR), distinguishing it from the unpleasant but occasional display of normal child behavior. Oppositional Defiant Disorder is most common in boys and presents with symptoms beyond malleable personality traits. Children with Oppositional Defiant Disorder act stubborn, demonstrate outbursts of temper, are argumentative, non-compliant, and refuse to obey—sometimes described as “willfully disobedient.” In addition, children diagnosed with Oppositional Defiant Disorder often blame others for their misbehavior or mistakes. In some children, this disorder co-occurs with ADHD.

Reactive Attachment Disorder

According to the DSM-IV TR, the essential feature of Reactive Attachment Disorder “is markedly disturbed and developmentally inappropriate social relatedness in most contexts that begin before age five years and is associated with grossly pathological care.” It develops when a child is unable to attach to a consistent caregiver in the first few years of life. When a baby cries to express a need and a caregiver meets the need consistently, trust develops. When an infant cries and his or her needs are not met consistently, a child fails to develop a strong attachment to a caregiver, learns that caregivers cannot be trusted, and learns to meet his or her own needs. These children fail to learn to give and receive affection.

There are two types of Reactive Attachment Disorder: inhibited type and disinhibited type. Some children display both types in different settings. Children with inhibited reactive attachment disorder tend to avoid relationships with everyone. They may avoid eye contact,

resist affection, and prefer to play alone. Disinhibited reactive attachment disorder may be manifested by readily going to strangers, seeking comfort from strangers, and displaying needs for help despite being able to do the task by themselves.

ACCOMMODATIONS AND INTERVIEW STRATEGIES FOR CHILDREN WITH SOCIAL AND EMOTIONAL DISABILITIES

The interview approach for children with social and emotional disabilities will depend on the type and extent of the disorder; use of the Demystifying Disability Rubric (Appendix 1) will help identify what difficulties the child experiences and what additional information may be helpful when interviewing the child. A review of the **Demystifying Social and Emotional Disabilities Checklist (Appendix 4)** may provide specific guidance for preparing and conducting the interview.

The Demystifying Disability Rubric:

- Does this child have a disability or difficulty with
 - Speaking, understanding, and using language?
 - Thinking and reasoning?
 - ***Socializing, feeling, and behaving?***
 - Hearing, vision, movement and health?
- How does the disability affect *this* child?
- What strengths or abilities does the child have?
- What else do I need to know about the disability and the child?
 - Are there medical or educational records available for review?
 - Who might be available for a general consultation on this disability?
- How can I structure the setting and the questions for a successful interview?

Once you have identified that a child has difficulty with socializing, feeling and/or behaving, utilize the following information regarding accommodations for children with social and emotional disabilities, so you can prepare for and successfully interview the child.

Social and emotional disabilities affect children's behaviors and the behaviors become the problem. Because social and emotional disabilities are less apparent than other disabilities (physical, communicative, intellectual), caregivers and society often have higher expectations for children with these disabilities. These expectations put children with behavioral difficulties at higher risk for maltreatment. As discussed in Chapter 1, parents and communities may become quickly frustrated with children who have social and emotional behavioral difficulties, increasing the risk for abuse. For this reason, it is especially important for professionals to recognize the risks of maltreatment for these children, and to protect them accordingly. In some cases, the interviewer may be the first professional to recognize that a child may have an

untreated mental illness affecting his or her behavior. Further psychiatric evaluation might be necessary to ensure proper care of the child.

Prior to the interview

Prior to beginning the interview, gather as much information as possible regarding the child's baseline behaviors and whether there have been any changes in his or her behaviors. Ask and consider how the child will react when feeling anxious, as the interview questions may provoke stress and anxiety. Ask about the dosage and timing of medications in order to schedule the interview at the best possible time. Find a location where environmental stimuli are limited. As well, this location should allow enough space for the child to move about the room, yet be secure, so the child cannot run off. Ask the caregiver if the child has had the appropriate medication today.

As a way to anticipate how the child will present during the interview and how you can best make accommodations, ask about his or her behavioral challenges. Do they include?

- Verbal perseverations
- Compulsive behaviors
- Self-abusive behaviors
- Assaultive behaviors (to people or objects)
- Pica behavior (eating nonnutritive substances)
- Sexualized behavior
- Hyperactive behavior
- Oppositional behavior
- Withdrawal
- Sensitivity to environmental stimuli (noises, mirrors, crowded rooms, number of people in one location)

Any of the above-mentioned behaviors require accommodations prior to the interview. For example:

- Schedule the interview at a time of day that is least stressful for the child.
- Anticipate and allow for possible behavioral change when asking questions that may be stressful for the child.
- Consult with the child's mental health provider about what type of supports the child may need, and to what extent he or she will be able to engage in the interview.
- Remove environmental stimuli from the waiting and interview rooms.

