



PROMOTING JUSTICE

An Essential Resource Guide
for Responding to Abuse Against Children with Disabilities

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Promoting Justice: An Essential Resource Guide for Responding to Abuse Against Children with Disabilities is expressly indicated for educational purposes. The guide does not provide advice regarding medical, psychiatric, or educational diagnosis or treatment for any individual child and is not meant as legal or clinical advice. The information of this manual is compiled from a variety of sources, including, but not limited to, experiences of SafePlace staff. SafePlace does not endorse any specific agency, organization, product, service, or other resources listed in this manual. Such resources are included for informational purposes only. SafePlace assumes no responsibility for claims, warranties, views, or opinions of any manufacturer, company, services, or individuals listed in the manual.

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INTRODUCTION

Children with disabilities are four times more likely to experience violence than are children without disabilities, and they are less likely to report the abuse and to see their cases prosecuted (World Health Organization, 2012).

We would like to see those statistics change. Cases of abuse against children with disabilities can be successfully investigated and prosecuted, particularly if each stakeholder – first responders, child advocates, law enforcement, and criminal justice staff – works together toward that goal.

You do not need to be an expert on disabilities to work with children with disabilities. You do need to be willing to take extra time if needed, pace your interactions and interviews, remain patient, do your research, and learn from children with disabilities and their supporters.

Like all child victims of abuse, children with disabilities need to be safe, to be believed, to have the abuse acknowledged, to have an opportunity for justice, and to recover and heal.

Promoting Justice was developed to assist multi-disciplinary team members and volunteers who respond to, assess, and investigate suspected abuse and neglect against children with disabilities. This guide includes an overview of the following topics:

- children with disabilities and abuse
- common questions about working with children with disabilities
- trauma-informed responses to children, family members, and care providers
- working with children with disabilities in general and with children with specific disabilities
- resources for working with children with disabilities

While this guide contains helpful tips and information about working with children with a variety of disabilities, the overarching advice from stakeholders who helped to develop this resource is simply put: *Treat a child with disabilities as you would any other child.* Children with disabilities, their families, loved ones, and care providers will guide your approach.

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ABUSE, NEGLECT, AND CHILDREN WITH DISABILITIES

Higher Rates of Abuse and Lower Levels of Reporting

Children with disabilities are at increased risk of abuse and neglect than are children without disabilities, and are less likely to report or see their cases prosecuted. In fact, according to a review by the World Health Organization (2012), children with disabilities are 4 times more likely to experience violence than their peers without disabilities.

Unfortunately, children with disabilities do not disclose as frequently as their peers, and when they do, they delay the disclosure for at least a month after the abuse occurred (Stalker & McArthur, 2010; as cited in Child Welfare Information Gateway, 2012). All children who are victimized have the right to be listened to, cared for medically and emotionally, have their case investigated, and to live free of abuse.

Increased risk for abuse

Children with and without disabilities experience many of the same risks for abuse. The unique risks for abuse experienced by children with disabilities include:

- Perpetrators may believe that children with disabilities are not able to report abuse and are easier to trick, bribe, or coerce.
- Children with disabilities may routinely have their bodies touched without permission, and have difficulty in distinguishing between a hygienic, medical, and abusive touch.
- Children with disabilities have a desire to please, to be accepted, and to have social connections.
- Children with physical disabilities may be less able to escape or defend themselves.
- Children with communication-related disabilities may not be able to report abuse.
- Parents, families, and professionals often lack information on identifying possible signs of abuse/maltreatment.

(Child Welfare Information Gateway, 2012)

Children with disabilities who are abused may face what two stakeholders refer to as a *cascade of injustices*.

- Not recognizing that abuse is wrong
- Not being able to disclose abuse
- Not having disclosure understood or believed
- Not having the abuse reported or 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 therapy appropriate to needs

(Steinberg & Hylton, 1998; as cited in Shelton, Bridenbaugh, Farrenkopf & Kroeger, 2010)

Indicators of Maltreatment

The two primary indicators of abuse are direct reports from the child about abuse and changes in behavior, mood, communication, sleeping patterns, and eating habits. In the cases of some children with disabilities, these changes may be the only indicators of abuse.

Examples of abuse/neglect related to children with disabilities:

- Overmedicated or medications not given at prescribed times or as prescribed by physician
- Lack of or limited access to adaptive aids such as wheelchair, oxygen, hearing aids, walker
- Mismanagement of finances by caregiver or relative

Possible behavioral indicators of abuse of children with disabilities:

- New or detailed interest in or knowledge of sexual matters
- Denies abuse, despite evidence; speaks highly of the caregiver despite apparent abuse/neglect

- Hesitates to speak while others are in the room; exhibits distrust of others
- Exhibits stress-related illness (physical complaints, including headaches or stomach aches)
- Incontinence
- Resistant to taking medication, bathing, eating
- Shows a rapid progression of physical deterioration
- Constant criticism of the caregiver—cursing, hitting, or scratching the caregiver
- Shakes, trembles, or cowers in presence of caregiver/abuser
- Hyper alert, vigilant in watching actions of caregiver/abuser
- Asks to be separated from the caregiver/abuser and/or is resistant to caregiver providing care
- Anxious to please caregiver

What is a Disability?

The diagnosis of disability can be useful, but it is also important to know how the child functions within that diagnosis. Disabilities can impact a child's health and ability to:

- communicate, speak, understand, and use language;
- think, reason, and learn;
- function socially and emotionally within the constraints of cultural norms; and
- use their senses and bodies.

(Adapted in part from Shelton, et al., 2010.)

Speaking of Disability

Disability is only one aspect of a child. How you speak of (and to) a child with disabilities will impact how that child and their supporters respond to you. Your response may also impact how others view the child. When talking about children with disabilities, reference the child first, and reference the disability only if it is relevant. You would say, for example, *child who has cerebral palsy* or *child who has an intellectual disability*. This is known as People First Language.

Exceptions to Person-First Language. Many people who are Deaf and are part of Deaf culture do not consider that they have a disability. In that case, the word Deaf is capitalized and is used first (i.e., Deaf woman). In addition, some people with Autism Spectrum Disorder are starting to identify themselves as an *autistic man* or *autistic woman*. The choice of how to self-identify is always up to the person with the disability. If you are not sure how to refer to a person with a disability, ask.

Laws Protecting Children with Disabilities

Three federal laws protect children with disabilities from discrimination and provide equal rights to services and schooling.

1. The Americans with Disabilities Act (ADA) is a civil rights law (1990, amended in 2008) that prohibits discrimination on the basis of disability in the areas of employment, state and local government, public accommodations, commercial facilities, transportation, and telecommunications.
2. The Rehabilitation Act, Section 504 (1973) requires school districts to provide a free, appropriate public education to children with disabilities who do not qualify under the Individuals with Disabilities Education Act.
3. The Individuals with Disabilities Education ACT (IDEA) (passed in 1975 and reauthorized most recently in 2004) requires public schools to make available to all eligible children with disabilities a free appropriate public education (FAPE) in the least restrictive environment, according to their needs. IDEA established regulations for early intervention programs for children from birth to 2 years and special education and related services for children 3-21.

(Shelton, et al., 2010)

Safety Planning and Children with Disabilities

Useful tips for parents, advocates, caregivers, and other providers to consider when safety planning with children with disabilities:

- **Be proactive in establishing a solid method of communication:** Parents and caregivers may believe that they know what their child needs or wants through years of interactions, but those needs may change. Not having a way to communicate with their primary caregiver can make children more vulnerable to abuse (D. Velasco, personal communication, February 30, 2014).
- **Feelings:** Discuss feelings (e.g., happy, scared, angry, safe, confused) and provide specific examples of situations when people may have these feelings.
- **Touches:** Identify touches that are appropriate (e.g., a goodnight kiss from mom, high fives with friends, medical check-ups) and touches that are not okay (e.g., pulling hair, hitting, slapping, or touching the private parts of others without permission).
- **Safety:** Discuss possible safe ways to respond to hurtful or dangerous situations. Examples include leaving the situation, asking or yelling for help if it is safe to do so, saying No!, and telling trusted adults. Ask children to identify who they trust.
- **Rights:** Talk to children about their rights. Encourage them to make choices and to say no to things that they do not want, so they have some experience saying no, even to authority figures.
- **Secrets:** Talk about fun and special secrets. A surprise birthday party is a fun secret and is okay not to tell. Special secrets – such as an adult touching a child’s genitals and threatening something bad if they tell – are not okay, and a child should tell that secret to a trusted adult.
- **Social behaviors:** Teach children about behaviors that are socially acceptable in public (e.g., shaking hands) versus private places (e.g., changing clothes).
- **School:** Ask the child’s school to provide abuse prevention, sexuality education, and personal safety drills to reinforce these concepts.
- **Outside caregivers:** Encourage children to identify safe people to talk to if they have questions or concerns about their personal care providers. Encourage parents to learn about warning signs of inappropriate behavior between outside caregivers and children. (Examples: Insists on or manages to spend time alone with children, buys children gifts or gives money for no reason, provides personal care beyond what is needed, and/or ignores children’s verbal or nonverbal cues about boundaries [Chicago Children’s Advocacy Center, n.d.])

(SafePlace, 2002)

Common Questions about Working with Children with Disabilities

Question: I do not have much experience working with children with disabilities. How do I increase the possibility of successful prosecution in cases of abuse and/or neglect against a child with a disability?

Suggestions:

- Plan to spend additional time in preparing for and investigating cases of abuse against children with disabilities. Gather as much information about the child as you can from key people in their life.
- Ask the right people. Your best resource will be the child survivor, the non-abusive family members or care providers, and other people who best know the child.
- Know when to get help. After consulting these resources, if you still feel you cannot provide adequate services or advocacy for this child, explore whether or not another staff member can assist or handle the interview (U.S. Department of Justice, 2011).
- Persevere. Cases of abuse against children with disabilities can be won. One prosecutor’s approach for all children has been to observe the original forensic interview and then meet the child so they can just to get to know each other. At the end of the meeting she would

say something like: *I'm in this job where I need to protect kids. I have become aware that something might have happened to you. We don't have to talk about it today...* Half of the kids would open up right then. She would stay in touch with the family or guardian of children who were not ready to talk. She never had a child who refused to talk forever. By the second meeting, most were able to tell her what happened. This approach allows children time and space for feelings and to retrieve the memory of what happened to them.

Question: How can I work with children with disabilities who may not be able to communicate their distress in court in ways that I and the judge understand? How do I work with children with disabilities who are overwhelmed, confused, or can't remember details?

Suggestions:

- All children are liable to become overwhelmed, confused, or forgetful in court. Learn each child's signs of distress in advance by spending time with the child and by asking people who know him/her best.
- Know how each child communicates so you can explain to the judge what type of accommodations might be needed. If prosecutors are convinced that the child would suffer undue psychological or physical harm through their involvement at the hearing or proceeding, they can file a motion and present the request (along with expert testimony) to the judge, who can order closed circuit TV.
- Be patient. It may take a long time for a child with disabilities to get over discomfort and testify in court. One Austin-area assistant district attorney prosecuted a case of abuse against a girl with an intellectual disability. Rather than testifying in court, the girl was allowed to testify on closed circuit TV. Even so, it took her a full 40 minutes to finally gather the courage to say the name of the abuser. (He was found guilty.)
- Prepare the child for what will happen in court. Bring the child to court when it is empty, when only the judge is in the room, and later when court is in session, to show how serious and rule-bound it can be.
- Decide whether to review the original interview. Not all prosecuting attorneys choose to do this, but one way to refresh the child's memory is to have her/him watch their original forensic interview. However, take into account that: a) the defense attorneys will likely ask in court if the child had recently seen the video, and b) watching the interview can re-traumatize the child. Prosecutors must also be careful to not appear as though they are encouraging a child to testify a certain way, but rather to tell the truth at all times. However, sometimes the trial is a year or year and a half later than the original interview and outcry. Having the child watch their own video statement can serve to refresh their memory about what they remembered closer to the time of making the outcry. For some prosecutors, having the child tell the same story can sometimes be worth that challenge from the defense attorney.

Question: How can I increase the odds of proving this child's case beyond reasonable doubt, of showing that the child is reliable and can tell what is real and not real?

Suggestions:

- Understand the child's individual needs. Children with certain disabilities – Autism Spectrum Disorder, communication disorders, and intellectual disabilities, for example – may have difficulty reporting abuse. The abuse itself can lead to anxiety disorders, Post-Traumatic Stress Disorder, and emotional disorders, all of which can impact the ability of children to focus and communicate what happened (Rainville, n.d., p. 6).

- Again, building a case involving a child with disabilities can take more time. Meet with treating therapists, teachers, special educators, interpreters, and child care providers. Document any behavior changes, ways to communicate, or other indications that will help all parties see this child as able to tell the truth and to know the difference between what is real and not real.
- Focus on communication. All children can communicate in some fashion, whether it is through behavior (look for or create documented behavior changes based on input from people living with the child); indicating yes or no to question (shaking or nodding head or tapping a pencil); drawing; showing what happened using anatomically correct dolls; texting; or using a communication device.

Question: How can I work with a child with a disability whose behavior is confusing, who is shutting down or who seems to not want to cooperate?

Suggestions:

- Ask parents, caregivers, family members or teachers to interpret the behaviors. One father of a child with Autism Spectrum Disorder, for example, knows that when his son flaps his hands and spins, he's happy. When he bites his hand, he's bored. He knows that when his son repeats things, he's not being sarcastic – he just doesn't know what to say. Knowing what these behaviors mean can help with the investigation and the interview (J. Roppolo, personal communication, May 24, 2014).
- Refuse to give up easily. It may mean that you keep coming back to visit a particular child, even with a busy schedule or a heavy caseload. The more silent or withdrawn a child is, the more likely it is that something terrible happened, or that trust in adults became eroded over a period of time. Keep showing up with a positive attitude and seeking some kind of common ground, and eventually the child is likely to connect with you. One child advocate worked with a girl with a disability for seven months. The first three visits, she refused to see him. Then she'd see him but sit with her arms closed. He kept showing up until she talked, and once she started talking, she became very communicative (I. Spechler, personal communication, February 4, 2014).

Trauma-Informed Approaches to Children with Disabilities

The Effect of Trauma on Children

Children with disabilities are not only at higher risk for abuse, but they are often socially isolated, set apart, laughed at, bullied, and given fewer choices. For many children with disabilities, these incidents occur on a daily basis and have a serious impact on their physical, emotional, and mental health.

What is trauma? *Trauma happens when any experience stuns us like a bolt out of the blue; it overwhelms us, leaving us altered and disconnected from our bodies. Any coping mechanisms we may have had are undermined, and we feel utterly helpless and hopeless. It is as if our legs are knocked out from under us* (Levine & Kline, 2007, p. 4).

According to the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5), post-traumatic stress or acute stress disorder can result from exposure to actual or threatened death, serious injury, or sexual violence through: direct experience, witnessing in person, learning that such an event occurred to a close friend or relative, and repeated or extreme exposure to aversive details of traumatic events (American Psychiatric Association, 2013).

Essentially, when too much happens too fast, a child's mind and body can perceive any number of situations to be life-threatening to themselves or others; they do not have to be significant losses, accidents, or injuries. According to Peter Levine and M. Kline, (2007) several factors contribute to

a child's experience of shock and terror, and create increased vulnerability to developing traumatic symptoms. In addition to age, a child's developmental level, intellectual understanding, and physical capacity for mobility and self-protection also influence their perception of danger during a moment of stress. For children with disabilities, these dynamics result in increased vulnerability to trauma.

How profoundly a stressful event affects a child depends upon some of the following factors:

- physical age and developmental age; the younger the child, the more likely they are to be overwhelmed because of underdeveloped nervous, motor, and perceptual systems
- child's previous history of traumatic experiences
- child's perception of danger and their experience of freeze/collapse during the dangerous event
- child's perception of successful fight and/or escape in response to the threat
- the number and intensity of traumatic events
- child's closeness to the threat (did it happen to child, family, friends?)
- if and how the child's support system is disrupted by the event
- parents' level of distress and child's interactions with and quality of care from adults before and after the event

(Adapted in part from Chadwick Center for Children and Families, 2013, p. 7; and Levine & Kline, 2007.)

Less obvious events that can add additional trauma to the lives of children with disabilities who have experienced abuse and neglect include *violent acts* (domestic violence, bullying); loss (of a loved one, divorce, abandonment, moves, loss of possessions); *environmental stressors* (natural and manmade disasters, exposure to extremes of temperature and loud noises as infants/young children); *medical and surgical procedures; accidents, falls, and sports injuries; fetal and birth interventions and complication* (fetal distress, exposure to drugs/alcohol in utero, chronic maternal stress, separation from mother at birth, intrusive medical interventions, and/or surgeries for an infant). (Adapted in part from Levine & Kline, 2007.)

