Project Ability

A Reference Guide for Interviewing Children with Disabilities

Oregon Children's Justice Act Taskforce
Oregon Department of Justice, Child Abuse Multidisciplinary Intervention (CAMI) Program
Oregon Network of Child Abuse Intervention Centers

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Introduction

PROJECT ABILITY: A REFERENCE GUIDE FOR INTERVIEWING CHILDREN WITH DISABILITIES

Project Ability was developed in 2008 as an advanced forensic interviewing guide for professionals throughout the State of Oregon who work with children with disabilities. The Oregon Children's Justice Act (CJA) Task Force commissioned the development of this work and specified a focus on strategies for interviewing children with disabilities about child abuse.

Oregon Interviewing Guidelines and the Oregon Child Forensic Training

In 2012, the *Oregon Interviewing Guidelines* (OIG) were updated to include forensically sound, research-based best practices in child interviewing. The guidelines inform forensic interviewers on how to elicit reliable, detailed information from a child about abuse in a child-sensitive, developmentally appropriate, and legally defensible manner. The *Oregon Child Forensic Interview Training* (OCFIT) was subsequently developed in 2012 to provide consistent, standardized training on the OIG for professionals across the State of Oregon. OCFIT provides a wealth of information regarding evidence-based practice supported by current research in forensic interviewing techniques to meet the needs of the multidisciplinary team (MDT) professionals in the state.

The OIG and OCFIT include fundamental information on interviewing children with disabilities. However, this topic is complicated. Additionally, research shows that children with disabilities are at greater risk of child maltreatment than children without disabilities. Unfortunately, most professionals who conduct child forensic interviews are not "experts" in the field of disability, which can lead to apprehension about conducting interviews with this vulnerable population. Therefore, this *Project Ability* reference guide has been updated to include more detailed information and advanced techniques derived from the OIG and OCFIT to help professionals interviewing children with disabilities achieve the best outcomes.

OBJECTIVES AND COMPETENCIES

After reviewing this guide, MDT professionals will be able to:

- Define the term "disability."
- Utilize five strategic questions when preparing for interviews with children with disabilities.
- Discuss the characteristics of and the interview accommodations for a child who has difficulties or delays in one or more of the following areas:
    - Communication, intelligence, social/emotional functioning, and physical functioning

Chapter 1: Disability Statistics, Definitions, and Vulnerabilities

In the 2012–2013 school year, approximately 13% of children and youth aged 3 to 21 years qualified for special education services nationally (U.S. Department of Education, National Center for Education Statistics, 2016). This statistic does not include children with undiagnosed/unidentified disabilities.

Undoubtedly, forensic interviewers will work with children with disabilities. Regardless of any condition, difficulty, or limitation a child may experience due to disability, interviewers must understand that the child is more similar to typically developing children than different. As an interviewer, it is crucial to build on the child's strengths and abilities. This shows respect for the child and, ultimately, allows for the best possible outcome: a successful interview and a safer child.

DEVELOPMENTAL DISABILITIES AND THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT

Developmental disabilities

Children grow and develop into adults according to a predictable schedule. They meet developmental milestones as they learn new skills and move through the ages and stages of childhood. Sometimes, children develop atypically, which can lead to developmental delays and/or disabilities.

In 2015, the Centers for Disease Control and Prevention (CDC) defined developmental disabilities as a group of conditions that are due to language, learning, behavioral, or physical impairments that become apparent as a child grows. The conditions may impact daily functioning in some capacity and usually last throughout a person's lifetime.

The Individuals with Disabilities Education Act (IDEA)

The Individuals with Disabilities Education Act (IDEA) is a federal law that was enacted in 1975. It mandates that public schools make available to all eligible children with disabilities appropriate public education in the least restrictive environment, according to their needs (U.S. Department of Education, n.d.). The IDEA identifies 10 categories of disabilities that qualify children and youth for special education services between the ages of 3 and 21. The 10 categories of disabilities include specific learning disabilities, speech or language impairments, autism, emotional disturbances, other health impairments, and physical disabilities (hearing and visual impairments, multiple disabilities, and traumatic brain injury). *Project Ability* will reference these categories of disabilities.