During the interview

During an interview, children may exhibit behavioral difficulties for a myriad of reasons other than pathology or diagnosis, such as

- Fears
- Defiance
- Medication mismanagement
- Drug use
- Anxiety about the interview process

The behaviors present as acting out, challenging, or withdrawing, or all simultaneously. Sometimes the source of the behavior is important, such as if the child is over or under medicated, as this can be corrected and the interview can proceed at a later date. Sometimes the source of the behavior can be addressed up front and neutralized, so the interview can proceed as planned. For example, for a child with Reactive Attachment Disorder, it may be difficult to separate from his or her caregiver. If separation is stressful for the child, spend more time with the care provider and child together, or invite the caregiver to transition the child to the evaluation. This may help ease the child's anxieties (and/or the caregiver's anxieties) and reduce stress. A careful review of the rules and structure of the interview process might also calm an anxious child.

In the beginning, spend time on your introduction. Introduce yourself, explain your role, and explain the interview room including what will happen during the interview.

When feeling anxious during the interview, the child may react either by becoming agitated or by withdrawing. Allow space for him or her move about, as kinetic activity may be a way for the child to calm him or herself. Likewise, if he is withdrawing, allow periods of silence to give him space to process his reactions. Take breaks as needed. If the child seems to dissociate, try engaging him in a non-threatening activity like drawing or Play-Doh, and then re-engage him in the discussion. Another approach would be to acknowledge the difficulty for the child in discussing the topic at hand. "It seems like this is hard to talk about."

Allowing space for the child to move, crawl, wiggle, or fidget may be helpful. However, if the behaviors become disruptive, either for the interviewer or the child, setting limits for the child and re-directing those disruptive behaviors may be necessary. For example, the child may be moving under the table, sitting on the floor, climbing on the couch, but remains engaged in the interview process. This behavior needs no redirection. However, if the child then begins dangerously jumping off the furniture, you might redirect him or her by saying "I'm worried you are going to hurt yourself. Come back to the chair so we can talk and be safe." For children whose behaviors are too disruptive, the interviewer may need to use clinical judgment in determining when to suspend or end an interview. Pick your battles; set clear and reasonable boundaries.

Special considerations for children with autism. The social connection interviewers may experience with children with autism may be different from that of typically developing children. Children with ASD are often unable to interpret facial expressions and are

disconnected with affect (his or her own and that of others). The child may not make eye contact with the interviewer, and may ignore an interviewer who attempts to maintain eye contact. **Eye contact should be minimized**, especially if the child is anxious about the social interaction or about the questions posed. Ground rules and structure are generally reassuring for the child, so be sure to discuss the protocol of the interview before beginning. It may be beneficial to give the child a tour of the interview room prior to the evaluation, to set the structure and ease his or her anxiety.

CONCLUSION

Each child with a social and emotional disability is unique in his or her abilities and limitations. The information in this chapter will guide you in understanding the child's disability and in making accommodations to tailor your interview to capitalize on the child's abilities. Best practice would dictate that this information is used in tandem with case consultation through ongoing training and peer review sessions.

INTRODUCTION

The fourth area in the Demystifying Disability Rubric (Appendix 1) deals with conditions directly related to physical functioning—hearing, vision, movement, and health. This area is diverse. It includes broad categories from the Individuals with Disabilities Education Act (IDEA), such as “other health impairments.” Numerous chronic conditions affect children’s performance in school and their ability to participate in an interview. For children with physical disabilities who take medications, side effects of the medications may influence these children’s speech and attention more than the underlying conditions themselves.

Definitions and classifications of physical disabilities vary widely but typically include orthopedic, neuromuscular, cardiovascular, and pulmonary disorders. People with physical disabilities often use assistive devices (e.g., wheelchairs, crutches, canes, artificial limbs) to obtain mobility. Other types of physical disabilities involve difficulties with hearing and seeing. Children with these types of disabilities also use assistive technology such as hearing aids, cochlear implants, eyeglasses, and computer screen readers to decrease the degree of disability. Sometimes children who are deaf will use sign language and a sign interpreter. American Sign Language (ASL) is the most used sign language for the deaf population; however, it is important to realize that children from regions outside the U.S. may use other sign languages. Therefore, the interviewer should obtain a skilled interpreter appropriate to the child’s language.