The Trauma Response

In a moment of actual and/or perceived danger, a child's or adult's physiology instinctually mobilizes a series of protective and defense responses, and the person's body prepares to actively engage in fight and/or flight. These rapid, involuntary reactions are intended to give a person a physical advantage in the face of stress and lethality. However, there are many instances of threat when it is either impossible or disadvantageous to defend oneself or to flee. When flight or fight (defense) is impossible or perceived to be impossible, a child's nervous system automatically engages a shutdown, freeze/collapse response (Levine & Kline, 2007). This freeze response is often the only survival option for infants and children due to their age, size, and phase of development. For children with disabilities, the immediate need to engage the freeze response may be even more likely depending on the nature of an individual child's perceptions and their capacity for mobilization. This experience of freeze and immobility during the traumatic event leaves all children and adults more vulnerable to experiencing symptoms of post-traumatic stress (Levine & Kline, 2007).

Initial signs of traumatic stress present differently in children versus adults due to a child's *brain development, level of reasoning and perceptual development, incomplete personality formation and dependency, restricted motor and language skills, and their attachment to adult caregivers* (Levine & Kline, 2007, p. 40). Core symptoms may initially arise in children (based on age group) in the following ways:

Early childhood

- Altered sleep patterns and activity levels, feeding difficulties, decreased capacity for being soothed by caregivers, developmental delays and/or regressions, disrupted attachment, elevated separation anxiety, exaggerated emotional responses of fear and anger, re-enactment of traumatic events through play, nightmares, aggression toward caregivers and/or peers, inability to focus and concentrate, somatic complaints and physical constriction, appearing withdrawn/zoned out

School-age children

- Patterns similar to early childhood with additional complexity: Persistent worry and thoughts about what happened, about their responses to the experience, and about their future safety, related to how the events impacted others; feelings of self-blame and shame; thoughts of revenge toward those involved in the event; emerging struggles at school, such as difficulty sustaining attention/focus and displaying aggression; and defiant behaviors with peers and/or adults

Adolescents

- Symptom clusters much like adults: Flashbacks, patterns of anxiety and/or depression, avoidance of reminders of the trauma, attempts to numb out through drugs/alcohol/thrill seeking/sex, difficulties at school related to relationship interactions and youth's capacity to stay focused on learning, sudden changes in behaviors/appearance/interest in activities

(Above section adapted in part from Chadwick Center for Children and Families, 2013; and Levine & Kline, 2007.)

Prolonged Exposure to Traumatic States

Prolonged struggles and symptoms of post-traumatic stress can be avoided when children receive immediate support from trauma-informed parents and professionals.

Some children do not get that support. Fight/flight/freeze responses are intended to be temporary and are designed to support a child's physiology in immediate threat. However, the nervous system of a traumatized child may stay locked in a state of high alert, especially if the traumatic stress was significantly intense, prolonged, or chronic. The child then remains in a continual physiological pattern of fight, flight, freeze/collapse, or any combination of the three. When children are locked in a past survival stance, it can be easy to misunderstand or misdiagnose their presenting behaviors, emotions, and cognitions. From an outsider's perspective, the child's present day experience can "appear" to be safe. However, a child stuck in this traumatized state then loses their capacity to regulate their internal states and may experience intense terror, helplessness, hopelessness, and loss of control (Levine & Kline, 2007). Immediate and delayed trauma symptoms may include:

Hyper-arousal

- panic attacks, anxiety, phobias, flashbacks
- exaggerated startle and emotional response; extreme sensitivity to light and sound
- hyperactivity, restlessness; nightmares and night terrors
- avoidance behaviors, clinging
- increased risk-taking behaviors
- frequent crying and irritability; abrupt mood swings (e.g. rage reactions and temper tantrums)
- in young children, regressive behaviors, such as wanting a bottle, bedwetting, using fewer words

Dissociation

- distractibility and inattentiveness
- amnesia and forgetfulness
- reduced ability to organize and plan
- feelings of isolation and detachment
- muted or diminished emotional responses, making it difficult to bond with others
- easily and frequently stressed out
- excessive shyness with time spent in an imaginary world

Constriction, Freeze, and Immobility

- headaches, stomachaches, asthma
- helplessness, shame, and guilt
- bed-wetting and soiling

- clinginess/regression to younger behaviors
- low energy/fatigues easily
- repetitive play
- diminished curiosity and capacity for pleasure

(Above sections adapted from Levine & Kline, 2007, pp. 75, 77 & 78.)

Working with Children with Disabilities Experiencing Traumatic Stress

Trauma is pervasive, and trauma symptoms often complicate children's accurate assessment and treatment. The historic service provider focus on children with emotional or mental health disabilities has been on eradicating *problem behaviors*. Behaviors labeled as *noncompliance* or *acting out* were often related to ongoing experiences of trauma. A child who perceives grave danger and is in flight or fight mode is not going to be able to respond rationally at that moment (adapted from Harvey, 2012).

Chronic trauma also impacts the brain development of children. Troubling and difficult behaviors shown by children in the child welfare system are often directly related to brain functioning. Youth who have a high number of child welfare system placements are particularly at risk for traumatic stress, as a result of continued rejections and lack of predictability (Chadwick Center for Children and Families, 2013).

Key questions and needs of children exposed to trauma:¹

1. Will I be safe here, physically and emotionally? (Safety first)
2. Can I believe in you to tell me the truth and be honest? (Trustworthiness)
3. Will I be able to make decisions? (Choice)
4. Will you tell me what to do or will you work with me? (Collaboration)
5. Will you support me to find and use my voice? (Empowerment)

(Harris & Fallot, 2001)

Talking to Children in Distress

Children who have experienced trauma are very often finely attuned to sensing stress and anxiety within others. Our stress can increase the child's stress, making it even more difficult to establish trust and safety within our interactions. The great news is that the opposite is also true. Our calmness and ease can support the child in finding greater comfort and safety. Therefore, a key component of being a trauma-informed professional is gaining awareness of our own stress patterns and then finding effective ways to ground ourselves when we are significantly impacted (triggered). This often includes seeking support around our own needs for safety, self-care and external validation.

Basic principles to keep in mind when supporting children in distress:

- Repeatedly check in and assess your own level of calmness/anxiety/stress.
- If you identify signs of distress/constriction/dissociation within yourself, actively ground and stabilize your body and nervous system.
- Be mindful of your size, posture, and physical orientation to the child.
- Keep your voice calm and low, and notice how your eye contact, facial expressions, tone of voice, timing/intensity of verbalizations, and gestures impact the child.
- Be attuned to the child's needs during times of stress and transition.

(Levine & Kline, 2007; and James, 1996)

¹ **Note:** Each need is derived from the five values of trauma-informed cultures of care. The five values are safety, trust, choice, collaboration, and empowerment (Harris & Fallot, 2001).

Grounding Exercises

Grounding is a mindfulness and body-based practice that helps us to be more attuned to the present moment. When we are more fully mindful of what is happening moment to moment, we are able to create greater stability within our nervous system. We feel a greater sense of safety, emotional containment, and appropriate control when we are grounded.

Quick tips for taking a *Time In* to find your ground:

- Bring your focus to your body and your present/immediate experience
- Feel your:
 - > FEET (*on the ground...*)
 - > SEAT (*on the chair...*)
 - > BACK (*against the back of the chair...*)
 - > HANDS (*wherever they might be resting...*)
- Check your breath...take a few deep breaths
- Take some time to look around...
 - > Find something pleasing to look at to orient you to the present and increase your sense of safety in the moment.

(Kline & Downing, 2012, as cited in Mastroleo & Schwartz, 2013)

Working with Family Members and Caregivers

Trauma-Informed Approaches

Parents and caregivers of children with disabilities face many social and service barriers:

- social prejudice, dismissal or shame against children and people with disabilities
- abusive parent blaming the other parent for the child's disability
- juggling parent's need to keep working to maintain health insurance for child
- using up all of allotted time off taking care of child's medical or other needs
- the needs of other children in the family
- financial stress from medical bills; transportation issues
- not knowing how to handle the overwhelming behavioral or emotional aspects of complex disabilities; along with lack of time, energy, and social supports

When you approach the family of a child who has been reported to be abused or neglected, unless there is a clear injury or abuse, find out more about the child and the family. Talk to the child's teacher, doctor, and others. Remember that what is immediately evident may not be the whole picture. Sometimes the family needs additional support and resources to help take care of a child (D. Velasco, personal communication, March 12, 2014). However, the child's need for care can never be justification for abuse.

When working with family and caregivers:

- Be flexible with appointments and time – family members are likely to be already negotiating with multiple systems.
- Provide information about the impacts of abuse on the family and child, along with links to trauma-informed counseling and support services.
- Provide as much support and resources as you can.
- Instill hope for recovery for child/family.
- Focus on establishing safety, trustworthiness, choice, collaboration, and empowerment.
- Without compromising the investigation, give as much choice and control over the environment as possible to the non-abusive parent. Trauma victims (primary or secondary victims) lose power all over again during traumatic events, which can bring up strong emotions and seemingly irrational actions and thoughts (Chadwick Center for Children and Families, 2013).

What Parents Need to Know

Taking the time to address the following common concerns and questions can reassure and engage non-abusive parents, family members, and/or caregivers. This reassurance can also support your interactions with the child victim.

1. Will you take good care of my child?
2. Will my child be safe and her/his needs considered?
3. How long will this interview, visit, or process last?
4. What are the possible outcomes?
5. Who can I talk with at your organization?
6. What do I do with the knowledge that my child is or may be a victim of abuse?
7. Are you telling me the truth?
8. What happens next? What can I do to support my child's recovery?²
9. What can I do to recover?

How Parents and Caregivers Can Help

Parents and other family members and caregivers usually know the child best. They know what works and what does not work, and what can calm or distress/aggravate a child. Important individuals in a child's life can provide information to investigators, child advocates, and others to increase the chances for successful interactions with the child with disabilities. *Practical questions to consider asking a parent, family member or caregiver about a child's disability-related needs can be found in Appendix A.*

Planning for Lives in Transition

Creating a transition plan for children who have been removed from their homes will help keep the best interest of the child and family at the forefront when there is a change of placement or an abusive incident. Transition plans provide concrete information about frequency of visits, locations, and phone contact. It eliminates confusion, helps assure safety, and gives everyone some order to confusing events/situations. Transition plans can also be altered during investigations and assessments (E. Parsons, personal communication, August 14, 2014). *For additional information about how to work with children in transition, see: <http://www.advokids.org/childhood-mental-health/transitions>*

Cultural Considerations

Cultural identity ... influences how the child and family experiences and interprets traumatic events. Culture also impacts how the child and families heal after trauma and loss (Chadwick Center for Children and Families, 2013, p. 28).

Cultural influences are much deeper and broader than the color of people's skin. Culture does include ethnicity and race, but it also includes spirituality, where people grew up, who they spend time with, politics, age, income, education, rituals, customs, and disability status.

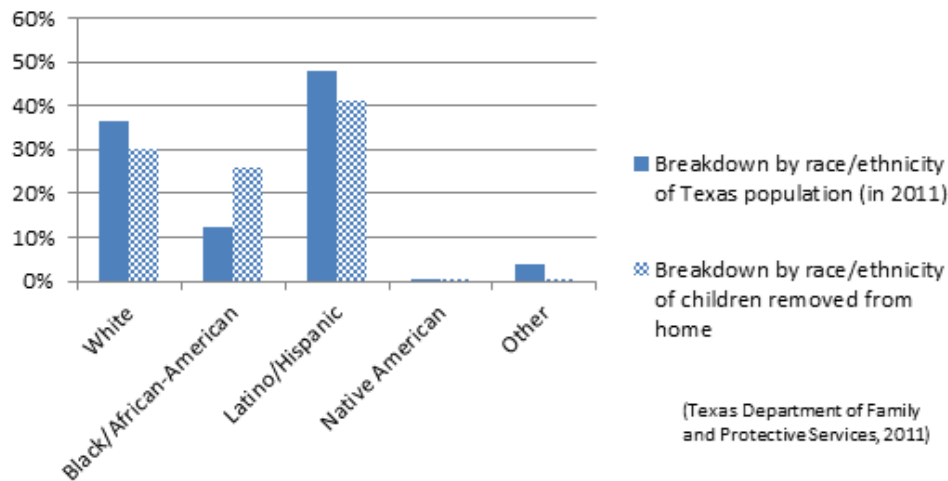
Consider how these factors might affect a family's reaction to professionals who work with abused and neglected children:

- Nationally, Black/African-American children are three times more likely to be in foster care when compared to Caucasian children, and stay in foster care for an average of nine months longer (McRoy, 2008, as cited in Chadwick Center for Children and Families, 2013, p. 29).

²(R. Alexander, personal communication, based on teachings by Jeff Garrison-Tate with The Center on Disability and Development at Texas A&M University.)

- Children from minority cultures do not recover from traumatic experiences as quickly as children who are from the majority culture. They are more likely to experience more severe symptoms for longer periods of time (Norris & Alegria, 2005, as cited in Ko, 2005, p. 1).
- In some cultures, the male child is seen as the most valuable offspring because he will be the family breadwinner. If a female sibling reports abuse against the son, it is the victim who may be seen as disloyal to the family (D. Velasco, personal communication, July 17, 2014).

Texas Children Removed from Home by Race/Ethnicity



Grief, Shame, Guilt, and Responsibility

In some cultures, families experience great shame about having a child with a disability. During an abuse investigation, these families may seem evasive or act guilty. Families from these cultures may have hidden away the child with a disability and even kept their child out of school (Shelton, et al., 2010, p. 5).

Conversely, other cultures are so family oriented and believe so strongly in taking care of “their own” that they may have difficulty with the concept of children and youth with disabilities being supported to live as independently as possible. The social push toward independence may not work for families of those cultures (D. Velasco, personal communication, July 17, 2014).

First Steps in Becoming More Culturally Sensitive and Aware

We can increase our awareness and understandings of the impact of culture in the following ways:

- Seek to understand the child and family’s experience of trauma and abuse through the lens of their cultural beliefs and values.
- Gain understanding of how our own cultural background impacts our perceptions and responses.
- Recognize that the family is the expert on its member’s needs and priorities.
- Include non-abusive family members in the decision-making process.

(Adapted in part from Arpaia, 2014; and Regional Research Institute for Human Services, 2003, as cited in Chadwick Center for Children and Families, 2013, p. 28.)

GENERAL TIPS

INTERACTING WITH CHILDREN WITH DISABILITIES

Children with disabilities are first and foremost children. It is not necessary to be an expert in all types of disabilities to work with children with disabilities.

Sources of information about children with disabilities include non-abusive parents and family members; teachers; doctors; occupational, physical or speech therapist; counselors; friends; or others.

First Response/First Contact

First contacts with children with disabilities set the stage for the investigation and can help determine how the case is resolved (Office for Victims of Crime, 2009).

Trauma-informed responses in high tension situations:

- Do everything you can to create a sense of the immediate safety for the child.
- Reduce noise. Children may be re-traumatized by loud voices, radios, beepers, phones, and other noises.
- Remove the child from the presence of an angry and out-of-control parent or caregiver as soon as possible.
- Wait to ask detailed questions until the child can be interviewed in a neutral setting.
- Explain what is going on and what will happen next in age-appropriate ways.
- Ask the child what they are worried about and what might make them feel safer. Try to follow through as much as possible.
- Answer any questions the child may have.
- Ask the parents or caregiver to reassure the child that they are safe and that the investigators are there to help.
- Treat the parent or caregiver with respect, even if the parent is being aggressive or hostile.

(Adapted from Chadwick Center for Children and Families, 2013.)

General tips for interacting with children with disabilities:

- Identify safe people who can inform you about the child – preferably someone the child has a relationship with and trusts.
- Be prepared to slow down the process and expect to spend more time.
- React to this child as you would any child. Speak plain English (or the child's original language) in your typical voice and at your normal pitch and volume.
- Address the child directly.
- Stay at eye level; some children with disabilities need a clear view of your face.
- Maintain your usual eye contact, unless it distresses the child. Do not force eye contact.
- Be aware that some children with disabilities have a sensitivity to or can be triggered by touch.
- If communication is a significant barrier, consider bringing in someone who is not the alleged abuser who knows and can communicate with the child. However, parents and others may intentionally or unintentionally influence what the child has to say.
- During times of high stress, distress will escalate. It may be difficult to follow conversations or speak. Some children will seem withdrawn, others may have involuntary movements or aggressive or frightened behaviors. You may need to ask the non-abusive parent how you can help children feel safer and calmer.
- Do not proceed with the field interview if the child seems too emotionally distraught or significantly distracted; does not have adequate language development to communicate; or lacks necessary communication aides – an interpreter, communication board, or device.