Figure 1 below is from the U.S. Department of Education, National Center for Education Statistics (2016). The graph shows the distribution of disabilities among children and youth aged 3 to 21 who qualified for special education services in the 2013–2014 school year.

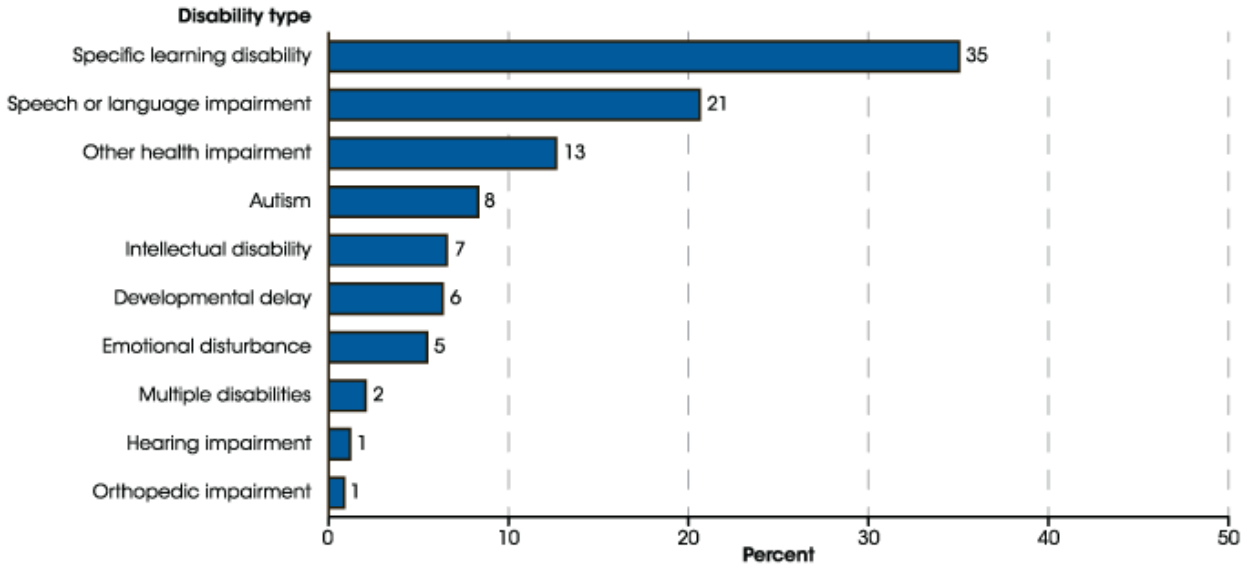


Figure 1. Disability types among U.S. schoolchildren who qualify for special education services

DEFINITION OF DISABILITY FOR THIS GUIDE

Professionals who interview children about possible abuse need to know how to interview children with disabilities, but it is unrealistic to expect them to develop expertise in every disability. Instead, regardless of the impairment's label or cause, interviewers should understand how disabilities can interfere with four basic areas (or domains) of functioning: communication, intelligence, social/emotional behavior, and physical functioning (sight, hearing, movement, and maintaining health).

For the purposes of this reference guide, *Project Ability* defines disability as a medical, educational, or psychological condition that interferes with a child's ability to:

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

In the subsequent chapters, *Project Ability* includes information about disabilities as they relate to the four basic domains of functioning (communication, intelligence, social/emotional behavior, and physical functioning), as well as appropriate accommodations to make for these disabilities.

DISABILITIES INCREASE VULNERABILITY TO CHILD ABUSE

Disability and maltreatment statistics

Research has consistently shown that children with disabilities are at an increased risk for maltreatment and abuse compared to children without disabilities. Some concerning statistics from large meta-analysis studies include:

- Through a systematic review and meta-analysis, Jones and colleagues (Jones, et al., 2012) noted that children with disabilities were over ***three times*** more likely to experience many types of abuse, including physical violence, sexual violence, emotional abuse, and neglect. In particular, youth with disabilities experienced the following types of violence (Jones, 2012, as cited by Hamby 2013):
    - Approximately 1 in 4 (27%) experienced physical violence.
    - Approximately 1 in 6 (15%) experienced sexual victimization.
    - Children with psychological or intellectual disabilities were at significantly higher risk of experiencing sexual violence compared to children with physical disabilities.
- A retrospective cohort study completed by Kristen and colleagues (Kristin, et al., 2016) noted that children with disabilities as compared to children without disabilities were approximately:
    - 14% more likely to be re-referred for concerns of abuse.
    - 9% more likely to experience substantiated maltreatment.
    - 4% more likely to be placed in foster care.
- According to the *Child Maltreatment 2009* annual report, which compiled and analyzed child maltreatment data from the National Child Abuse and Neglect Data System (NCANDS) from 48 states, **11% of child victims of maltreatment had a reported disability** (U. S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, 2009, as cited by Child Welfare Information Gateway, 2012).