Physical disabilities may be classified as a congenital condition (present at birth) or an acquired condition—those that result from injury, infection, or trauma after birth. Some physical disabilities are visible when mobility is limited; however, other physical disabilities are “hidden disabilities” and include conditions such as heart disease, respiratory conditions, seizure disorders, or kidney disease. As with other categories of disability, physical impairments can be mild or severe.

Sometimes physical impairments are temporary in nature, such as a broken leg or hip requiring assistance for mobility and rehabilitation but for which normal function will return. This type of condition may be called a short-term disability. The term “physical disabilities” is usually reserved for those conditions that are lifelong and severely impact function and activities of daily living.

Physical disabilities from the Individuals with Disabilities Education Act (IDEA) include deaf-blindness, hearing impairments including deafness, multiple disabilities, orthopedic impairments, other health impairments, and vision impairment and blindness. The focus of this chapter is on physical disabilities that are most likely to present challenges during an interview process.

Deaf-blindness is a combination of hearing and vision loss. Usually a child with deaf-blindness is not totally deaf and blind but the combination and degree of vision and hearing loss results in difficulties with communication, mobility, learning, and adaptive functioning. The hearing and vision losses may often have occurred at different times. For example, a premature baby may develop blindness because the development of the eye was interrupted by the premature birth. Later, the child may develop a hearing loss unrelated to the prematurity. Another child may have been born deaf and later acquired the vision impairment due to an injury to the eye. Fewer than 1 percent of all school children are considered to be deaf-blind.

Hearing impairments including deafness represent a continuum of difficulties with hearing. Hearing impairment is defined by IDEA as “an impairment in hearing, whether permanent or fluctuating, that adversely affects a child’s educational performance.” Deafness is defined as “a hearing impairment that is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification.” (IDEA, 2004) New technologies have created the opportunity for children with hearing impairments to succeed in school. Approximately 1.2 percent of school age children qualify for special education services because of hearing impairments. Please see the information published by the Center for Disease Control and Prevention (CDC) for an overview of hearing loss at www.cdc.gov/ncbddd/dd/ddhi.htm.

Multiple disabilities is the label that describes conditions that result when a child has impairments from more than one of the categories of disability named in IDEA, such as mental retardation-blindness or mental retardation-physical disabilities, causing such severe educational problems that the child cannot be accommodated in a special education program solely for one of the impairments. The term does not include deaf-blindness. Approximately 2.1 percent of all school age children meet the criteria for multiple disabilities under IDEA.

An **orthopedic impairment** as defined by IDEA is one that adversely affects educational performance. The term includes impairments such as amputation, absence of a limb, cerebral palsy, poliomyelitis, and bone tuberculosis. Some orthopedic impairments only affect mobility; by using an adaptive device—wheelchair, brace, or artificial limb—mobility can be significantly improved. Other orthopedic conditions are more complex, involving the bones and neuromuscular systems and difficulty in more than one part of the body. For example, cerebral palsy is a developmental disability that can affect posture and mobility, feeding and speech, and the respiratory musculature. Most children with cerebral palsy, even when mildly affected, are likely to require accommodations so the child may participate in an interview. Approximately 1.1 percent of school age children have an orthopedic impairment.

Other health impairment is a category of disabilities that do not fit definitively into other categories. IDEA defines other health impairments as “having limited strength, vitality, or alertness due to chronic or acute health problems such as a heart condition, rheumatic fever, asthma, hemophilia, and leukemia, which adversely affect educational performance.” Many

chronic conditions contribute to school absence, require medication at school, and limit children's ability to participate in school activities. Of school age children, 8.5 percent qualify for special education services under "other health impairment."

A child with ADHD and symptoms that interfere with school performance may qualify for special education services under "other health impairments." ADHD, as with autism, has features that are covered in the communication (Chapter 4) and behavior (Chapter 6) sections. As with these other complex diagnoses, children with ADHD may be more or less affected by each of the features of the disorder. ADHD is also co-morbid with other disabilities that impair communication and behavior. Please see the information published by the National Dissemination Center for Children with Disabilities (NICHCY) at www.nichcy.org/pubs/factshe/fs19txt.htm for an overview of this complex disorder.

Traumatic brain injury refers to an acquired injury to the brain results from external physical force causing functional disability and/or psychosocial impairment, which adversely affect educational performance. The injury can be an open or closed head injury sustained after birth and does not include injuries that are congenital, related to birth, or degenerative in nature. Traumatic brain injuries often cause difficulties in more than one domain. The IDEA definition includes the following types of impairments: cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual and motor abilities; psychosocial behavior; physical functions; information processing; and speech. Approximately 0.4 percent of children receiving special education services qualify because of having a traumatic brain injury.