(Adapted in part from Office for Victims of Crime, 2009; and Shelton, et al., 2010.)

If the child has to be removed from the home:

- When possible, ask the non-abusive parent what workers might do to make this child feel safe in a new or foster care setting.
- Ask about how the child best communicates, how the child's disability affects the child's daily functioning, disability-related routines, and about adaptive aids or tips for working with the child when she/he is distressed.
- Ask about bedtime rituals and morning routines; food likes, dislikes and allergies; nicknames, favorite TV programs or other routines; and how to help child cope with stress.
- Ask if the child can take a family photo, a favorite toy, stuffed animal, doll, blanket, or book.
- Explain to the child what is happening in an age-appropriate way.
- Explain that it is normal to feel confused and scared.
- Give information, if possible, about where the child is going; who they will be staying with; what will happen with school; and what is happening with siblings, parents, pets, and relatives.
- Repeat the information several times (or as needed), and give the child information and/or a phone number of someone they can call, such as a case manager.
- Give the child as much age-appropriate control and choice as possible. Ask what will help them sleep better and what they want to take from the house, such as a stuffed animal, favorite toy, or book.

(Adapted from Chadwick Center for Children and Families, 2013.)

Family and caregivers:

- Family members and caregivers may try to interpret for or intervene in your interactions with the child. If this continues, you may have to delay talking to the child until they are in a neutral setting, such as the hospital, police station or children's shelter.
- If the child lives in a group home or other congregate setting, residential staff may also interfere with your attempts to communicate with the child. Let the staff know that direct communication is in the child's best interest. If necessary, speak to a supervisor.
- In further interactions, limit conversations with care providers and other household members to getting information about the crime and possible accommodations for the child.

(Adapted from Office for Victims of Crime, 2009.)

Developing a Disability-based Investigative Process

In Vermont, an 8-year-old girl with a communication disability drew pictures in the sawdust in the barn while her uncle worked nearby. When her uncle saw that she had drawn pictures of 11 different abusers in the act of sexual abuse, he called the police. During the first meeting, once the topic turned to abuse, the child hid under the coffee table.

Staff of the county law enforcement and Department of Children and Families persisted, because they knew that of the 11 people she accused of abuse, 9 had histories of sexual abuse with children.

During the second meeting, the detective asked her to talk about just one person who hurt her. She picked one. *What about X do you want to talk about?* he asked. She began to speak, but as she told about the abuse, she lost her words. The detective gave her a pen and paper, and she wrote answers. When it came to questions about the act of penetration, the young girl could not speak, and just put her head down on the table. She was, however, able to demonstrate what the abuser did with her hands, a pen, and a pencil.

Criminal justice staff were concerned about a mistrial if the girl could not speak during cross examination. To address this concern, the investigators gave her 50 cue cards with phrases such as *I don't know, yes, no, I don't remember, numbers 1-20, it hurt, it tickled, it felt good*; the names of everybody she knew (including the 11 abusers); and body parts.

The abuser pled guilty and died in prison.

The county went on to develop an investigation practice that was effective in working with children with disabilities. Today, well over 50% of their sexual assault investigations involve children with disabilities.

(Adapted from Rainville, n.d.)

Preparing for Interaction/Interview

Only conduct an in-depth interview after child victims of sexual assault or other trauma have completed two sleep cycles, eaten, and received any other needed support. Return mobility devices being used as evidence as quickly as possible or provide a replacement.

Learn as much as you can about the child. Learning how the child functions will be more immediately useful than the disability diagnosis. To support your interview and investigation of abuse, gather the following information from records and by talking to people who know the child best.

Seek Out People Who See the Child Frequently

Contact therapists and teachers involved with the child. They can quickly tell you about the family participation; dynamics they observe between the child and caregiver at school; and the care given to the child – does she/he come to school clean, groomed, with the medications and other items needed for care? They can also provide information about how to best work and communicate with the child.

If these professionals and paraprofessionals do not know much about the child with disabilities, it may be because their contact is limited by the caregiver. The caregiver may continuously cancel appointments or keep the child out of school.

(D. Velasco, personal communication, July 22, 2014.)

Educational, medical, and psychological/psychiatric records may include:

- child's Individual Education Plan (IEP), Individual Transition Plan (ITP) and other school records
- history of prior interviews about the abuse, and the child's developmental stage and abilities
- photographs from the child's home, if pertinent

Ask teachers, therapist, speech therapist, physical therapist, parent, caregiver or others:

- how the child best communicates;
- what medications the child takes (and when) and how they impact the child;
- if discussions about the abuse have taken place in the child's presence;
- child's name for caregivers and body parts; and
- daily care routines and child's schedule and routine, including resting, getting up, exercising, eating, going to bed, even toileting. Include times and dates of favorite television shows, regular movie watching time, unusual activities, regular activities.

Communication needs:

- Find out what the child needs for communication and set up those resources before you conduct an interview. This may include American Sign Language interpreters, communication boards, software, or other communication devices.
- If the child has a complex communication disability and you are uncomfortable with your ability to understand, seek a speech-language therapist, interpreter, or another person who can interpret for the child. (Your local interpreter service might be able to assist you.) Contact Deaf Network of Texas to identify interpreter services in your area.

Note: For additional questions that can be useful in learning more about a particular child, see Appendix A.

A child who has been abused may need to visit your agency ahead of the time of the interview to get familiar with the environment. If multiple interviews are needed, ask people in contact with the child not to ask about the abuse or speak about it when the child is nearby.

(The above sections adapted in part from the U.S. Department of Justice, 2011; and Shelton, et al., 2010.)

Conduct the interview in a physical space that:

- has minimal distractions, including noise, light, interruptions, clutter, public address systems, and people coming in and out of the room;
- is private, so that passers by cannot see into the room or hear what is said;
- has room for 2-3 interpreters (if needed) to be positioned for the video camera;
- has adequate space, accessible bathrooms and doors, and elevators for children who use wheelchairs; and
- is well lit (particularly for Deaf children and children with visual disabilities).

Materials:

- Have materials available for alternate communication, such as drawing papers, pencil, anatomically correct dolls, and drawings of the human body.
- Also have materials available for children who are tactile and like to touch things, such as stress balls and Play-doh.

(Adapted in part from U.S. Department of Justice, 2011.)

Examine Your Own Perceptions

It is not uncommon for people who have no experience in the company of adults and children with disabilities to be embarrassed or ashamed; to not know what to say or how to act; and to feel pity, fear, dread, or even revulsion. Examine whatever myths and stereotypes you may believe, which can get in the way of your interaction. If you are unable to work through your own discomfort, find someone else on staff to lead while you become more familiar with children with disabilities.

(Adapted in part from Hoffman-Rosenfeld, 2004.)

During Interaction/Interview/Investigation

As with many child victims, children with disabilities may say what they think you want to hear. While generally parents and other caregivers are not allowed to be in the room during the forensic interview, if you cannot understand the child, the non-abusive parent might be able and willing to help with communication. Be cautious that the parent is not colluding with the abuser or influencing the child's story. Do not use parents or other caregivers to provide American Sign Language interpreting for children.

If the child is in too much distress about not being with the parent or caregiver, slow down the process. Consider allowing the parent/caregiver in the room for a few minutes of chatting. In some cases, this may be the only thing that happens during a first meeting.

Arrange seating so the child has a clear, visible path to the door.

Building Rapport:

Tips and strategies during rapport-building specific to children with disabilities:

- Arrange for both you and the child to be seated in a well-lit area.
- Reassure children with disabilities that they are not in trouble.
- Discuss truth and lies and try to establish the child's understanding of both.
- Observe the child's use of language, ability to understand and respond to questions, attention span and understanding, and reactions to specific topics.
- Assess the child's communication abilities by asking to write/spell name, sing the ABCs, give birthday date, name colors.
- Tailor questions and approach to the child's developmental stage.

(Adapted in part from Hoffman-Rosenfeld, 2004 and National Children's Advocacy Center, n.d.)

Communication:

- Reassure the child that it is okay to ask your questions, and then answer them as truthfully as possible.
- Provide the child time for thinking and responding.
- Ask the child to tell you if they do not understand.
- Resist speaking for the child.
- Do not baby children; seek to match the child's vocabulary, syntax, and grammar.
- If you are having difficulty, attempt multiple means of communication: speaking, writing, drawing, indication of yes/no.
- Ask short, simple questions in plain language. Use one idea per sentence.
- If needed, say you are confused or having trouble understanding today, and ask child to repeat.
- Children with some disabilities may be more concrete and have difficulties with abstract thinking, so use concrete phrases and avoid metaphors.
- Children with some disabilities may lack the vocabulary to describe sexual abuse. Use their words for body parts, and clarify what they mean when they describe an action.
- Make sure you and the child have the same meaning for words like rape, genitals, and other words.
- Use proper names for people, locations, and things to avoid confusion.
- If the child is repeating everything being said, be patient and try to reduce the child's anxiety.
- If the child focuses on a topic unrelated to the discussion, redirect.

Questions:

- Some children with disabilities may not be able to answer questions that start with *why*, *how*, and *if*. They may better answer questions that start with *who*, *what*, *where*, and *when*.
- Some children do not know days of the week or how to tell time. Use the child's routine to help set the time and day. Examples: *Tell me what happened after you came home from school. Tell me what happened before you went to physical therapy.*

- Open-ended questions can provide the most valid information, but children have to remember what happened and in what sequence. One strategy can be to use focused open-ended questions: *Tell me what happened on Friday*, or *Tell me what happened after school*.
- An additional strategy is to break down open-ended questions with specific questions, multiple-choice questions or either/or questions. Instead of asking, *What did you do in school?* Ask, *What did you do at recess? Did you go outside or play in the gym?*
- Using pictures for multiple choice questions can be effective for some children who do not read or have difficulty with memory.
- Some children will only be able to answer *yes/no* questions, by saying yes or no, by tapping a pencil yes, by giving a thumbs up/down for yes or no. Yes/no questions are useful for children with limited communication, intellectual disabilities, or speech that is difficult to understand. This method can be considered leading, so follow up with yes-no responses for accuracy.

(This section adapted in part from U.S. Department of Justice, 2011; Shelton, et al., 2010; Hoffman-Rosenfeld, 2004; National Children's Advocacy Center, n.d.; Modell, n.d.; and D. Velasco, personal communication, July 17, 2014.)

Interpreting Behavior:

Questions professionals might ask themselves when a child seems to be trying to communicate through their behavior:

1. Is this child showing signs of distress? (Such as withdrawing, distracting, fidgeting, humming, groaning, rocking, tapping.)
2. Is there something about this environment that may be distressing or upsetting?
3. What is happening at this time that may be distressing or upsetting?
4. Are things changing or moving too fast?
5. Could this interview/interaction take place across several sessions?
6. Does this child need some form of comfort? What has the care provider suggested?
7. How am I evaluating/interpreting this child's behavior?
8. Does this child need to take a sensory break every so often by doing some of the following things (e.g., rocking, spinning, chewing something crunchy, holding a weighted blanket).

If the child's distress is increasing, offer a break. Say: *Let's take a break* or *Would you like to take a break?*

Report Writing

What you write in the report will also influence what happens with this child's case. Tips:

- Write objectively. Use respectful language.
- Avoid language about that child that is demeaning, such as *wheelchair bound*, *can only grunt*, *suffers from cerebral palsy*. Instead, use respectful language that refers to the child first and the disability second. Examples: *the child communicates nonverbally*, *the child has cerebral palsy*, *the child uses a wheelchair*.
- Write what you observed about the child without making interpretations: *Child's wheelchair was broken*, *Child communicated yes and no by blinking eyes*, *Family members said child has been diagnosed with Autism Spectrum Disorder*.
- Document any information in reports about the child's disability, as well as any accommodations needed, and what responses were most and least helpful.

(Adapted from Office for Victims of Crime, 2009; and Shelton, et al., 2010.)

Investigation/Trial Preparation

- If possible, obtain the child's school, counseling, Early Childhood Intervention and medical records that might document any changes in behavior, mental health, or symptoms of distress.
- Explore child's pre-assault behavior, violent incident, and post-assault behavior.

- Explore the history of the alleged perpetrator and of the abuse, including:
 - > The perpetrator's use of isolation, manipulation, threatening or grooming behavior, forced compliance.
 - > Include behaviors and statements that indicate the child cried, closed eyes, squeezed legs together or was still throughout the assault/abuse. Document how the child said no.
- In one case, investigators could prove that the onset of Post-Traumatic Stress Syndrome symptoms began shortly after the girl disclosed sexual assault. In another, a child who had been raped when she was 10 suddenly refused to sit beside boys at that age. This evidence can be critical in convincing a jury (Rainville, n.d.).
- Use disability experts in jury trials, such as: physical, speech, and occupational therapists; and classroom and special education teachers to explain the child's disability(ies) and how it (they) affected their ability to report the assaults.
- Ask for or contract for an assessment of the child's developmental status, including cognitive, linguistic, gross and fine motor, emotional, and social skills, along with a full medical history (Chadwick Center for Children and Families, 2013).
- While returning to the field or scene of the crime is generally considered too distressing for the child, sometimes a child may request to return to where the abuse happened, to help show what happened and where.
- If the child is unable to verbally articulate what happened, his/her written word can be powerful trial evidence.

(Adapted from Rainville, n.d.; Chadwick Center for Children and Families, 2013; Illinois Family Violence Coordinating Council, n.d.; and U.S. Department of Justice, 2011.)

NEURODEVELOPMENTAL DISABILITIES

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (A-D/HD)

Attention-Deficit/Hyperactivity Disorder (A-D/HD) primary characteristics are patterns of inattention, hyperactivity, and impulsivity that are inconsistent with the child's developmental level and negatively impacts social and academic activities. Children with this disability may have difficulties with school performance, social acceptance, and family interactions. The patterns are persistent and interfere with functioning and/or development.

The child can have 1-3 of these areas of difficulty. They may be:

1. Only unable to pay attention (inattentive).
2. Hyperactive and impulsive, but able to pay attention.
3. Inattentive, hyperactive and impulsive (the most common form of A-D/HD).

(American Psychiatric Association, 2013)

What You Might Notice

Children with **Inattention** may:

- not seem to listen when spoken to directly
- have difficulty paying close attention to details
- have difficulty organizing tasks and activities
- avoid, dislike, or be reluctant to engage in tasks that require sustained mental effort
- be easily distracted by external stimuli; be forgetful

Children with **Hyperactivity** may often:

- fidget and squirm; leave their seats when sitting quietly is expected
- move around constantly, run or climb in situations where inappropriate
- feel restless and talk excessively, not be able to play or do activities quietly
- be "on the go," as if driven by a motor

Children with **Impulsivity** may:

- act without thinking
- say the wrong thing at the wrong time
- often interrupt or intrude on other people's conversations or games
- guess, rather than taking time to solve a problem

Executive functioning³ may also be affected in children with A-D/HD, so in addition to the above symptoms, you may note:

- weak problem-solving skills
- poor sense of time and timing
- difficulty resisting distraction and delaying gratification
- low tolerance for frustration, changeable mood, poor judgment

(The above sections adapted from American Psychiatric Association, 2013; APA, 2000, as cited in Fowler, 2002; and Smith & Segal, 2014.)

³ Executive functions include cognitive processes that coordinate, integrate, and control cognition, particularly in novel situations, and are necessary for higher-order problem solving and goal-directed behavior (Bernstein & Waber, 2007; Hughes & Graham, 2002; Marlow, 2000; Shallice & Burgess, 1991, as cited by Schmitt, Miller & Long, 2012).

What you might notice in an interview situation is that children with A-D/HD may:

- be unable to focus on what you are saying long enough to hear the entire message
- be unable to keep what you said in mind long enough to think of a reply, reply, and wait for you to respond
- get stuck on one topic or activity; go off topic with unimportant details

(Oregon Department of Justice, 2012, p. 30)

Preparing for Interaction/Interview

- Plan frequent breaks.
- Provide a squeeze ball or other manipulative toys if it helps the child feel calm while answering questions. For some children this may be more distracting.
- If the child is taking daily medication, find out the medication schedule and its effect. Children with A-D/HD may also have “drug free” weekends, so holding the interview on Monday morning may not be as effective.
- Avoid setting up interviews in a room that is near a window, is noisy or has other distractions.
- Keep the table surface clear and uncluttered.
- Provide space for children to get up and move around.
- Sometimes visual supports can help children with A-D/HD stay focused on the topic. Examples are a checklist of question topics, which can be crossed out as they are answered, or a picture representation of the topic as a reminder.