Factors that increase risk of maltreatment for children and youth with disabilities

In all cases of abuse (physical, sexual, emotional, and neglect), the most frequent abuser is the primary care provider. No single risk factor places children at risk of abuse or neglect; it is the interaction of various factors that increases the risk (Child Welfare Information Gateway, 2012). Common factors that increase the risk of maltreatment for any child, regardless of disability status, include:

- Parent's personal experience of abuse as a child
- Parent's negative attitude toward the child
- Parent's lack of child development knowledge
- Single-parent household
- Poverty or unemployment
- Parental substance abuse, mental health challenges (e.g., depression, anxiety), or antisocial behaviors

- Lack of social support; isolation
- Domestic or community violence

Given that these factors can occur for any family, it is important to keep in mind that caregivers of children with disabilities may be under even more stress. This stress may be caused by additional risk factors, such as:

- Lack of information and education on their child's disability, resulting in unrealistic expectations
- Lack of respite care and support services
- Child's increased need for daily care assistance (i.e., bathing, toileting, eating, mobility, dressing, and medical care)
- Behavioral management—coping with challenging behaviors such as temper tantrums, aggressiveness, and noncompliance
- Feelings of guilt over the child's disability

Plus, child-related risk factors can make children with disabilities more vulnerable to maltreatment, including:

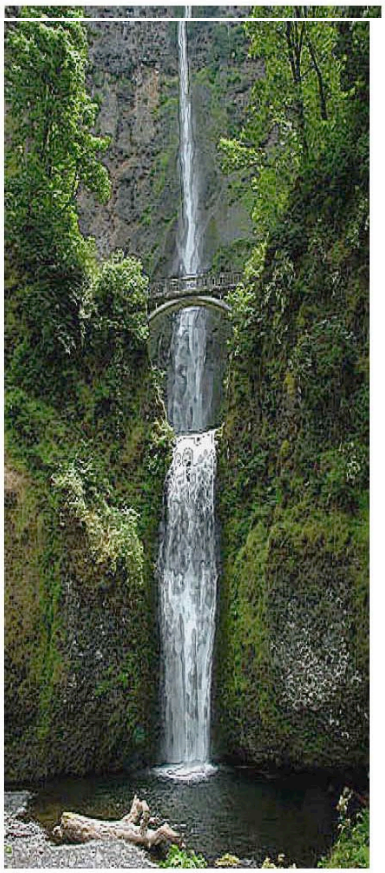
- Limited communication skills to tell and/or explain about the abuse
- Dependency on caregivers to help with daily care routines and inability to differentiate between appropriate touch and abusive acts
- Challenging behaviors that can overwhelm the caregiver

CASCADE OF INJUSTICES

In summary, children with disabilities are at higher risk for maltreatment. *Project Ability* is indebted to Mary Steinberg, MD, and Judith Hylton, M.Ed. (1997) for developing the Cascade of Injustices, which characterizes further increased risk for the aftermath of abuse.

Cascade of Injustices

People with disabilities are at greater risk for:



Abuse and neglect

Not recognizing abuse and neglect as wrong

Not having a disclosure understood or believed

Not having reports of abuse investigated

Not having investigations lead to trial

Not receiving therapy for the effects of the maltreatment

Not having the therapy appropriate to their needs

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

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

Chapter 2: Identifying Ability and Demystifying Disability—Child Development, Assessment, and Developmental Disabilities

The basis of understanding disabling conditions in children is rooted in typical child development. By learning "what went wrong" during typical development, it is easier to identify what is going well—thus, accentuating the child's strengths and abilities. Building on the child's strengths and identifying adaptations and accommodations for the difficulties the child experiences enables interviewers to conduct forensically sound interviews. This chapter reviews typical child development, emphasizing four main areas (or domains) of development, which will aid understanding of the most common types of developmental problems.