Vision impairment and blindness includes difficulties with vision that, even with correction, adversely affects a child's educational performance. The IDEA definition includes both partial sight and blindness. The phrase "impaired vision" defines corrected vision worse than 20/70; "low vision" indicates an inability to read newsprint even with correction. Approximately 0.4 percent of school children qualify for special education under this definition. Children with glasses only fit in this category if the degree of correction is insufficient and additional accommodations are needed. Please see the information published by the Center for Disease Control and Prevention (CDC) for an overview of vision impairment at www.cdc.gov/ncbddd/dd/ddvi.htm.

SELECTED DIAGNOSES AND PRESENTATIONS IN PHYSICAL DISABILITIES

Cerebral Palsy

Cerebral palsy is a group of disorders that affect movement and posture. Cerebral palsy is caused by a brain injury early in life, most often before, during, or soon after birth. The primary insult is in the brain and is static; the degree of impairment does not change over time but

CHAPTER 7: PHYSICAL DISABILITIES: HEARING, VISION, MOVEMENT, AND HEALTH

complications or secondary conditions may result in decreased function over time. Cerebral palsy is classified according to the anatomical location

- Diplegia primarily affects the legs
- Hemiplegia affects the arm and leg on the same side of the body
- Quadriplegia affects all four extremities
- Monoplegia affects only one limb, and is a rare condition
- Triplegia affects three limbs, typically both legs and one arm

Most often, cerebral palsy affects mobility; children with cerebral palsy may require braces or a wheelchair. Cerebral palsy can range from mild to severe. Many children with cerebral palsy learn to walk unaided and can enjoy most activities of childhood. Other children who are affected more seriously may undergo surgery to release tight muscles or correct anatomical abnormalities and/or use medications to reduce spasticity.

When the child with cerebral palsy has inadequate respiratory capacity or neuromuscular impairment affecting speech, augmentative communication devices can aid him or her in communicating. Augmentative communication devices are discussed in Chapter 4. In summary, the communication devices are complex devices and require at least low normal intelligence to learn how to use them. Simplified language boards are also available. In addition, children with cerebral palsy may drool if their motor dysfunction includes difficulties with swallowing, which can be a source of great embarrassment to them, and interferes with speech production.

For an overview of this complex disorder, please see the Fact Sheet published by the Center for Disease Control and prevention (CDC) at www.cdc.gov/ncbddd/dd/documents/CerebralPalsyFactSheet.pdf

Chronic Illness

Conditions such as severe allergies, asthma, seizure disorders, and diabetes may affect a child's performance in school because of frequent absences and interruptions in the school day to manage medications. Chronic illness usually will not affect a child's ability to participate in an interview if medications have been given and symptoms are well controlled.

Sometimes a child takes a medication with side effects that affect speech or attention. Medications for allergies and seizures may cause drowsiness that interferes with attention and comprehension. Several seizure medications may cause slurring of speech when prescribed in higher doses. Children with diabetes may appear disoriented when their medications have not been taken on time or are not well-controlled.

**ACCOMMODATIONS AND INTERVIEW STRATEGIES FOR CHILDREN
WITH PHYSICAL DISABILITIES**

The interview approach for children with physical disabilities will depend on the type and extent of the disability; use of the Demystifying Disability Rubric (Appendix 1) below will help identify what difficulties the child experiences and what additional information may be helpful when interviewing the child. A review of the **Demystifying Physical Disabilities Checklist (Appendix 5)** may provide specific guidance for preparing and conducting the interview.

The Demystifying Disability Rubric

- Does this child have a disability or difficulty with
 - Speaking, understanding, and using language?
 - Thinking and reasoning?
 - Socializing, feeling, and behaving?
 - **Hearing, vision, movement and health?**
- How does the disability affect *this* child?
- What strengths or abilities does the child have?
- What else do I need to know about the disability and the child?
 - Are there medical or educational records available for review?
 - Who might be available for a general consultation on this disability?
- How can I structure the setting and the questions for a successful interview?

Once you have identified that a child has difficulty with hearing, vision, movement, and/or health, refer to the following information regarding accommodations for children with intellectual disabilities, so you can prepare for and successfully interview the child.