(Adapted in part from New York State Office of Child and Family Services, 2004; and B. Crawford, personal communication, July 11, 2014.)

During Interaction/Interview/Investigation

- Talk in a calm voice. Use simple requests.
- Assess the child’s level of attention by asking them to summarize something you said.
- If you believe the child is distracted or has drifted off, repeat the question, but let them know you do not think their answer is incorrect. (Example: *You seem distracted, let me ask again.*)
- Try asking focused questions. (Example: *Tell me more about what Tommy did.*)
- Allow the child to move around or fidget, which can help them focus.
- Provide positive feedback to help the child understand what you expect. (Example: *You’re doing a good job sitting here for so long.*)
- Maintain focused eye contact while interviewing, which can help the child concentrate.
- If the child does not immediately answer a question, it is better to wait than to ask the question again right away, which could be more confusing.

Adapted from Debbaudt, 2012; New York State Office of Child and Family Services, 2004; and Oregon Department of Justice, 2012, p. 30.)

AUTISM SPECTRUM DISORDER

Autism Spectrum Disorder (ASD)* is a complex neurodevelopmental disability that tends to be noticed between 2-3 years of age. ASD affects children differently and in varying degrees, but children and adults with ASD tend to have difficulties with verbal and nonverbal communication; developing, maintaining, and understanding relationships; sensory integration; repetitive behaviors; and adjusting to change. Some of the more common difficulties can be with:

- initiating or responding to social interactions; social and emotional reciprocity
- eye contact, body language, gestures, facial expressions
- sharing, making friends, engaging in imaginative play
- inflexibility, insistence on sameness, extreme distress at small changes
- rigid thinking patterns, transitions, changes in schedule or food
- restricted interests with greater intensity or focus than most people
- reactivity to sensory input, including adverse responses to specific sounds or textures, smells

Some children with ASD may have difficulty with basic life skills and may require a full-time caregiver, while others will grow into adults living independently. ASD can also be associated with intellectual disabilities; difficulties in language, motor coordination, attention; and physical health issues, such as sleep and gastrointestinal disturbances.

Fastest Growing – ASD is the fastest-growing serious developmental disability in the U.S., affecting about one in 68 children. It is almost five times more common among boys (one in 42) than among girls (one in 189).

(Centers for Disease Control and Prevention, 2014; Autism Speaks, 2014; Autism Society, 2014; and American Psychiatric Association, 2013.)

**In the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-4), children could be diagnosed with four separate disorders within the Autism Spectrum, including Autistic Disorder and Asperger's Disorder. In the new DSM-5, these categories have been combined under the umbrella diagnosis of Autism Spectrum Disorder.*

What You Might Notice

Children with ASD tend to have difficulties with social interaction and communication, sensory integration, repetitive behaviors, and adjusting to change. However, do not assume that communications skills are related to intelligence or understanding. Traits range enormously, but common characteristics are described below.

Social Interaction

Children who struggle with social interaction may:

- have flat affect and seem unengaged or lack interest in making friends;
- prefer to be alone and have difficulty interacting with others;
- laugh or giggle inappropriately and have difficulty expressing needs;
- be literal and not understand double meaning, sarcasm, figurative speech, jokes, or slang;
- be unable to “read” body language or facial expression to understand social cues; and/or
- actively avoid eye contact or physical contact.

Social Communication

Children with ASD display a huge range of communication skills. Some children can talk and have conversations with others, while some are not able to talk or have limited vocabulary. Children also may:

- have highly-developed memory skills;
- have difficulty with volume and speak in loud whisper, monotone, or rote, like a computer;
- cover ears, look away, talk to themselves, echo words and phrases;
- repeat back words or phrases (echolalia); sometimes long after original interaction;

- seem distracted or seem not to hear you, turn away or physically withdraw; and/or
- focus on one specific topic.

Reactivity to Sensory Input

ASD can affect a child's responses to even regular levels of light, sound, touch, odor, and taste.

Children may also:

- not feel well in crowds or in situations with lots of noise, lights, moving objects;
- seek sensory stimulation, including heavy pressure;
- have strong attachments to objects;
- show a fascination with water, lights, reflections and shiny objects, such as badges or guns; and/or
- have a high tolerance to pain.

Restricted or Repetitive Patterns of Behavior, Interests, and Activities

Children may:

- show stereotyped or repetitive use of speech and behavior;
- use odd phrases; and/or
- line up toys, flip objects; spin or twirl objects and flick fingers, arm, or wrist.

Inflexibility, Highly Restricted, or Fixed Interests

Children may:

- react or get upset with changes in routine and insist on sameness;
- engage in ritualized behavior and have rigid thinking patterns; and/or
- want the same food and resist change or have difficulty with transitions.

(Above section adapted in part from Anderson & Heath, 2006; Debbaudt, 2012; New York State Office of Child and Family Services, 2004; Fowler, 2002; Oregon Department of Justice, 2012; American Psychiatric Association, 2013.)

Preparing for Interaction/Interview

Before the interview, gather as much information as possible about the child; how she/he communicates, reaction to sensory stimulation, any additional disabilities. When preparing:

- If possible, plan a pre-interview visit to the interview room and building.
- Plan for extended time, and schedule at best time of day for the child.
- If possible, set the interview in a familiar setting for the child.
- Keep the meeting space free from distractions, bright lights, and background noise. What is loud for a child with ASD may not be considered loud for the investigator/interviewer.
- Become familiar with whatever type of communication options the child prefers (i.e., social stories, picture symbols, notebooks, and augmentative devices).
- Ask non-offending people who are close to the child about what he or she might be trying to communicate with any particular behavior.
- Where you have flexibility, plan your questions and questioning style based on what you know about the child's communication ability.
- Consult with the occupational or physical therapists to understand how the child's ASD idiosyncrasies and sensory issues might impact their understanding of abuse.

During Interaction/Interview/Investigation

For first responders:

- If possible, turn off (or down) radios, flashing lights, sirens.
- Remove as much sensory stimulation as possible – people, dogs, chaos. If possible, take the child to a quieter area they are familiar with.

- If the child is reacting by cowering, covering eyes or ears, they may be having a strong reaction to overwhelming sights, strong smells, loud sounds, or unwelcome touch.
- Try to find someone who knows the child's routine, and any objects or places that are familiar or calming (e.g., a particular chair, room in home, toy, blanket).
- Children with ASD may be distracted by or drawn to reach out for badges, guns, keys, belt buckles, radio, or other shiny objects.
- Children with ASD often do not like to be touched. If it is absolutely necessary to touch a child with ASD for safety or emergency reasons, tell them beforehand, and explain what is going to happen.
- If a child is in a dangerous setting and must be moved immediately but is unable to respond, (e.g., in the case of a fire) wrap the child in blankets with her/his arms inside. This can help children with ASD feel more secure. Be prepared; the child may try to run away when they get outside.
- A child with ASD who is distressed may:
 - > rock, pace, grunt, make noises, talk to himself/herself, run into walls, head bang, hide under large mattresses or other large objects;
 - > run toward officers or others and become aggressive to avoid a situation/person; not necessarily with the intent to hurt, but to get away;
 - > flail against medical treatment; and/or
 - > run into a dangerous setting – traffic, burning house.

(Adapted from Debbaudt, 2012, p. 4.)

Communication:

- Speak calmly and talk to the child as if they fully understand you. Model calm body language and avoid quick movements.
- Minimize the number of people talking to the child.
- Be concrete and specific, and use simple sentences. Avoid slang, jokes, or figurative expressions. Many children with ASD are very literal.
- Make eye contact without forcing the child to look at you. If the child is anxious, minimize your own eye contact.
- The child may not make eye contact or may speak in a flat or rote voice, but still be engaged.
- Explain every step in detail and what the process is going to be.
- Ask about one thing at a time, and break requests into steps, using direct, short sentences (e.g., *let's go to the room; you can sit at that chair; I'm going to ask you some questions now*).
- Spend some time getting to know the child's communication style before asking about the event.
- Some children may repeat what you just said, recite the words of a TV commercial, or turn away.
- Let the child know that you may have to ask questions more than once.
- Because pronouns can be confusing, use actual names.
- A child with ASD may provide a lot of detail in response to your question because he or she is not sure what is important. If possible, let the child finish the answers.
- While the child may seem to understand what you are asking, check in to see if they are retaining the information or really do understand.

Interview:

- Consider breaking the interview into several short sessions.
- Depending on the circumstance, consider having a safe person the child trusts at the interview.
- If the child does not have a sense of time or day, compare events in their daily schedule to that timeframe. (Examples: School, television shows, therapy, regular outings.)
- If possible, avoid wearing a uniform, which can be confusing or frightening to children.

Responding to emotional distress:

- If there is no physical danger, giving a child time and space may be enough for them to calm down.
- If the child does not respond to what you are asking, do not assume they are uncooperative. Loss of routine or change may be highly distressing.
- Obtain information and assistance from the parents/caregivers or others at the scene about how to best communicate and reduce escalation of possible harmful behavior.
- If the child is fascinated by an object and it is safe to do so, allow them to hold it.
- Unless there is a danger, do not try to stop a child with ASD from repetitive behavior, which can be calming. These behaviors can include twirling an object, finger or hand flicking, rocking, pacing or talking to themselves, or smelling or touching objects.
- The child may not ask for help or show signs of pain, even when injured.
- If it is safe, just maintain a safe distance until any distressed behaviors lessen.

(Above section adapted from Farrar, 1996, as cited in Debbaudt, 2012; Debbaudt, 2012, p. 4; New York State Office of Child and Family Services, 2004; Oregon Department of Justice, 2012; and J. Roppolo, personal communication, May 24, 2014.)

Preparation for Court

Children with ASD tend to be visual thinkers. It may be helpful to create a picture book of the court room. However, if you take pictures of people in the jury box, make sure the people are not identifiable, or the child might focus on the difference during the trial. If possible, allow the child to visit the court room where the trial will be held, talk to the judge, and even visit another trial to become familiar with the environment and the process.

COMMUNICATION DISABILITIES

Communication Disabilities can affect a child's ability to receive, send, process, and understand verbal and other communication. The range of communication disorders includes: 1) use of vocabulary and sentence structure or abilities to use language to explain or describe topics or events; 2) speech articulation, fluency, voice, and resonance; 3) use of social verbal and non-verbal communication to influence the behavior, idea, or attitudes of another person; and 4) use of communication for social purposes (e.g., greeting, sharing information, taking turns, and rephrasing if misunderstood, matching conversation to the needs of a listener).

Difficulties with speech and communication must also take into account a person's cultural and language context, particularly for children growing up in bilingual environments. By first grade, an estimated 5% of children have noticeable speech disorders.

(Adapted from American Speech-Language-Hearing Association, 2014; American Psychiatric Association, 2013; and D. Velasco, personal communication, July 17, 2014.)

What You Might Notice

- Some children may have fluency difficulty, such as a stutter or difficulties with articulation, while others may have difficulty using language for social purposes.
- While children with a speaking disability might be difficult to understand at first, repeated exposure or length of time together will make it easier to understand.
- Some children with complex disabilities, such as Autism Spectrum Disorder, cerebral palsy, or Traumatic Brain Injury, also have difficulty with speech and comprehension.
- Communication aids may include:
 - > a simple paper tablet or white board for children to write on.
 - > for children who cannot read, an individually customized picture board or picture notebook with pictures of food, people, activities, clothing, places.
 - > facilitated communication, a technique where a "facilitator" provides physical and other supports to assist a person with a significant communication disability to point to pictures, objects, printed letters and words, or to a keyboard. (Note: Facilitated communication is controversial.)
 - > word boards containing frequently used words, which allows children to communicate quickly.
 - > an electronic device that matches the child's literacy skills and allows the child to use voiced communication.

Preparing for Interaction/Interview

- Find out specifics about the child's communication disability. Is it primarily in understanding what is being said, producing speech, sound, or a combination of several areas?
- Find out how the child best communicates and what communication aids they might use.
- If the child uses a communication device, check with the nonabusive family member, caregiver, or speech therapist to make sure that it includes the language or symbols necessary to disclose abuse. Ask the speech therapist or family member to program in words the child might need, including the child's words for body parts, and words for violent actions, such as kicking, hitting.
- If English is not the child's primary language, arrange for a qualified, licensed interpreter (e.g., American Sign Language, Spanish, or other language).
- Ask about other disabilities that might affect your interview preparation.

During Interaction/Interview/Investigation

Check your assumptions:

- Do not equate communication disabilities with overall intellectual functioning and comprehension.
- Begin by assuming you will be able to understand each other; the child may very well be able to understand and process what you are saying.
- You may not understand the mode of communication, but the child does. He or she communicates every day the same way.

Set the stage:

- Speak normally. Look directly at the child, not at others who are providing assistance.
- The calmer and less stressful the setting, the more readily children can communicate. (Stress can impact the ability of all children to produce and comprehend verbal and nonverbal communication.)
- Take some time getting familiar with the child's speech patterns and inflections. If the process is frustrating the child or no progress is being made, consider calling in a support person who knows the child but has no investment in the outcome, such as a teacher, speech therapist, or interpreter. If the teacher or speech therapist is actually the reporter of the abuse or neglect, select another person who can understand the child's speech.
- If the child uses a speaking device, become familiar and comfortable with how to communicate through it before actually beginning with crucial aspects of the interview.
- Unless the child requires someone to interpret, do not allow a third party to speak for him/her.

Set the pace:

- Allow extra time for communication.
- Be prepared to slow the pace of the interaction. Offer breaks. Some children's speech may become more slurred when they are stressed or tired.
- Wait after asking a question. It may take the child time to develop a message through alternative communication devices.
- Repeat what you hear to clarify the meaning.

Work through difficulties:

- Do not pretend to understand if you don't. Be honest, and ask the child to repeat it.
- If you are still having consistent difficulty understanding:
 - > **Wait:** Decoding speech patterns that your ears are not trained for can take a little time. Listen to the whole sentence or phrase. Become comfortable with some wait time. Let the conversational context help you.
 - > **Repeat:** Simply repeating the sentence or thought may be enough. However, sometimes repeating does not help because the child cannot change the way a specific word is pronounced. In that case, move on to another strategy.
 - > **Rephrase:** Ask the child to try and express the same thought using different words. Often, the misunderstanding hinges on one or two words in a sentence.
 - > **Identify** which part of the sentence or thought was not understood: If you know most of the phrase or sentence that has been spoken and can identify which part(s) are unclear, you might try repeating back to the child what you know has been said, and asking them to focus on repeating the part you did not get.

- > Finally, if the above-mentioned strategies are not effective, consider the following:
 - If the child can spell, ask them to spell it out for you. It usually just takes the first few letters of the word to clear up the confusion.
 - Ask the child to write it down, or you can write down what you thought they said, and you can give each other feedback.

Comprehension:

If the child has difficulty with comprehension or understanding what is being said or written (receptive communication):

- Minimize distractions.
- Use short sentences and express one thought at a time.
- Allow for long silences if needed, and stop regularly to ask if the child has questions.
- Pay attention to eye contact, body language, and other cues that the child does not understand.

(Oregon Department of Justice, 2012)

Producing language:

If the child has difficulty communicating by speaking, writing or sign language (expressive communication):

- Realize that the child may understand you fully.
- Become familiar with what the child's behaviors, sounds, or movements mean in response to your questions.
- The child who cannot speak can still indicate yes or no with a tapping pencil, nodding, blinking eyes, thumbs up, thumbs down. Note: For investigative purposes, this method of communication would need to be documented prior to starting the interview.
- If the child is unable to speak or use a communication device, the interviewer may need to do all of the speaking. Even so, yes/no questions do not have to be leading. You may rely on drawings, pictures, and anatomically correct dolls. (Use these in accordance with the standards set by the American Society of Abuse of Children.)
- Again, allow for silence, and avoid the temptation to fill in the blanks.
- Acknowledge challenges in the beginning of the interview by saying: *You are new to me. Sometimes it is hard for me to understand what new people are saying. I may ask you to repeat things. Or: I have to learn what words you use for different things. I may ask you to make drawings to help me understand what happened* (Oregon Department of Justice, 2012, p. 29).
- Listen carefully to what words the child uses and what those words mean to him. Clarify: *When you say, "She 'jumped' you, what do you mean?"*
- Repeat back what the child said.

(Adapted in part from Hoffman-Rosenfield, 2004; and Oregon Department of Justice, 2012.)