TYPICAL CHILD DEVELOPMENT

Almost everyone has some formal and/or informal knowledge about children. Even a non-expert on the subject can discuss child development informally because of personal experiences as a child growing up, going to school, and observing children's similarities and differences. As adults, raising children or watching others raise children can reveal the predictability of child development.

From each of these perspectives, it is apparent that all children start small and grow larger, know little at first and learn many things very rapidly, and often develop ahead or behind another child the same age in one way or another. So the *process* of child development is sequential and predictable. The *speed* at which the process unfolds varies from child to child, but the general *sequence* through which children pass is similar. "Typical development" refers to children acquiring a wide range of skills similar to the majority of children their same age within their same culture.

Domains of child development

Child development is often described in terms of **domains** (i.e., physical development and cognitive development) and by ages and stages (i.e., the predictable process of growing from infancy to adulthood) (Centers for Disease Control and Prevention (CDC), 2015). *Project Ability* references four primary domains of development: physical, intellectual, speech and language, and social and emotional.

Physical development involves increases in height, weight, and head circumference along a predictable trajectory. Physical development also includes motor development:

- Gross motor skills involve the use of large muscle groups for physical movement (crawling, walking, running).

- Fine motor skills (dexterity) have to do with coordinating small muscles in movement, often relating use of hands and feet with eye coordination, as well as movements like grasping items and writing.

Intellectual development refers to how the brain takes in, processes, and uses information.

- Intellectual development involves both accumulating information (learning) and processing the knowledge.
- The development and use of reasoning and judgment are part of intellectual development.
- Intellectual development may be measured using intelligence tests as well as tests for processing and learning styles.

Speech and language development involves the production of speech sounds and the use of language for communication and comprehension.

- Speech is making the sounds that become words.
    - Speech begins in infancy and proper articulation of all speech sounds is usually mastered by age 8 or 9.
- Language is the use of words and gestures to communicate.
    - Language includes expressive language (messages sent) and receptive language (messages received).
- Speech and language development varies somewhat across specific languages and is certainly more complex for children growing up in bilingual homes and communities.

Social/emotional development involves developing skills for interactions and implementing emotional development in a social setting.

- Social development involves learning how to select behaviors that are appropriate to the setting and situation.
    - Behavior is an observable manifestation of cognitive processes directing and sometimes overriding emotional wants and needs.
- Emotional development has to do with psychological development—establishing personal identity, meeting personal needs, and finding one's place in relationships within family, school, work, and community.
    - The acquisition of self-esteem and self-regulation is part of emotional development.
- While all of the ages and stages of childhood are influenced by environment, social development and emotional development are very much an interactional process.

VARIATION IN CHILD DEVELOPMENT

In daily life, informal assessments of children's development often occur. At the very least, it is noticeable when children do not "act their age" or are taller/shorter than other children their age. A chart of typical child development is frequently used to show how close a child is in their

development as compared to their same-aged peers. In cases where the variation is wider for a single developmental domain, atypical development can be explained as an *individual difference,* and the child often catches up. When the process and/or speed of a child's development are significantly different from their same-aged peers, it may be considered a *developmental delay.*

A child with a possible developmental delay should receive a formal evaluation from a health care provider, from a team of multidisciplinary providers, or through school. Yet the forensic interviewer's role is not to be a formal developmental evaluator, but rather to recognize the delay in order to interact with the child on their developmental level and capacity.

VARIATION IN DISABILITIES

Disabilities and chronic conditions can vary in presentation, and they can affect multiple domains of functioning. Table 1 below provides examples of how disabilities can affect various areas of functioning.