In some cases, interviewing children with physical disabilities may be quite challenging, such as those with severe cerebral palsy affecting speech. In other cases, difficulty with communication is not an issue as the physical adaptation is the only necessary accommodation. Barring co-occurring disorders, children with physical disabilities understand and process information similarly to children without physical impairments.

Prior to the interview

To adequately accommodate a child with a physical disability, information about how the child is affected by the disability and what physical accommodations are necessary should be gathered beforehand. Attention must be paid to:

- Arranging transportation and parking
- Physical access to the building and interview room
- Waiting area and bathroom accessibility
- Timing of the appointment (morning vs. afternoon)

Strategies for specific diagnoses

Deaf or hearing impaired. Many people who are deaf or hearing impaired do not see themselves as having a disability; they see themselves as part of a culture with different means of communication. This method of communication depends on when the person acquired hearing loss and the means communication at home and in school. When interviewing a child who is deaf or hearing impaired, gather this information beforehand, so you know what type of communication is preferred. Do not assume that the child has no usable hearing.

Children with hearing impairments will communicate in a variety of ways. Sign language may be the preferred choice, or speaking, or writing. Writing is a useful accommodation when clarification is needed.

American Sign Language and English Sign Language differ, and other countries have their own sign language versions. When using an interpreter during an interview, look directly at the child you are conversing with, not at the interpreter. Be sure you have the child's attention before beginning, and speak slowly and clearly. Do not rely on writing or lip reading. Ask where he or she would like to sit in the room and position the interpreter in a spot where neither you nor the deaf person will have to move to see the interpretation. As with foreign language interpreters, sign language interpreters are valuable in providing a cultural context for words and meanings, as well as accepted communication practices.

Additional strategies:

- Always explain interruptions or odd noises (such as a door slamming or a cell phone)
- Touching the child's arm or shoulder to get his attention is culturally appropriate and acceptable
- Eye contact is essential, as is pantomime and gestures, when appropriate
- Speak in a normal voice; yelling may distort words and interfere with lip reading
- Sit close enough that the child can see you and the interpreter

Visually impaired. Do not assume that the child has no usable vision; many people who are "legally blind" can see shapes, colors, and light. To accommodate for children with visual impairments:

- Ask where he or she would like to sit in the room.
- Do not sit the child directly in front of a light or window; have the primary light source behind the child so he can see you well.
- Use natural or lamp lighting; fluorescent lights can be particularly distressing.
- Announce yourself when you enter or leave the room.
- Always ask before petting a service animal, remember that the animal is not a pet, it is working.

- To guide a child who is blind, let him or her take your arm, not the other way around. Say where you are going and what is in front of you before you get there.
- If possible, have written materials available in other formats, such as Braille, large print, audiotape, or picture.
- Instead of drawing or coloring, Play-Doh can be used for a calming activity for the child.
- When assessing knowledge of prepositions, ask the child to hold an object, such as a pen, to show where the object is (i.e. up, down, in, on, under, or behind).

Cerebral Palsy. As stated in the above section, children with cerebral palsy have affected movement and speech, but their brains function perfectly well (barring any co-occurring disorders). Do not make assumptions about intellectual delays based on the child's involuntary movements or speech affect. Rather,

- Ask where he or she would like to sit in the room.
- Offer water or a snack.
- Allow for movement in the interview room, or at anytime during the interview.
- If using a wheelchair, do not touch the wheelchair or maneuver it without the child's permission.
- Expect emotional dysregulation and quick mood swings, which may be neurocognitive in origin.
- Pay attention to needs for repositioning for comfort and respiratory efficiency.

As communication might be difficult due to speech affect, simply ask the child how he or she likes to communicate. Picture/word boards or augmentative communication devices can aid in communication, but are time consuming and can be exhausting. The child might prefer to talk. Remember, it is your job as the interviewer to accommodate the child, not the other way around.

Chronic conditions. When aware of a child's chronic condition, ask about medications and when the child took the last dose. If possible, arrange the time of the interview to occur between doses. Ask the child or family members if there is anything the interviewer should know about the child's medication and side effects if the interviewer is not familiar with it.

If children have *food or respiratory allergies*, inspect the interview room for possible allergens prior to beginning the interview. For example, if a child has a peanut allergy, check the wastebasket for discarded peanut butter sandwiches or empty peanut snack wrappers. If a child has respiratory allergies, close any open windows. Before offering the child a snack, ask about allergies and check the label for warning about allergy-related ingredients. For the child with asthma, ask the older child or caregiver for a young child, if the inhaler needs to be brought to the interview room.