Interpreters:

- Familiarize yourself with the ethics of working with an interpreter, as well as the required standards and level of certification.
- Sometimes, only the teacher, speech pathologist, or the care provider will be able to understand the child's communication.
- Always speak to the child, not the interpreter.
- Be prepared for your agency to cover the costs of interpreter services, as needed.
- Be sure the interpreter is present before starting the interview, is familiar with and can operate the communication system used by the child, and that all parties and devices are positioned in the room for clear communication.

- Avoid using a parent or family member to facilitate communication, as that person may be the abuser, may collude with the abuser, or may have other reasons for not providing a proper interpretation.

(The above sections adapted in part from New York State Office of Child and Family Services, 2004; U.S. Department of Justice, 2011; Hoffman-Rosenfeld, 2004; and Chadwick Center for Children and Families, 2013.)

A Caution about Alleged Perpetrators and Communication Devices

An abuser may withhold and/or break communication devices in an attempt to silence the child. In addition, some abusers may attempt to “speak for” the child to prevent her/him from speaking about what happened. Other perpetrators may refuse to program augmentative communication devices to further prevent disclosure. When interacting with the child who may use these types of communication supports, be aware of this dynamic and include it in any safety planning that you may offer.

INTELLECTUAL/DEVELOPMENTAL DISABILITIES

Intellectual and/or Developmental Disabilities (I/DD) usually begin during the developmental period and include both intellectual and adaptive functioning difficulties in conceptual, social, and practical areas of life. These disabilities often co-occur (i.e., a child with an intellectual disability may also meet criteria for Attention-Deficit/Hyperactivity Disorder). The severity of the disability is based on the child's adaptive functioning and can range from mild to profound.

Intellectual functioning refers to general mental capacity, such as learning, reasoning, problem solving, planning, judgment, academic learning, and learning from experience. Intellectual disabilities impact the adaptive skills used in everyday life. The person may need supports in:

- *Conceptual skills* – language and literacy; money, time and number concepts; and self-direction.
- *Social skills* – interpersonal skills, social responsibility, self-esteem, gullibility, social problem solving, and the ability to follow rules, obey laws, and avoid being victimized.
- *Practical skills*—personal care, work skills, travel/transportation, schedules/routines, safety, use of money, use of the telephone.

(American Psychiatric Association, 2013;
American Association on Intellectual and Developmental Disabilities, 2013)

What You Might Notice

Children with intellectual disabilities:

- have a range of practical skills. Some are able to use money, tell time, and read, and some are not able to dress themselves, use the toilet, or feed themselves.
- may not be aware of or perceive situations that are dangerous.
- generally have some difficulty with abstract concepts.
- often want to please others, especially if they have been taught from early childhood on to comply with authority.
- may make impulsive decisions.
- have more difficulties in thinking and reasoning than the typically developing child, but do have normal sexual development.
- have a high rate of undiagnosed hearing and speech disorders.
- may sometimes understand more than they can express.

(Adapted in part from the Oregon Department of Justice, 2012 and
New York State Office on Child and Family Services, 2004.)

Preparing for Interaction/Interview

- If possible, obtain the child's school Individual Education Plan (IEP) to gain information about the child's strengths, areas of struggle, and how best to communicate.
- Ask nonabusive caregivers and family members about what you most need to know to have a successful interview with the child.
- Have visual aids available, such as anatomically correct dolls, drawings, or other objects.
- Ask if the child has a hearing or speech disorder.

During Interaction/Interview/Investigation

Introductions and rapport-building:

- Tell the child who you are and why you are there. Use common, plain, and concrete language. Keep questions as short, straightforward, and uncomplicated as possible.
- If the child does not answer a question, say their name and repeat the question exactly the same way. It is sometimes helpful for children with intellectual disabilities to hear the question several times. If you rephrase it too soon, it may confuse the child.
- There is no need to "talk down" to a child with disabilities. Match your language to the child's.

- Speak directly to the child. Make eye contact before you speak, and say the child's name often, particularly before asking a question.
- Introduce everybody in the room. Explain what will happen and how long it will take.
- Spend extra time establishing rapport to become familiar with the child's language abilities.
- To gauge the child's ability to understand abstract questioning, ask a potentially difficult question, such as, *What time do you go to bed...or...Where do you live?*
- Allow children to speak at their own pace, with time for silence.
- You may have to explain that: 1) what happened to the child was a crime, 2) someone else broke the law, 3) what happened was not their fault, and 4) they are not in trouble.
- It may be tempting to treat children with intellectual disabilities as if they were younger than their chronological age, but developmental functioning can be complicated. For example, a child of 12 may have strong social skills and a broad vocabulary and yet not be able to think abstractly (Shelton, et al., 2010).

Pay attention:

- Notice changes in behavior, such as humming, groaning, withdrawal, or fixation on one topic. Any of these changes may indicate the child is becoming anxious or tired.
- If the child shows signs of fatigue, anxiety, or distraction, take a break from the interview or the topic. A pressure-free way to do this: *I think we need a break, would you like one?*
- Give permission to take a break or use restroom if needed.
- Be sensitive to the child's possible feelings of guilt, self-blame, and fear.
- Pay attention to the child's non-verbal cues, over compliance, and body language.
- Listen with all your senses. Being fully present with the child will help build rapport and let them know you really want to listen. As you show you are caring and want to understand, they will be more likely to open up to you.
- Some children may be conditioned to comply with authority figures. Others may be fairly isolated and eager to please and to connect with social supports. These experiences may affect the way the child thinks about responding to interview questions.

Pacing and questions:

- Speak in your typical tone of voice and slow your pace.
- Ask *who*, *what*, or *where* questions. *When*, *how*, and particularly *why* questions may be difficult.
- Avoid yes/no questions; children may say yes to please, or because of fear or misunderstanding.
- Break large instructions down into smaller parts. Give one instruction at a time. Ask only one question at a time.
- Provide a menu of questions: Open-ended, yes-or-no, and multiple choices.
- Avoid instructions and questions that involve abstract reasoning, such as time.
- Many children with disabilities follow routine activities, which can help you establish the time of events: before school, after dinner, during a TV show.
- Ask for concrete details. *What kind of hair did the man have? What color was the car?*
- If the child is unable to respond verbally, explore other means of communication, such as visual aids (objects, pictures, or drawings).
- Perpetrators may convince child victims that sexual abuse is special time or use a euphemism for abuse. If, for example, a child says he and the abuser went on a picnic, ask what they did on the picnic. If the child cannot explain, ask him to show you.
- If the child keeps repeating, walk through what happened with them, breaking it down step by step.

(This section adapted in part from New York State Office of Child and Family Services, 2004; SafePlace, 2000; and Oregon Department of Justice, 2012; Hoffman-Rosenfeld, 2004.)

SPECIFIC LEARNING DISABILITIES

Specific Learning Disabilities are neurodevelopmental disabilities with a biological origin that affects the brain's ability to perceive or process verbal or non-verbal information efficiently and accurately. Learning disabilities are a result of how the brain receives, processes, and responds to information. While learning disabilities do not go away, children and adults can use strategies to adapt to them. Specific learning disabilities impact the following areas:

- Reading – difficulty with word accuracy, reading rate, fluency, and comprehension
- Written expression – impacts spelling, grammar and punctuation, clarity or organization of written expression (i.e., Dyslexia – trouble understanding written words; sometimes called a reading disability)
- Mathematics – difficulty with number sequencing, memorization of arithmetic facts, calculation, and math reasoning (i.e., Dyscalculia – difficulty with arithmetic and mathematical concepts)

(American Psychiatric Association, 2013; Shelton, et al., 2010)

What You Might Notice

A child with learning disabilities may struggle with:

- understanding questions and following directions.
- using filler words – *um, thing, or stuff*, while searching for correct words.
- repeating numbers in sequence, such as phone numbers or addresses.
- knowing right from left.
- confusing the order of words, numbers, or sequence in a story.
- telling time and having a concept of time.

(Adapted in part from Shelton, et al., 2010)

Many children with specific learning disabilities attend school in mainstream classrooms with their peers without disabilities. To avoid being made fun of or shamed by classmates, they may have learned strategies for hiding learning difficulties (e.g., pretending to read, distracting other students or teachers). It may not be immediately evident that the child has a learning disability.

Preparing for Interaction/Interview

- Learn from the child's teacher, Individual Education Plan (IEP), parents, or caregivers about the child's learning disability and how it affects him/her in practical terms.
- Ask about what adaptations help the child function in school and at home, and modify them for your interaction.
- Find out the child's regular schedule, including times of regular television shows, school, therapies, and other activities.
- If the child has difficulty understanding written or spoken language, consult with teachers or caregivers beforehand about how to make your questions as understandable as possible.

During Interaction/Interview/Investigation

- Make adaptations for the child based on the information you have gathered. Examples:
 - > If the child has dyslexia, or difficulty understanding written words, and needs to review written material, read the material, or prepare the material in plain language beforehand.
 - > If the child has difficulty understanding written or spoken language, check in frequently to make sure they understand what you are asking or saying.

- > If the child has difficulty with the concept of time:
 - If you are trying to pin down a time during a particular day, ask about regularly scheduled activities in the child's day, such as school, afternoon television program, after-school activities. You can ask if the abuse happened before or after a favorite television program.
 - If you are trying to find out if the abuse happened ON a particular day or week or month, try to find out the child's long-term schedule or events that they might remember, such as a special activity, holiday, birthday, or other event.

PHYSICAL AND SENSORY DISABILITIES

PHYSICAL DISABILITIES

Physical disabilities occur as a result of muscular/skeletal or neuromotor dysfunction. Physical disability pertains to **total** or **partial loss** of a person's bodily functions (e.g., walking, gross motor skills, bladder control) and total or partial loss of a part of the body (e.g., a person with an amputation).

Neuromotor impairments are conditions caused by damage to the central nervous system (the brain and the spinal cord) which limit muscular control and movement.

Examples of **physical disability** include

- amputation
- arthritis
- cerebral palsy
- multiple sclerosis
- muscular dystrophy
- acquired spinal injury (paraplegia or quadriplegia)
- post-polio syndrome
- spina bifida
- seizure disorder

(Adapted from Smith, 2014 and Physical Disability Council of NSW, 2009.)

What You Might Notice

- Children may have one disability – such as amputation of a limb – or several disabilities. For example, children with cerebral palsy often have both a speech and physical disability.
- The child's disability may be apparent, (i.e., spina bifida) or hidden (i.e., seizure disorder).
- The same disabilities impact each child differently.

Preparing for Interaction/Interview

- If your agency is not physically accessible and the child uses a wheelchair, plan to meet at an alternate, private, and safe accessible location.
- Inform the child's support person about accessible parking, entrance, and similar features.
- Know the accessible transportation options to get to your office, crisis programs, and court.
- Build in extra time for late arrival from public or private accessible transportation. At times, these delays are inevitable.
- Review the child's Individual Education Plan (IEP).
- Talk to teachers, physical and occupational therapists, and family members/caregivers about how the child is impacted by their disability and what accommodations you might need to offer. Examples: The child may become fatigued at certain times of the day, may not tolerate fluorescent lighting and need to be in a room with lamps or other physical modifications.

During Interaction/Interview/Investigation

- Ask the child where they would like to sit.
- Do not make assumptions about the child's abilities.
- Unless another disability is present, children with physical disabilities process information similarly to children without disabilities (Oregon Department of Justice, 2012).
- If you offer assistance, wait until the child has specifically said how you can help.
- Do not insist on helping. The child is the expert about what they can or cannot do.
- Be respectful of personal space: Do not touch or move wheelchairs, crutches, or other mobility aids without permission.

- If the suspect was a caregiver, the child or new caregiver may need help finding a personal care attendant. (This service may be available through health insurance, Home Health Services, or other means.)
- The child may need to be physically repositioned during the interview.
- If the child's mobility aid – wheelchair, walker, cane – is kept as part of evidence, consider how to replace it. These devices support a child's independence.

BLINDNESS AND LOW VISION

Blindness/Low Vision: No two people see exactly the same. Total blindness refers to people with very little or no functional use of vision (no light perception or only bare light perception). A child who is considered legally blind may be able to – indistinctly – see light, shapes, colors, and objects. Even with some functional vision and corrective lenses, the child may have difficulty with visual tasks. The ability to function visually can be increased through compensatory strategies, low vision devices, and modifications.

Because there are many different causes of visual impairment, how significantly the child will be impacted will depend on:

- the child's particular eye condition;
- how the child's visual system is affected – ability to detect light, shape, or color; ability to see things at a distance, up close, or peripherally;
- how much correction is possible through glasses, contacts, medicine or surgery.

(Adapted from Center for Parent Information and Resources, June 2014; Corn and Koenig, 1996, as cited Moore & LeJeune, 2010.)

What You Might Notice

- Children who are blind or have low vision may also have another disability (i.e., an intellectual or developmental delay).
- Some children are only able to see objects and people in motion, but not those standing still.
- Children will use whatever vision they have. Children who have vision that is on the outer quadrant, for example, will turn their heads to see out of that side.

Preparing for Interaction/Interview

- Ask about a child's level of usable vision and use of adaptive aids. Many children who are "legally blind" can see shapes, colors, and lights; or may read large print, use audio materials, etc.
- Use natural lighting or lamp lighting, if possible. Windows can create glare.
- Remove any unnecessary equipment or materials from the table surface, which can get in the way of the child's visual fields.
- If the child is of reading age, ask what format they prefer for written materials to be in: large print, audio, Braille, flash drive. Only 10% of children who are blind read with Braille (National Federation for the Blind, 2014).
- If the information is brief, or the child is young, be prepared to read it aloud.

During Interaction/Interview/Investigation

Getting around:

- Depending on the child's height, offer your elbow as you both walk. If the child uses a white cane, he/she may be able to follow you without holding your elbow. The child may walk slightly behind you to follow your lead.
- Walk slowly and provide details about obstacles such as steps, doorways, furniture, wet floors, low-hanging objects, or open file drawers.
- Describe the interview room as you enter it (i.e., *this room has a table with a chair on each side, this room has a couch in front of a window and two chairs*).
- Lightly tap the chair or table to help the child locate furniture.
- Ask where the child would like to sit. A child who is not totally blind may prefer to be in front of the main source of light.

Etiquette:

- Identify yourself and other people by name when entering and leaving the room.
- When talking, continue to address others by name, so the child can follow the conversation.
- Ask the child how you can assist, as needed, but only assist with permission.
- Explain things the child cannot see – *I'm getting up to open the door. I'm looking through these papers.* Particularly in a stressful situation, children who do not know what is going on may misinterpret, or think that you do not believe them, or that you aren't paying attention.
- Maintain eye contact with the child. The child may not be able to see that you are doing so, but this conversational courtesy will help you stay focused on the interaction.
- Speak clearly and at a normal pace.
- The child will respond to your tone of voice, body language, and use of space.
- If you must touch the child as part of a SANE exam or therapy, ask before doing so.
- It is okay to use terms such as *see you later*.
- Offer to read aloud any materials that are not available in an alternate format.
- If pertinent, to assess the child's understanding of spatial relationships, ask the child to use a pen and another object to demonstrate concepts such as *over, under, behind, inside*.
- While the child may not be able to provide a clear physical description, they may be able to describe and identify the abuser by sight, name, smell, skin texture, voice, hair texture, and other characteristics.

(Adapted in part from New York State Office of Child and Family Services, 2004; and Oregon Department of Justice, 2012.)

DEAFNESS/HARD OF HEARING

Deafness/Hard of Hearing: The medical definition of Deafness and hearing loss is partial or complete loss of hearing. This loss can be slight, mild, moderate, severe, or profound, depending upon how well a person can hear the loudness (intensities) and/or pitch (frequencies) of sound. It may exist in only one ear or in both ears. Generally, only children whose hearing loss is greater than 90 decibels (dB) are considered Deaf/deaf. Profound deafness occurs in 4-11 per 10,000 children; in at least 50% of these cases, the cause is genetic (Center for Parent Information and Resources, 2010).

The cultural description of what it means to a Deaf is much more complex.

Big D, Little d. Many adults who are Deaf do not consider themselves to have a disability at all. They identify with the Deaf culture and community, a minority group with its own language, history, traditions, clubs, churches, values, and cultural norms. People who identify themselves as Deaf with a big (capital) "D" firmly believe that they are not in need of a fix or a cure.

Little "d" usually often refers to people who do not identify with the Deaf culture and community. One example is people who lose their hearing later in life.

Historical context. In Deaf schools across the country until the 1970s, Deaf children were largely required to communicate through oralism, a combination of spoken English and lip reading. They were often denied the use of their actual language (American Sign Language [ASL]) to the point of literally having their hands tied behind their backs. Many Deaf children grew up without early language at all, which has profound impacts on learning and development.