Distribution of Difficulties Across Several IDEA Categories of Disability				
	Speaking, Understanding, and Using Language	**Thinking and Reasoning**	**Socializing, Feeling, and Behaving**	**Hearing, Vision, Movement, and Health**
Autism spectrum disorder (ASD)	**X**	**X**	**X**	
Emotional disturbance			**X**	
Hearing impairment and deafness	**MAYBE**			**X**
Intellectual disabilities	**X**	**X**		
Multiple disabilities	**X**	**X**	**X**	**X**
ADHD		**X**	**X**	
Specific learning disability	**X**			
Speech or language impairment	**X**			

Table 1. Breakdown by disability category of difficulties across different domains of functioning

No two disabilities affect a person's functioning the same way. For this reason, it is important to understand that disabilities vary in severity, complexity, and frequency. For example, two children who both have been diagnosed with autism spectrum disorder (ASD) can have vastly

different functioning and abilities. One child with ASD may have limited communication skills, sensory difficulties, gastrointestinal problems, and intellectual delays. The other child may have higher functioning abilities, including normal intellectual and verbal skills, and no problems with digestion, but that child may have difficulty relating socially and emotionally to others. Also, certain disabilities occur much more frequently than others, such as children with specific learning problems versus children with genetic disorders. The frequency of genetic disorders among children is quite low compared to the frequency of children with specific learning problems. (See Table 2.)

Frequency and Intensity of Disabilities			
		Frequency	
		High	**Low**
Intensity	**High**	ASD (in Oregon)	Visual impairment Hearing impairment Chronic illness Genetic disorders
	Low	Learning problems Speech and language problems Conduct disorders ADHD	

Table 2. Frequency and intensity levels of certain disabilities

Disabilities also vary according to *co-occurring conditions*. This means that there are clusters of disabilities that may occur together frequently enough for a statistical correlation but not occurring in all children all the time. There is also variation among children in the *number of disabilities* they have, as some children have been identified and/or diagnosed with multiple disabilities. Regardless, remember that the role of an interviewer is to understand that children with disabilities are all different in presentation and abilities. Understanding the severity, frequency, and complexity of the disability paves the path toward accentuating and focusing on that child's abilities and strengths.

The next chapters discuss the difficulties experienced by children with disabilities in four basic areas: communication, intelligence, social/emotional behavior, and physical functioning. Subsequent chapters review and discuss considerations and accommodations for interviewers to make when interviewing a child with disabilities.

Chapter 3: Communication Disabilities—Speaking, Understanding, and Using Language

Project Ability identifies four domains of functioning affected by disabilities: communication, intelligence, social/emotional behavior, and physical functioning. This chapter explores how disabilities can impact communication, including the ability to speak, use, and/or understand language.

Communication difficulties can present in a vast number of different identified disabilities/disorders, including autism spectrum disorder (ASD), intellectual disabilities, learning disabilities, and physical disabilities such as cerebral palsy. Also, communication challenges between the interviewer and child can occur even when the child has never been identified or diagnosed with a disability. Regardless of the diagnosis, disability, or label, the interviewer must be able to adapt to the child's communication abilities in order to conduct a successful interview.

In situations where there is concern of abuse, an interviewer's role is to elicit a narrative from the child that includes details, context, and clarification about the abusive event. If this child has difficulties with communication, the job of eliciting a narrative is more difficult and may require accommodations by the interviewer.

COMMUNICATION DISABILITIES

Difficulties with communication fall into two main categories—speech and language (American Speech-Language-Hearing Association, n.d.).

- **Speech** difficulties involve problems with the production of understandable sounds used for words and communication.
- **Language** difficulties involve problems with sharing thoughts, ideas, feelings, and information.
    - **Expressive** language refers to what and how the child speaks.
    - **Receptive** language refers to what the child hears and understands.

A child can have difficulty with one or both of these areas of development.

Speech and language problems range from mild to severe, from simple mispronunciations of certain sounds to not understanding spoken or written language to damage of the oral-motor muscles and nerves used for speech and feeding. Many times the actual cause of speech and language problems is unknown. However, hearing loss, brain injury, intellectual delays, and birth defects such as cleft lip and palate are associated with speech and language problems (Center for Parent Information and Resources, 2015).