CONCLUSION

This training aimed to demystify disabilities for professionals who interview children with disabilities about abuse. A huge amount of information has been distilled into four problem areas that can result from almost all disabling conditions: difficulties with communication, intelligence, behavior, and physical functioning.

The one-day training is a “drop in the bucket” of information about disabilities. Do not hesitate to quickly consult a family member, fact sheet, refer to this manual, or call a community expert in disabilities if you are unsure about a child’s condition or how to conduct the interview.

The best advice we can offer is to remember that the child is first and foremost a child. As with all children, he or she has strengths and limitations. Build on the child’s strengths and make accommodations for the things he or she cannot do. The child and family will be grateful.

This rubric is a simple tool for professionals to use when planning an interview with a child who has a disability or difficulty with communication, intelligence, behavior, or physical functioning. **Ask yourself the five questions in the rubric prior to the interview.** For children with complex disabilities, you may have to do some reading and/or research to know best how to conduct the interview. Most times, however, you can approach a child after gathering a minimal amount of information from family members or the child.

- **Does this child have a disability or difficulty with**
 - Speaking, understanding, and using language?
 - Thinking and reasoning?
 - Socializing, feeling, and behaving?
 - Hearing, vision, movement, or health?
- **How does the disability affect *this* child?**
- **What strengths or abilities does the child have?**
- **What else do I need to know about the disability and the child?**
 - Are there medical or educational records available for review?
 - Who might be available for a general consultation on this disability?
- **How can I structure the setting and the questions for a successful interview?**

APPENDIX 2: DEMYSTIFYING *COMMUNICATION* DISABILITIES CHECKLIST

Communication Difficulties with Speaking, Understanding, and Using Language

<i>Speech disorders—Sound production</i>		
Does the child have difficulties with:		
Y	N	Articulation: Pronounces words understandably for age?
Y	N	Fluency: Smooth flow of speech (rate, repetition of sounds)?
Y	N	Voice: Voice quality, pitch, loudness, and resonance?
Y	N	Phonology: Production of speech sounds necessary for speech?
Y	N	Dysarthria: Speech disorder due to paralysis, weakness, or coordination of speech muscles?
Y	N	Apraxia: Difficulty initiating and executing movement patterns for speech?

<i>Language disorders—Use and comprehension of language</i>		
Does the child have difficulties with:		
Y	N	Semantics: The meanings of language?
Y	N	Syntax: Grammatical construction of language?
Y	N	Pragmatics: Social use of language, including conversational skills?
Y	N	Phonological awareness: Knowledge of sound structure of language?
Y	N	Aphasia: Language disorder due to brain damage or disease?

<i>Specific learning disabilities—Learning and using language</i>		
Does the child have difficulties with:		
Y	N	Learning new vocabulary through reading or listening?
Y	N	Understanding or telling the plot of a story?
Y	N	Understanding questions?
Y	N	Following directions?
Y	N	Using filler words such as “um,” “thing,” or “stuff” while searching for correct word?
Y	N	Problems understanding and/or communicating about sequence, order, counting, telling time?

APPENDIX 2: DEMYSTIFYING *COMMUNICATION* DISABILITIES CHECKLIST

Communication Difficulties Associated with Autism and ADHD

Autism		
Does the child:		
Y	N	Have difficulty using words to communicate needs and engage socially with others?
Y	N	Respond with words to the conversation of others?
Y	N	Use non-verbal gestures or sounds instead of words to communicate?
Y	N	Avoid eye contact while communicating?
Y	N	Actively avoid physical contact during communication?
Y	N	Scream, rock, or hide when others try to communicate with him or her?

ADHD		
Does the child:		
Y	N	Struggle with paying attention during conversation or questioning?
Y	N	Fail to filter out most external distractions during conversation?
Y	N	Become hyperfocused on a topic rather than follow the conversational flow?
Y	N	Not know what details are salient or important about a topic?
Y	N	Misunderstand what is being implied in open-ended questions?
Y	N	Converse while fidgeting and moving about at the same time?

If you mark any statements “YES,” you may have to make accommodations in your interview. See suggestions in CHAPTER 4: COMMUNICATION DISABILITIES.