Within the Deaf culture, cochlear implants, which are surgically implanted electronic devices designed to "replace" hearing for children and adults who are Deaf or have profound hearing loss, are controversial. Some Deaf adults fear use of the implants may deprive Deaf children of their culture while not improving their hearing enough to fully fit in the hearing world. But some Deaf adults born to hearing parents have cochlear implants and still consider themselves to be capital D Deaf.

Since more than 90% of children with permanent hearing loss are born to hearing parents, there is also a concern among advocates that hearing parents may not understand the potential importance to their children of early language development in ASL and Deaf culture and identity.

Hearing parents, on the other hand, often want their children to function as fully as possible in the hearing world. An increasing compromise may be the combination of both oral (spoken English) learning and full immersion into American Sign Language at an early age.

The Importance of Early Language

- Deaf children who have not been fully immersed into ASL at a young age may develop early language delays, along with delays in cognitive and psychosocial development. In fact, not having early language can interfere with short-term and long-term memory functions, memory capacity, recall strategies, and organization (Edwards, 2004, as cited in Chandler, 2006).
- American Sign Language (ASL) allows full fluency in communication, has its own grammar and syntax, and relies heavily on facial expression and body movement.

What You Might Notice

- Many Deaf children normalize their experience of having been sexually or physically abused and/or exploited because they do not have the awareness that it is not normal.
- Abused children and youth are not likely to discuss the abuse unless they are specifically asked.
- If Deaf/hard-of-hearing children who are Deaf or are hard of hearing and their parents do not share a common language, it can be difficult to discuss complex issues like preventing or disclosing abuse. These communication issues may actually lead some parents to disbelieve their child who reports abuse or inappropriate sexual experiences.
- A Deaf child or child who is hard of hearing may not be at the same developmental age as their chronological age, and are likely to be delayed in their ability to express themselves.
- For children who are hard of hearing:
 - > Speech can be delayed and not clear.
 - > Children who cannot hear well are often mistakenly accused of not paying attention or ignoring directions.
 - > Children who are hard of hearing may seem to understand but are not getting clear information, miss the point, and become confused.
 - > Family members of hard-of-hearing children often alert them where to look if someone is speaking or where to direct their attention; without those cues, they may have difficulty in an interview or interaction.

(Adapted in part from Chandler, 2006; and Centers for Disease Control and Prevention, 2014, August 11.)

About Cochlear Implants

Cochlear implants are essentially a replacement for hearing for children or adults who are Deaf or have profound hearing loss. The child may adapt quickly or with difficulty to a cochlear implant. Sometimes children may recognize noises, but not words, or vice versa. Cochlear implants can also be overwhelming to a child if there's too much noise, since they may not have learned how to filter out background noise yet.

If a child seems distressed, take note of any possible background noise that could be the source of the problem and ask what is wrong. If they indicate their cochlear implant, check with a parent on how you should respond to the child's discomfort. Parents usually have a specific speech/hearing therapy plan with the child's cochlear implant from audiologists and doctors, and will know how to respond. For example, if the implant is hurting or giving the child a headache, the parents usually can tell you if the implant can be turned on/off or if you need to lower the sound setting.

(T. Gentry, personal communication, July 22, 2014)

Preparing for Interaction/Interview

Communication:

- Find out how the child best communicates: sign language, speaking, writing, assistive listening devices. Before scheduling an interpreter, clarify the child's primary language: American Sign Language, Canadian Sign Language, Mexican Sign Language or other.
- If the child communicates through American Sign Language, schedule a certified sign language interpreter, preferably with experience interpreting in cases of child abuse.
- Request separate interpreters for interviewing a victim and suspect.
- For court proceedings, interpreters must hold a current court interpreter certification issued by the Texas Department of Assistive and Rehabilitative Services (DARS) Office for Deaf and Hard of Hearing Services (DHHS), or a current legal certificate issued by the National Registry of Interpreters for the Deaf (Texas Department of Assistive and Rehabilitative Services, n.d.).

- Become familiar with whatever assistive listening devices the child uses. In addition to hearing aids and cochlear implants, the child may use an independent amplification system. Individual personal amplifiers amplify close sounds while reducing background noises. The listener wears headphones, small earplugs, or hearing aids.
- Keep visual aids (drawing, dolls, chalk, or dry erase boards) available.
- Let the child know before the interview that family members will not be helping with communication during the interview, and why.
- Collect the English and American Sign Language (ASL) names and specific relationships of the people in the child's life. ASL names are in sign language, and may be the first initial of a child's name, or some distinctive characteristics, such as long or curly hair.
- Because Deaf children may only know the signed ASL names of family members, not English names, have pictures of family members or other pertinent people available to clarify which person the child is talking about.

Physical environment:

- Choose a location without loud background noises (copiers, loud air conditioners, or other sounds that may be amplified by the child's hearing aid or cochlear implant).
- Choose a room that is well-lit from internal lamps and lights, rather than sunlight.
- Arrange furniture so that you or the interpreter are not sitting or standing in front of a window or bright light, which can throw your face into shadows. The child will need to have a clear view of your face at all times.
- Eliminate any visual distractions from the table or desk that might get in the way of the child seeing you or the interpreter. A large portion of American Sign Language relies on body language and visual cues.

(The above sections adapted in part from Hoffman-Rosenfeld, 2004.)

During Interaction/Interview/Investigation

First response:

- Touch the child's arm or shoulder to get attention, or wave your hand in their field of vision.
- Do not use people who can sign, but are not professional interpreters (such as relatives, volunteers, school staff) except to obtain the child's name, address, and other basic information.
- If family is present, do not allow the person with "better" communication to take over.
- If the child wants to communicate by writing, keep messages short and to the point. English is a second language for many Deaf children. Sign language and English have different syntaxes.
- If an interpreter is called, inform through speech/gesture/writing how soon he/she will arrive.

(Adapted in part from Hoffman-Rosenfeld, 2004.)

Communication:

- Match your facial expression and body language to your words and keep eye contact.
- Do not shout. If the child is Deaf, shouting will not help them hear/understand better.
- If the child is reading your lips, look directly at them, speak naturally, and keep your mouth free of distractions. Just looking at the child will help, since it ensures you don't move your head too much when you talk (T. Gentry, personal communication, July 22, 2014). However, lip-reading is not an effective form of communication in these circumstances; only about 30% of lip-reading is understood, and the rest is inferred.
- Speak slowly and maintain eye contact, but do not exaggerate, which can distort meaning.
- Always explain any interruptions: *Someone's at the door, I'm going to open it now.*
- Although a child who is hard of hearing may speak clearly, do not assume they can hear clearly. A cochlear implant or hearing aid improves hearing, but their effectiveness varies widely.
- Make sure that only one person is speaking at a time, and that it is clear who the speaker is.

- Watch for signs that the child feels embarrassed or afraid to say they do not understand.
- Evaluate the child's knowledge about their family, and vocabulary and signs related to sexual and emotional topics. Ask the child to let you know if they don't understand something.

(Adapted from Chandler, 2006; and New York State Office of Child and Family Services, 2004.)

Sign Language Interpreters:

- If the American Sign Language interpreter, who is hearing, is having difficulty understanding the child, consider using a Certified Deaf Interpreter (CDI). A CDI is a Deaf interpreter who is specially trained in adapting to an individual's mode of communication, especially young children who are not yet fluent in ASL. CDIs can also help interpret "home" sign, foreign sign language, or just gesturing, and can aid the hearing ASL interpreter greatly in communication.
- Having multiple interpreters present, along with the interviewer, can be overwhelming for the child, particularly in talking about a traumatic situation. The child may shut down. Take more time for rapport building, slow the pace down and consider multiple sessions.
- The interpreter may also assist with written materials.
- Interpreters have a code of ethics about confidentiality, but because the Deaf community is small, the child and interpreter may know each other. Make sure the child is comfortable.
- Interpreters often work in teams of two, taking turns to prevent fatigue.

Role of interpreter:

- The interpreter's role is only to facilitate communication and not to provide information or opinions about the crime or to answer any questions.
- Interpreters must be comfortable with interpreting conversations about abuse and sexually explicit events. They should be familiar with idiosyncratic signs for sexual behavior, body parts, and sexual functions. The interpreters should use the same signs as the child uses.

Your role:

- Avoid asking the interpreter: *Tell her/him ... or Ask her/him...* Just speak directly to the child.
- The child may address the interpreter because they have not used interpreters before, or because they want to know the interpreter can understand and is interpreting correctly.
- If the child is engaged in an activity (looking at pictures, drawing), pause and gain their attention before continuing with questions.

Seating:

- Generally, an interpreter will sit by the interviewer, and both will face the child, so the child can look at both people at once. She or he will be looking to the interpreter for translation, but will also be looking to you for visual cues.
- For videotaped interviews, it's best to have two cameras recording front views of everyone who is signing (Chandler, 2006).

(Adapted from Chandler, 2006; Hoffman-Rosenfeld, 2004; Rainville, nd; and T. Gentry, personal communication, July 22, 2014.)

TRAUMATIC BRAIN INJURY/ MENTAL HEALTH DISABILITIES

NEUROCOGNITIVE DISABILITY DUE TO TRAUMATIC BRAIN INJURY

Traumatic Brain Injury (TBI) is caused by an impact to the head, or other mechanism of rapid movement or displacement of the brain within the skull. It can also be called acquired brain injury or head injury. Children may sustain mild to severe traumatic brain injuries from abuse and/or accidents. Children with TBI may show developmental delays, worse academic performance, and possible social development delays. These injuries may also result in physical and communication disabilities. Some children develop long-term medical complications such as seizure disorder.

Recovery is difficult to predict. Symptoms vary depending on the extent and location of the brain injury, but the greatest challenges to children with TBI are changes in their abilities to think, learn, remember, and to interact socially. Symptoms of TBI in children and adults are similar, but a brain injury can actually have a more devastating impact on children than adults because their brains are continuing to develop. In addition, the impact of a brain injury may only become apparent as the child gets older and learning becomes more complex.

(Adapted from Brain Injury Association of America, 2014; Castrogiovanni, 2010; and American Psychiatric Association, 2013.)

What You Might Notice

Traumatic brain injuries can range from mild to severe and can impact physical, cognitive, and social-emotional functioning. Symptoms can include:

Physical impacts:

- Problems speaking, seeing, hearing, smelling, tasting, and touching
- Sleep disturbances
- Headaches and fatigue
- Trouble writing and drawing
- Spasticity – muscles suddenly contracting or tightening
- Difficulties with balance and walking, tinnitus, vertigo, and dizziness
- Paralysis on one or both sides and seizure disorders

Cognitive impacts:

Difficulty with:

- Memory; concentrating, only able to focus for a short time
- Reading, writing, planning, judgment
- Understanding the order of events
- Understanding non-verbal communication and social cues
- Communication skills; speaking or understanding spoken language
- Learning; slowed speed of information processing

Social/emotional impacts:

- Mood swings, anxiety and depression; restless or laugh and cry a lot
- Aggression, suspiciousness; trouble relating to others
- Lack of motivation or control over emotions; easily frustrated
- Increase in risk taking and impulsivity

After a TBI, caregivers may notice these symptoms in children:

- Seizures
- Dizziness or confusion
- Change in personality
- Change in nursing or eating habits
- Becoming upset easily or increased temper tantrums
- Sad or lethargic mood
- Lack of interest in favorite toys

(The above section adapted from Brain Injury Association of America, 2014; and Center for Parent Information and Resources, 2014.)

Leading Cause of Disability and Death

Traumatic brain injury (TBI) is the leading cause of disability and death in children and adolescents in the U.S. According to the Centers for Disease Control and Prevention, the two age groups at greatest risk for TBI are age 0-4 and 15-19; through car accidents, falls, sports injuries, abuse, and other causes (Brain Injury Association of America, 2014).

Preparing for Interaction/Interview

- Consult with audiologist or speech therapist if the child has a communication disability.
- Consult with teachers, family members, therapists, Individual Education Plan (IEP) about the extent of the TBI and its impact, and methods the child uses to increase function.
- Consider how to adapt questions for children with memory issues.
- If fatigue is an issue, find out when they are most rested and schedule the interview accordingly.

During Interview/Interaction/Investigation

Attention:

If the child shows reduced concentration, attention, or focus, try to:

- Meet when the child tends to be more alert.
- Have shorter, more frequent meetings.
- Limit distractions (both visual and verbal) by meeting in a quiet environment.
- Focus on one topic during each meeting, if possible, or focus on one topic at a time.
- Encourage the child to rephrase what you said to check comprehension.
- If you are providing written material, modify it to make it concise and to the point. Ask the child to read the material out loud to make sure they can read and understand.
- If you are not sure the child understood the question, ask them to summarize.
- Use words to alert the child, such as *listen*, *look*.

Processing speed:

If the child has cognitive difficulty in processing information, speaking, or writing:

- Speak slowly and check-in that the child understands your question.
- Frequently repeat and summarize information.
- Allow additional time for the child to answer.

Communication:

If the child has difficulty with speech, finding the right words, naming objects, or has disorganized communication:

- Help the child stay on topic by bringing the focus back to the original question.
- When possible, include yes/no or structured formats.
- Take time to become familiar with the child's speech.

Learning and Memory:

If the child has problems with immediate memory, short-term, and/or long-term memory storage and recall:

- As much as possible, keep meetings short.
- Be consistent. Whenever possible, meet on the same days in the same place and at the same time.
- Be as concrete and concise as possible when talking with the child.

Emotional/Behavioral Changes:

If the child is depressed, anxious, has a poor tolerance for frustration, is showing impulsivity, does not recognize social cues, or is restless or irritable:

- Reassure the child and provide structure to minimize anxiety.
- Recognize that a lack of emotion may not indicate a lack of interest.
- Suggest breaks if the child becomes irritable or agitated.
- Establish an agenda and follow it.
- Avoid discussion when the child is fatigued or over-stimulated.
- Confrontation can shut down thinking and make the child rigid; be flexible with resistance.
- Be direct and clear about what you are asking if children are missing social clues.

Physical:

If the child has headaches, dizziness, sleeping problems, fatigue, sensitivity to noise, nausea, problems with balance, sluggishness: Keep the environment as quiet as possible; keep noise and lights to a minimum; and keep sessions shorter.

(The above section was adapted in part from P. Campbell, personal communication, November 8, 2005; Campbell, Fawber & Pramuka, 2001; Johnstone-Smith, 2004; Ohio Valley Center for Brain Injury Prevention and Rehabilitation, n.d.; all as cited in SafePlace, 2007.)

Investigation:

- If you suspect a TBI, arrange for a medical examination, if it has not already happened.
- Be cautious: If children with TBI from abuse are returned to a violent home, they are at high risk of being hurt again or killed.
- Evaluate whether the explanation of the injury is developmentally appropriate for the child. If not, child abuse is a possible explanation.
- The child may not have a documented history of trauma. In some cases, parents or other caretakers may not report a history of TBI, because they were not aware of it or because they are hiding it. If a baby or young child has symptoms of TBI, consider the possibility of abuse.

(Adapted in part from Brain Injury Association of America, 2014.)

MENTAL HEALTH/BEHAVIORAL SYMPTOMS

Mental Health/Behavioral Symptoms: The signs and indicators of mental/behavioral health conditions are referred to in a multitude of ways – mental health issues or conditions, emotional distress, mental disorders, behavioral issues or disorders, symptoms of mental illness, and impacts of trauma and traumatic stress, among others. Despite the many labels, one indisputable truth is that adverse childhood experiences, which can include violence, abuse, and neglect, will impact a child’s sense of well-being, safety, trust, and her/his long-term mental and physical health and ability to function in everyday life (Stevens, 2012; Felitti, 2002; Felitti, et al., 1998).

The formal classification system of mental disorders and the diagnostic criteria relied on as a standard clinical reference in the field of mental health (for children and adults) is contained in the *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5)*. According to the DSM-5, a “mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (American Psychiatric Association, 2013, p. 20). Further, according to the DSM-5, these disorders are often related to distress or disability in social, employment/occupation, and other critical activities of daily living.

There is a fair amount of disagreement around the diagnosis and treatment of children who have been identified as having emotional and/or behavioral symptoms. Controversy also exists about the ages at which a mental health diagnosis may become appropriate; over medication of children and the side effects of psychotropic medicines; the role of pharmaceutical companies in developing and recommending drugs for use by children; the various risks of failing to provide appropriate treatment; and supportive resources for children with mental healthcare needs.

Even so, behavioral health specialists are increasingly recognizing that children who experience child maltreatment, including domestic, caregiver and/or sexual violence, are likely to experience lasting negative neurodevelopmental, physical, behavioral and mental health effects of trauma – unless they can receive the appropriate interventions and supports (Substance Abuse and Mental Health Services Administration, 2014).