Communication difficulties are complex because they involve at least a four-way interaction:

- What the child says
- What we hear
- What the child understands about what we say
- What we understand about what the child says

With or without specific information about a child's ability to communicate, the interviewer can listen and observe a child to identify problems with:

- Articulation (pronunciation)
- Fluency (rate, flow, and repetitions in speech, such as stuttering)
- Voice quality, pitch, loudness, and resonance
- Phonology (full range of speech sounds expected for age)
- Comprehension of spoken and/or written language
- Semantics (meanings of words)
- Syntax (grammatical construction of phrases and sentences)
- Pragmatics (use of conversational speech)
- Reading and writing

Speech development

Speech includes a series of distinct and complex parts that ends in an understandable verbal message. Children learn speech and vocabulary quickly. By 18 months, typically developing children say several single words, at 24 months they say two-word to four-word sentences, and by age 3, children can carry on a conversation using two to three sentences. As preschoolers, children continue to expand their vocabulary, but the greatest development occurs in the language area—grappling with grammar, syntax, and the abstraction and utility of language for communicating ideas, thoughts, and feelings (Centers for Disease Control and Prevention [CDC], 2016).

Problems with speech

Articulation problems

Typically, all speech sounds are not mastered until age 8 or 9. Articulation problems are not the same as mispronunciations made when children learn new words. There are four main types of articulation problems: omissions, substitutions, distortions, and/or additions (Daymut, 2009).

- **Substitutions** are when a child replaces one sound for another sound. Examples include "wabbit" for "rabbit," "thoda" for "soda," and "wong thick" for "long stick."
- **Omissions** are when a child omits a sound in a word. Examples include "g_een __ees" for "green trees" and "_ad" for "dad."
- **Distortions** are when a child produces a sound in an unfamiliar manner, such as producing a nasal sound for a consonant. (The word "pen" sounds more like "men" or the word "bat" sounds more like "pat.")

- **Additions** are when a child inserts an extra sound within a word, such as saying "runuh" for "run."

Often articulation problems fade as children grow and are able to master correct sounds, vowels, and consonants. Many children and adults can tune their ears to understand a child who has articulation problems.

Diagnoses associated with speech problems

When preparing for an interview, check available records for any diagnoses related to speech problems. If diagnoses are noted, then it's helpful to research their diagnostic criteria and characteristics. Speech and language resource information can be found through the American Speech-Language-Hearing Association (www.asha.org) and the National Institute on Deafness and Other Communication Disorders (www.nidcd.nih.gov). Two examples of specific speech disabilities are apraxia and dysarthria (National Institute on Deafness and Other Communication Disorders [NIDCD], 2010).

- **Apraxia:** Sometimes called dyspraxia, this is a motor disorder where children have trouble planning and making the very precise movements of the lips, tongue, jaw, and palate that produce understandable speech sounds.
- **Dysarthria:** Dysarthria is a more involved articulation problem caused by oral and facial muscle weakness or paralysis. Children with dysarthria often have a history of feeding problems and may have other medical conditions as well.

Problems with language

During interviews, children's language abilities affect how they can relay their experiences in a way that is understandable, credible, and clear. The interviewer's language must be tailored to appropriately communicate with each child in a developmentally appropriate manner. Communication between child and interviewer is challenging when working with typically developing children. Such communication becomes even harder if the children have difficulty articulating their experiences and/or understanding the questions posed to them or what is being expected of them.

Two types of language are necessary for communication to occur: expressive language and receptive language.

Expressive language

Children with expressive language disorders have difficulty expressing their thoughts and/or feelings. They may have limited accessible vocabulary and/or have difficulty articulating complex sentences (Victoria State Government, Better Health Channel, 2016). Children with an expressive language disorder may:

- Provide shorter, less complex sentences when expressing themselves than their same-aged peers
- Have difficulty finding words needed to express thoughts

- Use “empty” words, such as “this,” “that,” and “thing” instead of using descriptive words
- Use words in the wrong context or in confusing ways
- Hesitate to answer questions or provide minimal-word responses to questions
- Talk in circles without clearly making a point
- Repeat or “echo” a speaker’s words

Children who have difficulty with expressive language can experience lower self-esteem, learning problems, and social isolation (Kaneshiro, 2014). However, it is important to understand that children who have difficulty with expressive language may have receptive language skills that are age and developmentally appropriate. Their comprehension of language may be normal without any impairment.