APPENDIX 3: DEMYSTIFYING *INTELLECTUAL* DISABILITIES CHECKLIST

Difficulties with thinking and reasoning		
Does the child:		
Y	N	Behave younger than his or her chronological age?
Y	N	Appear to make decisions without benefit of a systematic way of thinking?
Y	N	Converse in an immature manner?
Y	N	Demonstrate speech patterns of a younger child?
Y	N	Enjoy jokes and topics that seem immature for age?
Y	N	Have difficulty understanding abstract concepts but does well with concrete concepts, i.e., thinks like a younger child?
Y	N	Interpret words and gestures literally?
Y	N	Use less sophisticated problem solving skills than age mates?
Y	N	Have difficulty integrating new knowledge into established problem-solving patterns or behavior patterns?
Y	N	Not perceive danger when danger presents as an abstraction?
Y	N	Present or act “slow”?
Y	N	Have problems in other areas of development in addition to intellectual difficulties?

If you mark any statements “YES,” you may have to make accommodations in your interview. See suggestions in CHAPTER 5: *INTELLECTUAL DISABILITIES*.

APPENDIX 4: DEMYSTIFYING *SOCIAL AND EMOTIONAL* DISABILITIES CHECKLIST

Difficulties with socializing, feeling and behaving		
Does the child:		
Y	N	Engage in conversation with you in an inappropriate way for his or her age?
Y	N	Approach or react to you in a belligerent or aggressive way?
Y	N	Appear sad or unhappy?
Y	N	Act anxious or worried despite your attempt to allay fears?
Y	N	Argue or dispute everything you say?
Y	N	Avoid talking or interacting with you?
Y	N	Seem overly friendly?
Y	N	Resist comfort in frightening situations?
Y	N	Shriek, howl, or recoil in fear rather than respond with words?
Y	N	Have a history of wide mood swings?
Y	N	Behave younger than his or her chronological age?
Y	N	Blurt out responses to questions before you have finished asking the question?
Y	N	Fidget, pace, or seem unable to sit still?

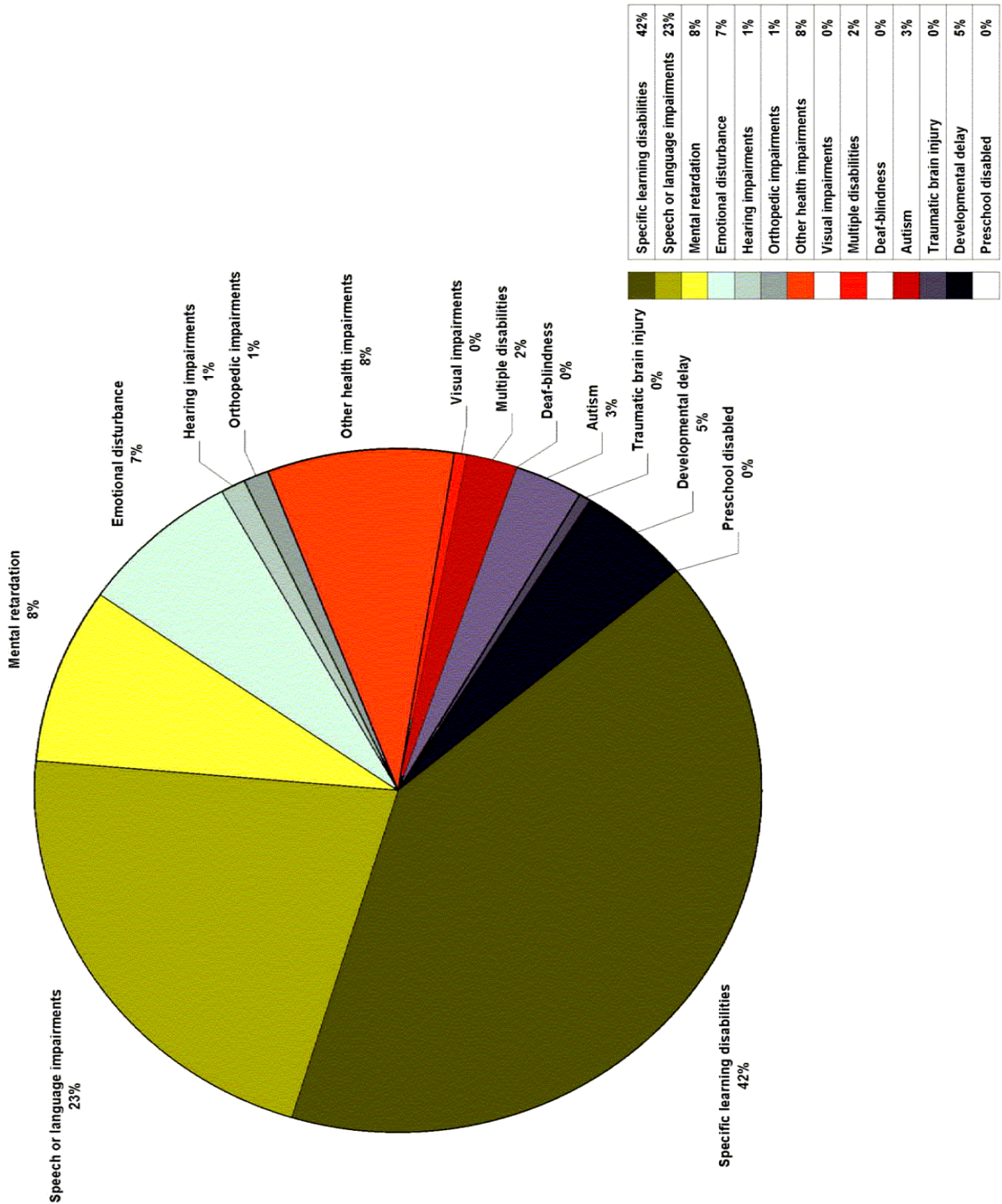
If you mark any statements “YES,” you may have to make accommodations in your interview. See suggestions in CHAPTER 6: *SOCIAL AND EMOTIONAL DISABILITIES*.