What You Might Notice

There is a great deal of overlap in symptoms of complex emotional trauma and the various mental health disorders/diagnosis. Both may be misdiagnosed, undiagnosed, or misunderstood; both also tend to be less visible than other kinds of disabilities.

Indicators of Complex Emotional Trauma in Children	Indicators of Mental/Emotional Distress in Children
Difficulty with self regulation, resulting in: Over or under response to sensory stimuli; difficulty calming down when upset; shutting down; panic.	Feelings of overwhelming fear for no reason, which may include a racing heart or fast breathing; or worries or fears intense enough to interfere with daily activities.
Physical complaints	Physical complaints
Risky behaviors Attempts to numb out through use of drugs/alcohol/thrill seeking/sex	Impulsiveness, short attention span Skipping school, stealing, damaging property Abuse of alcohol and drugs
Difficulty identifying, expressing, or managing emotions	Mood swings
Internalizing or externalizing stress, resulting in: Depression/ anxiety, anger/rage, aggression and defiance	High anxiety or worrying Crying, angry outbursts, difficulty coping, raging Aggression or self-injurious behavior
Hyper-vigilance, guardedness	Withdrawal (not interacting with others, excessive fear or anxiety)
Aggressive response to blame or perceived attack	Aggressive actions, acting out
Emotional numbness, detachment, distance Mentally separate from what is going on	Detachment, disinterest Marked increase in time alone Loss of interest in friends and activities
Trouble thinking clearly, reasoning, or problem solving. Emerging struggles at school such as sustaining attention/ focus.	Learning difficulties (performing below grade level) Changes in school performance
Self-perception of being damaged, powerlessness, and having no hope	Hopelessness, helplessness
Over controlled or over compliant	Distorted thinking
Altered sleep patterns	Changes in eating and sleeping habits
Suicidal thoughts, self harm	Talk of death, self-injurious behavior
Nightmares	Ongoing nightmares or night terrors
Eating disorders	Preoccupation with weight, poor appetite, eating disorders
Flashbacks, hallucinations	Hearing or seeing things that are not there

(Adapted from National Child Traumatic Stress Network, 2014; Chadwick Center for Children and Families, 2013; Levine & Kline, 2007; and Mayo Clinic, 2012.)

Doing the best that they can

.... many of the children who come into contact with the child welfare system have experienced chronic and complex trauma which has detrimentally impacted their brain development. ..many of the troubling and difficult behaviors exhibited by the child ... are directly related to brain functioning, and they are doing the very best they can.

(Chadwick Center for Children and Families, 2013, p. 35)

Preparing for Interaction/Interview

- Gather information from the school, counselor, caregivers, and others about the child's history of trauma, diagnosis, and coping skills (which can be adaptive and/or harmful).
- In addition to learning about the child's specific diagnosis, learn from records and interviews how the child functions on a daily basis; how she or he manages school, family, and friends.
- Not all children who experience trauma develop symptoms of post-traumatic stress disorder (PTSD). PTSD is most common in children who have experienced severe, chronic and/or interpersonal trauma. Children with any level of traumatic stress, whether their symptoms meet the criteria for PTSD or not, can benefit from a trauma-informed approach.
- Find out if there have been recent changes in the child's reactions and behaviors, what medications the child is taking and the possible side effects; and if there are any words, situations, or questions that might be particularly distressing, or triggering, to this child. Gather information about how to help the child best cope with any stress from the interview.

(Adapted from Oregon Department of Justice, 2012; Chadwick Center for Children and Families, 2013; and Kupper, n.d.)

During Interaction/Interview/Investigation

Set the stage:

- Keep the meeting space free of distractions. Leave a clear path to the exit.
- Be direct and clear about who you are and what your role will be.
- Structure the meeting. Explain what you will talk about and do and for how long.
- Support the child in controlling the situation as much as possible. For example, allow children to choose where to sit in the interview room.
- Ask if there is anything you can do to help the child feel more comfortable. However, because children who have experienced abuse and traumatic stress may not routinely have their needs taken into account, they may have difficulty articulating what they need. Offer concrete choices and identify what you can and cannot do (D. Velasco, personal communication, July 27, 2014).

Respond to the child:

- Let the child know that talking about this subject is difficult for most children.
- If the child withdraws, give her/him some time and space to process reactions.
- If the child is not talking, introduce another activity, such as drawing or playing with Play-Doh, and then restart the conversation. Tactile interaction can help the child talk, think, and process. Have soft pillows available for holding, if possible.
- If the child becomes agitated, consider allowing her/him to move about, fidget, or jump in place, because it may help them self-soothe. If the activity becomes disruptive or isn't soothing, redirect the child back to the conversation.
- If the child seems volatile, but is still safe, provide space for him or her calm down. If the child is not calming down, reschedule the meeting.
- If the child is getting distressed, and you have gathered information that includes how to best help the child become calm, consult your notes. (See Appendix A for this and other helpful questions.)
- Be at ease and empathetic. Ask how you can assist the child to be more comfortable. Offer a short break or provide more space.
- If the child is raging or experiencing overwhelming distress and this distress does not decrease with time, seek assistance from the child's caregiver or support person. If necessary, call the local mental health crisis unit, if available. If unavailable, call Emergency Medical Services (EMS).

Follow-up:

- If possible, refer the child for trauma-informed therapeutic interventions and treatments for ongoing support.

- Work with local mental health providers to conduct a comprehensive trauma-informed assessment that includes information on symptoms, functioning, strengths and resilience.
- Offer information and available supports to the child’s caregivers to increase their capacity to support the child in recovery.

(Above sections adapted in part from Chadwick Center for Children and Families, 2013; and Oregon Department of Justice, 2012)

Children and Youth with Co-Occurring Substance Abuse/Addiction

Children and adults who have experienced trauma are at greater risk of self-medicating by using alcohol and drugs. Teens may use substances as coping strategies for anxiety, depression, and problems with social skills. Other risk factors for children and youth include: a family history of substance use disorders; depression and low self-esteem; and children who do feel like they don’t fit in (American Academy of Child and Adolescent Psychiatry, 2014).

Warning signs of teenage drug or alcohol abuse may include:

Physical Symptoms:

- Bloodshot eyes
- Small or large pupils
- Frequent nosebleeds (methamphetamine or cocaine)
- Changes in appetite or sleep patterns
- Sudden weight loss or weight gain
- Seizures without a history or seizure disorder
- Deterioration in personal grooming or physical appearance
- Impaired coordination
- Injuries/accidents/bruises that they can’t explain
- Unusual smells on breath, body, or clothing
- Shakes, tremors, incoherent or slurred speech, impaired or unstable coordination

Behavioral Symptoms:

- Skipping class, declining grades, getting in trouble at school
- Drop in attendance and performance at work
- Loss of interest in extracurricular activities, hobbies, sports, or exercise
- Complaints from co-workers, supervisors, teachers, or classmates
- Missing money, valuables, prescriptions, or prescription drugs.
- Borrowing and stealing money
- Acting isolated, silent, withdrawn, engaging in secretive or suspicious behaviors
- Clashing with family values and beliefs
- Preoccupation with alcohol and drug-related lifestyle in music, clothing, and posters
- Demanding more privacy, locking doors, and avoiding eye contact
- Sudden change in relationships, friends, favorite hangouts, and hobbies
- Frequently getting into trouble (arguments, fights, accidents, illegal activities)
- Using incense, perfume, air freshener to hide smell of smoke or drugs
- Using eye drops to mask bloodshot eyes and dilated pupils

Psychological Symptoms:

- Unexplained, confusing change in personality and/or attitude
- Sudden mood changes, irritability, angry outbursts, or laughing at nothing
- Periods of unusual hyperactivity or agitation
- Lack of motivation; inability to focus, appears lethargic or “spaced out”
- Appears fearful, withdrawn, anxious, or paranoid, with no apparent reason

(Above sections adapted from National Council on Alcoholism and Drug Dependence, n.d.; National Alliance on Mental Health, n.d.)

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APPENDIX

- A. **Helpful Information to Support Interactions with a Child who has a Disability**
- B. **Resources**

APPENDIX A. HELPFUL INFORMATION TO SUPPORT INTERACTIONS WITH A CHILD WHO HAS A DISABILITY

Asking parents, family members, or caregivers the following practical questions is likely to facilitate your interaction with each child with a disability.

Name of Child:

Date:

Interviewer:

Question	Answer each question in the space provided below.
Does _____ have any drink, food and/or environmental allergies and intolerances, including potentially life-threatening reactions?	
What language does _____ speak or hear at home?	
How does _____ best communicate? Examples include using a communication board, taking more time, taking frequent breaks, needing a patient listener.	
How does _____ best communicate basic needs (e.g., needing a break for restroom, wants water or break, is cold, hot, etc.)?	
What are the signs and indicators that _____ is becoming tired or frustrated, or needs help?	
What tends to make _____ anxious?	

Question	Answer each question in the space provided below.
What is reassuring, soothing, and calming to _____ (certain toys, stuffed animals, places)?	
What do other people like about _____ ?	
What is important to _____?	
What supports does _____ need during the day?	
What behaviors may be misunderstood by others but are typical for _____ ?	
Are there certain things that trigger or cause _____ to become upset?	
What is helpful when _____ is angry, upset, or acting out?	

This information was provided by: _____

Relationship to the child: _____

(This form was adapted from personal communication with R. Alexander.)

APPENDIX B. RESOURCES

- Resources Addressing Abuse and Children with Disabilities
- Victim Service Resources
- Disability-Specific Resources
- Parent Resources
- Trauma-Informed Resources
- Substance Abuse Resources
- ADA-Legal Resources
- Texas State Agencies

Resources Addressing Abuse and Children with Disabilities

The Adverse Childhood Experiences (ACE) Study

<http://www.cestudy.org/>

The ACE Study is ongoing collaborative research between the Centers for Disease Control and Prevention in Atlanta, GA, and Kaiser Permanente in San Diego, CA. Data from 17,000 adults reveals staggering proof of the health, social, and economic risks that result from childhood trauma. This site provides access to the peer-reviewed publications resulting from The ACE Study.

Autism Risk & Safety Management – Resources for Law Enforcement.

<http://www.autismriskmanagement.com/>

Autism training and resources for law enforcement, emergency first responders, parents, educators, care providers, and the autism community. Dennis Debbaudt is the father of a young man who has autism, and is also an author, a professional investigator, and a law enforcement trainer.

Child Abuse & Children with Disabilities- A New York State Perspective

<http://disabilityabuse.org/>

This website provides an overview of child abuse and children with disabilities with a focus on interviewing strategies, along with other resources. Its goal is providing information for working more effectively with child abuse cases that may involve children with disabilities and their families.

Child Welfare Information Gateway

<http://www.childwelfare.gov>

Connects child welfare and related professionals to comprehensive information and resources to help protect children and strengthen families. Topics range from prevention to permanency, and include child abuse and neglect, foster care, and adoption.

Childhelp

<http://www.childhelpusa.org>

Exists to meet the physical, emotional, educational, and spiritual needs of abused, neglected, and at-risk children. Focus is on advocacy, prevention, treatment, and community outreach. 1.800.422.4453 - Hotline and Information

Children’s Advocacy Centers of Texas, Inc.

<http://www.cactx.org>

Supports Texas Children’s Advocacy Centers (CACs) in partnership with local communities and agencies investigating and prosecuting child abuse. Provides contact information for local CACs, which provide a safe, child-friendly environment where law enforcement, child welfare and protective services, prosecution, medical, and mental health professionals may share information and develop effective, coordinated strategies sensitive to the needs of each unique case and child.

Disability and Abuse Project

<http://www.disability-abuse.com>

The Disability and Abuse Project focuses on the physical, sexual, and emotional abuse of people with developmental or intellectual disabilities. The project works to identify ways to reduce the risk of abuse, to promote healing for victims, and to seek justice for those who have been victimized through public awareness, education and training, policy development, law enforcement, and professional consulting.

Disability Rights Texas

<http://www.disabilityrightstx.org>

1-800-252-9108

This state-wide protection and advocacy organization offers legal services and advocacy for children and adults with disabilities in the areas of accessibility, community living, education, employment, health care, housing, protection and civil rights, and transportation. Their website has resources on legal issues facing people with disabilities.

Hill Country MHDD Centers

<http://www.hillcountry.org>

Among its other programs, provides early childhood intervention (ECI) services throughout the greater Texas Hill Country (Bandera, Blanco, Comal, Gillespie, Hays, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real, and Uvalde counties). ECI is a statewide program for families with children (0-3) with disabilities and developmental delays. ECI supports families to help their children reach their potential through developmental services.

National Center for Missing and Exploited Children

<http://www.missingkids.com/home>

The National Center for Missing & Exploited Children (NCMEC) works in partnership with the U.S. Department of Justice to help law enforcement find missing children, eliminate child sexual exploitation, and prevent child victimization.

- *Missing Children with Special Needs – NC13 – Investigator’s Package*

<http://www.missingkids.com/publications/NC13>

http://www.missingkids.com/en_US/publications/SpecialNeeds_Addendum.pdf

http://www.missingkids.com/en_US/publications/SpecialNeeds_Questionnaire.pdf

Oregon Project Ability: Demystifying Disability in Child Abuse Interviewing

<http://www.oregon.gov/dhs/children/committees/cja/ProjectAbility-DemystifyingDisabilityinChildAbuseInterviewing.pdf>

Project Ability: Demystifying Disability in Child Abuse Interviewing is a training curriculum for professionals who work with children with disabilities. While it was developed for use in Oregon, it can be downloaded free of charge online and is pertinent to child maltreatment providers in the U.S.

Prevent Child Abuse Texas

<http://www.preventchildabusetexas.org/>

Prevent Child Abuse Texas provides legislative advocacy and hosts conferences and trainings throughout Texas on the subject of child abuse.

Safe Start Center

<http://www.safestartcenter.wordpress.com/>

The Safe Start National Resource Center works to raise awareness, develop effective community action, and move from evidence to action to prevent and reduce the impact of violence on children and their families. This includes those who are both direct victims of violence and those who witness, hear, see, or experience the aftermath of violent events in the home, school, and community. The website includes tip sheets and issues briefs about children’s exposure to violence.

SafePlace

<http://www.safeplace.org/about/programs-and-services/disability-services-asap/>

SafePlace is the domestic violence/sexual assault center in Austin-Travis County, and has developed a national reputation for addressing violence against children and adults with disabilities. SafePlace’s Disability Services provides training and education to help increase awareness about and prevent sexual and domestic violence and abuse against people with disabilities.

Texas Lawyers for Children

<http://http://www.TexasLawyersforChildren.org>

TLC provides statewide assistance to judges and attorneys who handle child abuse and neglect cases. TLC's services include an online legal resource center, secure communication tools, and a network of pro bono attorneys available to mentor our site users.

Texprotects

<http://www.texprotects.org/>

Texprotects performs legislative advocacy and research on child abuse and neglect. Texprotects also offers presentations, webinars, and other educational opportunities at no cost.

Victim Service Resources

National Center for Victims of Crime

<http://www.ncvc.org>

The National Center for Victims of Crime (NCVC) is a nonprofit organization that advocates for adult and youth victims' rights, trains professionals who work with victims, and serves as a trusted source of information on victims' issues. The website contains information and resources for crime victims, including for child abuse and child sexual abuse.

2000 M Street NW, Suite 480, Washington, DC 20036 • 202.467.8700

National Coalition Against Domestic Violence

<http://www.ncadv.org>

The National Coalition against Domestic Violence (NCADV) works to build coalitions at the local, state, regional, and national levels; supports the provision of community-based, non-violent alternatives (such as safe home and shelter programs) for battered women and their children; provides public education and technical assistance; engages in policy development and innovative legislation; and seeks to eradicate social conditions which contribute to violence against women and children. The website includes free or lost cost publications, including one on working with survivors with disabilities.

One Broadway, Suite B210, Denver, CO 80203 • 303.839.1852 • 303.839.8459 TTY

Email: mainoffice@ncadv.org

National Domestic Violence Hotline

<http://www.ndvh.org>

Advocates are available 24/7 to talk confidentially with anyone experiencing domestic violence, seeking resources or information, or questioning unhealthy aspects of their relationship.

1.800.799-7233 • 1.800.787.3224 (TTY) • 855.812.1001 (VP)

Email: deafhelp@thehotline.org

National Resource Center on Domestic Violence

<http://www.nrcdv.org>

The National Resource Center on Domestic Violence (NRCDV) is a comprehensive source of information for those wanting to educate themselves and help others on the many issues related to domestic violence. NRCDV works to improve community response to domestic violence and, ultimately, prevent its occurrence through technical assistance, training, and resource development to people who are working to end domestic violence in relationships and communities.