Receptive language

Receptive language involves attending to, processing, understanding, retaining, and integrating into context a spoken message. Children with receptive language deficits may have difficulty understanding directions, or they may struggle to filter out background sounds and conversations in order to concentrate on what is being said to them. Some characteristics of receptive language issues include (Special Education Support Service (SESS), n.d.):

- Difficulty remembering strings of words said or following complex/compound questions
- Difficulty comprehending the context of what is being said or conveyed
- Difficulty understanding subtle forms of communication such as body language, facial expressions, and taking turns in conversations
- Difficulty maintaining attention long enough to fully take in what is being said

Children with receptive language deficits sometimes are able to mask their lack of comprehension because their expressive language skills are developmentally age appropriate.

SPECIFIC DIAGNOSES ASSOCIATED WITH COMMUNICATION DISABILITIES

Many of the symptoms associated with expressive and/or receptive language are part of the diagnostic criteria for various disabilities, such as autism spectrum disorder (ASD), learning disabilities, and attention deficit hyperactivity disorder (ADHD).

Autism spectrum disorder (ASD)

ASD is a neurodevelopmental disorder that impairs a child’s ability to communicate and interact with others. In 2013, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; known as the DSM-5; American Psychiatric Association [APA], 2013) incorporated several previously separate disorders into this single disorder. The separate disorders included autism, Asperger’s disorder (also known as Asperger Syndrome), childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (PDD-NOS).

Criteria for ASD have two domains of impairment: 1) social interaction and social communication and 2) restricted interests and repetitive behaviors, which include sensory differences and challenges (APA, 2013). Symptom severity and frequency can vary widely between individuals who have been diagnosed with ASD. Signs and symptoms of ASD typically are present before age 3 and include the following:

- Difficulty relating and interacting with others
- Delayed or lack of verbal communication
- Engagement in repetitive activities and stereotyped movements
- Resistance to environmental change or change in daily routines
- Unusual responses to sensory experiences

ASD can impact all four domains of functioning identified in *Project Ability* as illustrated in Table 3 below.

	Speaking, Understanding, and Using Language	Thinking and Reasoning	Socializing, Feeling, and Behaving	Hearing, Vision, Movement, and Health
ASD	• May or may not speak • May have unusual speech flow, intonation • May repeat others' words, use echolalia; limited topics	• May have in-depth knowledge about certain things • May have difficulty with abstract concepts • May have low or high IQ	• May have problems relating to people, especially unfamiliar people • Play is solitary, repetitive • May be inflexible about changes in routine	• Often employs rocking or other repetitive motions • My have unusual responses to sensory information

Table 3. Effects of ASD by developmental domain

This section focuses on the communication aspects of ASD. However, it is important to remember that the distinction between communication problems and social and emotional difficulties is arbitrary because of the interrelationships of the four developmental domains. Please refer to Chapter 4: Social and Emotional Disabilities—Socializing, Feeling, and Behaving for more information regarding ASD's impact on social and emotional functioning.

Communication difficulties for children with ASD

Children with ASD may find it difficult to develop language, understand what others say to them, and use and/or interpret facial expressions and nonverbal gestures. Such difficulties make communication quite challenging (CDC, 2016). As stated previously, communication skills and capacities vary greatly among individuals with ASD. Some children may have a rich vocabulary and can discuss in great depth topics of interest, while other children may have

minimal vocabulary. Most children with ASD do not have problems with speech and word pronunciation, but almost all children with ASD have some difficulty with expressive and receptive language skills (National Institute on Deafness and Other Communication Disorders [NIDCD], 2016). Some hallmark communication challenges for children with ASD include:

- **Repetitive language:** Children with ASD may use words without any context or meaning within a conversation. For example, they may list models and makes of cars when asked about their day.
- **Echolalia:** Children using echolalia take words or phrases they have heard and repeat them over and over; the repeated words may be immediately echoed, or there can be a delay before the child repeats the words. Children with ASD may use echolalia when they do not understand what has been said to them and/or when they are unable to make a response using more appropriate speech. An example of echolalia would be a child repeating, "How are you?" when asked about their day.
- **Unusual tone or speech pattern, lack of eye contact:** Children may speak in a monotone, without inflection or emotion noted in their speech. They may have pressured speech and may appear disengaged although in reality this is not the case.
- **Narrow interests and exceptional abilities:** Some children may be able to converse in-depth on topics of interest, but they cannot engage in a two-way conversation about those topics. For example, a child interested in cars provides detailed information about the cars of interest, but when asked which car is the favorite, the child cannot respond or continue the conversation.
- **Inability to read nonverbal cues, understand abstract concepts, or understand sarcasm:** Common slang, dry humor, subtle gestures, etc. can be very difficult for a child with ASD to understand. Generally, children with ASD are concrete in thought and understand literal concepts. For example, a child with ASD may interpret the phrase "she has a chip on her shoulder" as a girl with a potato chip placed on her shoulder.
- **Difficulty providing personal narratives of events, social situations, and experiences:** A personal narrative is the retelling of a past experience that includes details of what happened and feelings/attitudes about the experience (Rollins, 2014). A child with ASD may have difficulty providing a personal narrative due to difficulty connecting events in a personally meaningful way and then relaying that information in a familiar and cohesive manner to another person (Brown, Morris, Nida, & Baker-Ward, 2012).