APPENDIX 5: DEMYSTIFYING *PHYSICAL* DISABILITIES CHECKLIST

Difficulties in hearing, vision, movement, or health?		
Does the child:		
Y	N	Have poor vision despite correction (glasses or contacts)?
Y	N	Have difficulty hearing normal speech sounds when aware that he or she is being addressed?
Y	N	Use a wheelchair, brace, walker, or crutches to aid in mobility?
Y	N	Walk or move unsteadily?
Y	N	Need assistance with fine motor activities such as writing, buttoning, zipping, and/or opening and closing objects?
Y	N	Have serious food or respiratory allergies?
Y	N	Use an inhaler for asthma?
Y	N	Have anything unusual about the physical appearance that might suggest a disability?
Y	N	Have a history of traumatic brain injury?
Y	N	Wear a Medical Alert watch or bracelet?
Y	N	Have a physical condition related to a communication disorder, intellectual disability, or social-emotional disability? (For example: Autism—gastrointestinal problems, seizure disorders, sleep disorders; Down Syndrome—heart disease, respiratory infection)

If you mark any statements “YES,” you may have to make accommodations in your interview. See suggestions in CHAPTER 7: *PHYSICAL DISABILITIES*.

APPENDIX 6: DISTRIBUTION OF DISABILITIES IN CHILDREN RECEIVING SPECIAL EDUCATION



NATIONAL MODELS

Child Abuse and Children with Disabilities: A New York State Perspective --

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Child Abuse Victims with Disabilities: A Curriculum for Law Enforcement First Responders and Child Protective Services Frontline Workers. Nora Baladarian, PhD; Candace Heisler, JD; Lt. Mike Hertica, LMFT. The Child Abuse and Neglect Disability Outreach (CAN DO) Program of Arc Riverside, California, 2007, notebook and training.

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APPENDIX 7: NATIONAL MODELS AND RESOURCES

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CHAPTER 1: DEFINITIONS, MODELS, LAWS, ABUSE

Centers for Disease Control and Prevention

National Center on Birth Defects and Developmental Disabilities

www.cdc.gov/ncbddd

World Health Organization

International Classification of Functioning, Disability and Health (ICF)

www.who.int/classifications/icf/en

U.S. Department of Justice

Americans with Disabilities Act (ADA)

www.ada.gov

A Guide to Disability Rights Laws : The Rehabilitation Act, Section 504

www.ada.gov/cguide.htm#anchor65610

National Dissemination Center for Children with Disabilities (NICHCY)

The Individuals with Disabilities Education Act (IDEA)

www.nichcy.org/idea.htm

CHAPTER 4: COMMUNICATION DISABILITIES: SPEAKING, UNDERSTANDING, AND USING LANGUAGE

The National Dissemination Center for Children with Disabilities (NICHCY)

Autism Resources

www.nichcy.org/resources/autism.asp

Asperger's Syndrome Resources

www.nichcy.org/resources/asperger.asp

Rett Syndrome Resources

www.nichcy.org/resources/rett.asp

Pervasive Developmental Disorder Not Otherwise Specified

www.nichcy.org/resources/pddnos.asp

Speech and Language Impairments Fact Sheet

www.nichcy.org/pubs/factshe/fs11txt.htm

National Institutes of Health

The National Institute of Deafness and Other Communication Disorders

Apraxia of Speech Fact Sheet

www.nidcd.nih.gov/health/voice/apraxia.htm