National Sexual Violence Resource Center

<http://www.nsvrc.org>

The NSVRC's mission is to provide leadership in preventing and responding to sexual violence through collaboration, sharing and creating resources, and promoting research.

123 North Enola Drive, Enola, PA 17025

1.877.739.3895 • 717.909.0715 (TTY)

Email: resources@nsvrc.org

Rape, Abuse, and Incest National Network (RAINN)

<http://www.rainn.org>

RAINN created and operates the National Sexual Assault Hotline in partnership with more than 1,100 local rape crisis centers across the country and also carries out programs to prevent sexual violence, help victims, and ensure that rapists are brought to justice.

National Sexual Assault Hotline

1220 L Street NW, Suite 505, Washington, DC 20005 • 1.800.656.4673

Email: info@rainn.org

Disability-Specific Resources

Attention Deficit Disorder

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)

<http://www.chadd.org>

CHADD is a national non-profit membership organization providing education, advocacy, and support for individuals with A-D/HD. Some materials about A-D/HD are available free of charge on the website.

8181 Professional Place, Suite 150, Landover, MD 20785

301.306.7070 • 1.800.233.4050 (Voice mail to request information packet)

Attention Deficit Disorders Association - Southern Region (ADDA-SR)

<http://www.adda-sr.org>

ADDA is a membership organization that provides a resource network, supports individuals impacted by A-D/HD and related conditions, and advocates for the development of community resources.

12345 Jones Road, Suite 287-7, Houston, TX 77070 • 281.897.0982

Email: addaoffice@sbcglobal.net

Autism Spectrum Disorder

Autism Society of America

<http://www.autism-society.org>

The Autism Society and its affiliates share a common mission of providing information and education, supporting research, and advocating for programs and services for the autism community.

4340 East-West Hwy., Suite 350, Bethesda, MD 20814

301.657-0881 • 1.800.3-AUTISM (328.8476)

Blindness

American Council of the Blind

<http://www.acb.org>

The American Council of the Blind strives to increase the independence, security, equality of opportunity, and quality of life for all people who are blind and visually impaired. The website also has a list of resources.

Email: info@acb.org

American Council of the Blind of Texas

<http://www.acbtexas.org>

American Council of the Blind of Texas is a membership group that works to be an advocacy organization and positive, proactive support system to Texans who are blind or visually impaired.

The website contains information about local chapters, local Texas para-transit services, information about travel, etc.

American Foundation for the Blind Center on Vision Loss

<http://www.afb.org/info/programs-and-services/center-on-vision-loss/12>

Website hosts an online community that offers tips and support to parents of children who are blind, as well as information about specific diagnosis of vision loss, and information about technology resources at <http://www.afb.org/info/living-with-vision-loss/using-technology/12>

Audio Taping Services

Reading and Radio Resource

Reading & Radio Resource provides direct distribution of audio books for adults and children via digital streaming

2007 Randall, Dallas, TX 75201 • 214.871.7668

<http://www.readingresource.org>

Books on Tape

Talking Book Program

The Talking Book Program provides free library service to Texans of all ages who are unable to read standard print material due to visual, physical, or reading disabilities – whether permanent or temporary.

Texas State Library

1201 Brazos Street, Austin, TX 78701 • 512.463.5455

Email: info@tsl.state.tx.us

<http://www.tsl.texas.gov/tbp/index.html>

Texas School for the Blind and Visually Impaired

<http://www.tsbvi.edu>

Texas School for the Blind and Visually Impaired (TSBVI) is a school serving Texas children who are blind or who have a visual impairment.

1100 W. 45th St., Austin, TX 78756 • 512.454.8631 • 1.800.872.5273

Brain Injury

Texas Brain Injury Alliance

<http://www.texasbia.org/>

Texas Brain Injury Alliance is a Texas-wide community of people with brain injuries, their families, friends, and dedicated professionals. Website provides online resources and links for professionals and survivors.

2051 Gattis School Rd., Suite 540/ #50 Round Rock • 1.800.392.0040 (in Texas)

Email: info@texasbia.org

Cerebral Palsy

United Cerebral Palsy

<http://www.ucp.org>

UCP educates, advocates, and provides support services to ensure a life without limits for people with a spectrum of disabilities.

1825 K Street NW, Suite 600, Washington, DC 20006 • 1.800.872.5827 • 202.776.0406

Email: info@ucp.org

Deafness and Hard-of-Hearing

American Sign Language Interpreter Agencies

Communication By Hand

CBH provides ASL interpreter services in Austin, TX.

P.O. Box 9064, Austin, TX 78766, 512.467.1917

Email: communicationbyhand@yahoo.com

<http://www.communicationbyhand.com>

Communication Services for the Deaf (CSD) Corporate

<http://www.c-s-d.org>

CSD is a non-profit organization on a mission to change how Deaf people communicate and interact with the world. Website hosts an online interpreter request and management system.

1.800.642.6410 (Voice) • 1.866.273-3323 (TTY) • 1.605.496.0738 (VP)

Email: inquiry@c-s-d.org (for local services)

Hearing Loss Association of America (HLAA)

<http://www.hearingloss.org/>

HLAA provides assistance and resources for people who experience hearing loss and their families to learn how to adjust to living with hearing loss. Website provides links to resources for parents of children with hearing loss and young adults with hearing loss.

7910 Woodmont Ave., Suite 1200, Bethesda, MD 20814 • 301.657.2248

Relay Services

Telecommunications Relay Services for Individuals who are Deaf, Hard of Hearing, or with Speech Impairments

<http://www.consumer.att.com/relay/speechtospeech.html>

Relay service for people with speech disabilities who have difficulty being understood over the phone.

Captioned Telephone: 1.877.401.8668 Email: CapTel@CapTel.com

Speech to Speech: English: 1.866.988.4288; Spanish: 1.866.288.7504

SafePlace Deaf Services

<http://www.SafePlace.org/about/programs-and-services/DeafServices/>

SafePlace Deaf services provides counseling, parenting classes, case management and advocacy services, and community trainings for the D/deaf community in Austin-Travis County.

24 Hour Hotline: 512.267.7233 (Voice/VRS)

SafePlace, P.O. Box 19454, Austin, TX, 78760

Email: DeafServices@SafePlace.org

Texas Association of the Deaf

<http://www.facebook.com/pages/Texas-Association-of-the-Deaf/290960611446>

Texas Association of the Deaf promotes leadership, growth, and equality among Deaf Texans and hard-of-hearing Texans.

Texas School for the Deaf

<http://www.tsd.state.tx.us>

The mission of the Texas School for the Deaf is to ensure that students excel in an environment where they learn, grow, and belong.

1102 South Congress, Austin, TX 78704 • 512.462.5353 (Voice & TTY)

Travis County Services for the Deaf and Hard of Hearing

<https://http://www.traviscountytexas.gov/health-human-services/deaf-hard-of-hearing>

Travis County Services for the Deaf and Hard of Hearing offers case management, interpreting services, and legal, advocacy, and outreach services.

2201 Post Road, #100, Austin, Texas 78704

512.410.1598 (VP)

Email: doug.rollins@co.travis.tx.us

Intellectual/Developmental Disabilities

The Arc of Texas

<http://www.thearcoftexas.org>

The Arc of Texas creates opportunities for all people with intellectual and developmental disabilities to actively participate in their communities and make the choices that affect their lives in a positive manner.

8001 Centre Park Drive, Austin, TX 78754 • 512.454.6694 • 1.800.252.9729

Email: secretary@thearcoftexas.org

Mental Health Resources

Mental Health America - Texas

<http://www.mhatexas.org>

Mental Health America offers training on parenting and suicide prevention as well as training, technical assistance, and consultation to individuals in recovery from mental illness, their family members, youth, and mental health professionals throughout the state of Texas. Resources and information on types of mental illnesses, factors that contribute to mental illness, cultural competency, how to get help, and links to local service providers are available through its website.

1210 San Antonio, Suite 200, Austin, TX 78701 • 512.454.3706

Email: mhainfo@mhatexas.org

NAMI Texas

<http://www.namitexas.org>

NAMI Texas works to inform the public about mental illness. NAMI offers support groups and referrals to local mental health services.

Fountain Park Plaza III

2800 South IH 35, Suite 140, Austin, TX 78704 • 512.693.2000 • 1.800.633.3760

Email: namitexas@texami.org

Seizure Disorder

Epilepsy Foundation Texas

<http://www.eftx.org>

Epilepsy Foundation Texas provides a wide array of programs and services to benefit people with epilepsy and their families. Programs and services offered include support groups, medical services and training programs.

Locations in Amarillo, Addison, Houston, and Lubbock, see website or call toll free number for details 1.888.548.9716

General Information about Disabilities

Centers for Disease Control and Prevention

<http://www.cdc.gov/ncbddd/index.html>

National Center on Birth Defects and Developmental Disabilities

Includes information about disabilities.

National Dissemination Center for Children with Disabilities

<http://www.parentcenterhub.org/resources/>

Central source of information on disabilities in infants, toddlers, children, and youth.

Parent Resources

PACER Center- Parent Advocacy Coalition for Educational Rights

<http://www.pacer.org>

PACER Center is a parent training and information center for families of children and youth with all disabilities from birth through 21 years old. Parents can find publications, workshops, and other resources to help make decisions about education, vocational training, employment, and other services for their children with disabilities. PACER's National Bullying Prevention Center provides resources designed to benefit all students, including those with disabilities.

Partners Resource Network

<http://www.partnerstx.org/>

The Partners Resource Network provides training and information (online and throughout Texas) to help parents, professionals, and self-advocates understand and advocate for children's disability issues throughout Texas and online.

Texas Parent to Parent

<http://www.txp2p.org/index.html>

Texas Parent to Parent (TxP2P) empowers families to be strong advocates through parent-to-parent support, resource referral, and education. In addition, TxP2P educates professionals about the unique needs of our children with the goal of improving care and opportunities for our children. Lastly, TxP2P is dedicated to championing the efforts of a diverse set of parent support groups and advocacy on behalf of our children's well-being.

TxP2P provides an on-line Resource Directory organized by counties.

Texas Project First

<http://www.texasprojectfirst.org/index.html>

The Texas Project First website, operated by the Family to Family Network, provides links to online and local resources and trainings around issues concerning children with disabilities.

Trauma-Informed Resources

National Child Traumatic Stress Network

<http://www.nctsn.org>

The National Child Traumatic Stress Network provides informational resources and online training with the goal of improving access to services and raising the standard of care for traumatized children and their families.

Stop it Now

<http://www.stopitnow.org/>

Stop it Now is a national organization dedicated to preventing childhood sexual abuse. Services include a national prevention hotline, an online help center and advice column, public policy advocacy, online training and educational resources, and consulting and training services

Somatic Experiencing Trauma Institute

<http://www.traumahealing.com/>

The Somatic Experiencing Trauma Institute provides education and training in the Somatic Experiencing treatment approach to trauma. Website features a blog and articles about trauma from a somatic experiencing perspective.

Substance Abuse Resources

The Association of Substance Abuse Programs (ASAP)

<http://www.asaptexas.org/index.html>

ASAP is a state organization that represents over 60 community-based, nonprofit substance abuse and treatment organizations. ASAP advocates to improve substance abuse service delivery on a state and local level. The website provides general information about substance abuse as well as information about substance abuse public policy and links to ASAP's member organizations

Substance Abuse and Mental Health Services Administration (SAMHSA)

<http://www.samhsa.gov/>

SAMHSA's mission is to reduce the impact of substance abuse and mental illness in America's communities. The website provides access to information and research relevant to substance abuse and mental health, including substance abuse and mental health issues among children.

Partnership for a Drug-Free Texas

<http://www.drugfreetexas.org/>

Website provides online information, teaching materials, and resources to aide in drug use prevention and intervention for children.

ADA - Legal Resources

Americans with Disabilities Act

Americans with Disabilities Act Information and Technical Assistance

U. S. Department of Justice Disability Rights Division

<http://www.ada.gov>

U. S. Department of Justice

950 Pennsylvania Avenue, NW, Civil Rights Division

Disability Rights Section- NYA, Washington, D.C. 20530

1.800.514.0301 (Voice) • 1.800.514.0383 (TTY)

Regional ADA & IT Technical Assistance Center

<http://www.southwestada.org>

The Center's mission is to promote voluntary compliance with the Americans with Disabilities Act (ADA) by providing technical assistance, training and materials dissemination.

Southwest ADA Center

TIRR Memorial Hermann - ILRU 1333 Moursund

Houston, TX 77030 713.520.0232 • 1.800.949.4232

E-mail: swdbtac@ilru.org

Legal Advocacy

Disability Rights Texas

<http://www.disabilityrightstx.org>

Disability Rights Texas is a state-wide agency that provides legal and advocacy services for people with disabilities in Texas.

2222 West Braker Lane, Austin, Texas 78758 • 512.454-4816(Voice) • 1.866.362-2851(VP)

Texas State Agencies

Texas Council for Developmental Disabilities

<http://www.txddc.state.tx.us>

The Texas Council for Developmental Disabilities helps people with developmental disabilities achieve their potential for independence, productivity, and integration into their communities by working to develop a comprehensive system of service and supports in Texas.

6201 East Oltorf, Suite 600, Austin, TX 78741.7509 • 512.437.5432 • 1.800.262.0334

Email: tcdd@tcdd.texas.gov

Texas Department of Assistive and Rehabilitative Services (DARS)

<http://www.dars.state.tx.us>

Services for children and adults with disabilities.

Email: DARS.Inquiries@dars.state.tx.us

1.800.628.5115 (voice or relay)

- Autism Program: <http://www.dars.state.tx.us/stakeholders/autism/index.shtml>
- Division for Blind Services: <http://www.dars.state.tx.us/dbs/index.shtml>
- Office for Deaf and Hard of Hearing Services: <http://www.dars.state.tx.us/dhhs/index.shtml>

Texas Department of Family and Protective Services (DFPS) - Child Protective Services

<http://www.txabusehotline.org>

DFPS provides this secure website for reporting suspicions of abuse, neglect, and exploitation of children, adults with disabilities, or people who are elderly (65 years or older)

State Office: 701 W. 51st St., Austin, Texas 78751 • 512.438.4800

<http://www.txabusehotline.org> or 1.800.252.5400

Texas Department of State Health Services - Mental Health Services

<http://www.dshs.state.tx.us/MHSA/>

The Texas Department of State Health Services Mental Health and Substance Abuse Division funds providers of mental health and substance abuse services who then assist those in need of such services.

1100 West 49th Street, Austin, TX 78756 • 512.776.7111 • 1.888.963.7111

Telecommunications Device for the Deaf (TDD) Relay Texas: 1.800.735.2989

Email: web.master@dshs.state.tx.us

ABOUT SAFEPLACE

During the past 40 years, SafePlace has provided services to Austin/Travis County youth and adult survivors of domestic/sexual violence to help them heal, gain resources and skills, and build self-sufficient, peaceful futures. We also offer abuse prevention programs, trainings, and other resources to the community to help address and end this violence.

SafePlace and Austin Children's Services (ACS) are founding partner agencies of LIFT: An Alliance to End Abuse. LIFT's mission is *to eliminate child, sexual and domestic violence and abuse through the power of our combined voices and actions.*

SafePlace's services include:

- *Safety:* 24-hour crisis Hotline; 105-bed Family Shelter; support for rape survivors at hospitals; support for abuse survivors in courtrooms; on-site K-12 charter school for youth living at SafePlace and at Austin Children's Services, and a child care center for families at SafePlace. In collaboration with Travis County, we offer PlanetSafe, a safe exchange and supervised visitation center for abuse survivors and their children.
- *Healing:* Therapeutic counseling, up to 51 transitional housing apartments, case management, and Life Skills classes, among other services.
- *Prevention:* To stop violence and promote healthy relationships, SafePlace provides abuse prevention programs and other resources in schools and to the community. These programs include the Expect Respect program, to prevent youth sexual/dating violence; and the Disability Services and Deaf Services programs, to prevent abuse of people with disabilities and Deaf people.
- *Social Change:* Working with others, we advance alternatives to attitudes, behaviors, and policies that perpetuate acceptance of interpersonal violence, especially violence against women.

Since its inception as a SafePlace program in 1996, Disability Services has been nationally recognized as one of the primary leaders in the field of domestic/sexual violence prevention and intervention for people with disabilities. Program staff has provided training and education on topics related to violence against people with disabilities to approximately 70,000 people with disabilities; family members; and disability, crisis service, child advocacy, and criminal justice professionals.