Different levels of functioning for children with ASD

<u>High-functioning ASD (includes children formerly identified with Asperger's disorder)</u>

Children with high-functioning ASD may have normal to advanced intellect and can function close to, if not at, grade level (Autism Speaks, n.d.). Often, children with high-functioning ASD can participate successfully in interviews.

<u>Lower-functioning ASD</u>

Children with lower-functioning ASD may present with limited verbal skills and may only speak a few words. Or, some of these children may have age-appropriate vocabulary but are unable

to process the vocabulary into conversational language (APA, 2013). These children may only be able to engage minimally in interviews, possibly answering focused and direct questions. They may not be able to provide running narratives or give peripheral, sensory, or other clarifying details during an interview.

Social (pragmatic) communication disorder (SCD)

The DSM-5 (APA, 2013) identifies social (pragmatic) communication disorder (SCD) as a condition in which children have difficulty with social verbal and nonverbal (pragmatic) communication. In the past, children with SCD often were identified with ASD, PDD-NOS, or Asperger syndrome. This new disorder's important distinction from ASD is that children with SCD do not present with repetitive behaviors or restricted interests like children with ASD do. The DSM-5 (APA, 2013) indicates the following characteristics associated with SCD:

- Difficulty engaging in social conversations (e.g., greeting others, sharing information within a social context)
- Difficulty matching conversational style among different contexts or listeners' needs (e.g., not adjusting speech from the playground to the library)
- Difficulty following social communication rules and expectations (e.g., taking turns in conversation, rephrasing if misunderstood)
- Difficulty understanding abstract concepts or making inferences

Learning disabilities

Learning disabilities are neurologically based processing problems that can interfere with the ability to read, write, and understand math. Learning disabilities can also interfere with organizational skills, time management, abstract reasoning, comprehension, attention, and memory (Learning Disabilities Association of America [LDA], 2016).

According to the U.S. Department of Education, National Center for Education Statistics (2016), children identified with specific learning disabilities account for the majority of children who qualify for special education services in public schools. Learning disabilities are often identified when a gap is noticed between a child's potential for achievement and the actual level of performance. Learning disabilities are not a result of low intelligence but rather a function of how the brain receives, processes, and responds to information. People with learning disabilities often have average to above average intelligence and can master strategies for success (LDA, 2016). Learning disabilities include:

- **Dyslexia:** Trouble understanding written words; reading disability
- **Dysgraphia**: Trouble forming letters or writing in a defined space
- **Dyscalculia**: Trouble with mathematic concepts and arithmetic
- **Auditory and visual processing disorders**: Trouble understanding written or spoken language despite normal vision and hearing
- **Nonverbal learning disabilities:** Discrepancy between stronger verbal skills and weaker gross or fine motor skills, visual-spatial abilities, and social skills; often difficulties

interpreting nonverbal cues, such as understanding facial expressions

Learning disabilities also can impact a child's memory. Three types of memory are important for a child's learning: *working memory, short-term memory,* and *long-term memory*. *Working memory* involves retaining pieces of information and processing this information together at the same time in bigger chunks (Malekpour, Aghababaei, & Abedi, 2013). For instance, when a child reads, the child's working memory holds onto the words, then the sentence, then the paragraph to process the content of what is read. *Short-term memory* is the active process of storing information obtained and retrieving it over a brief period of time, such as reading a chapter and remembering details of that chapter for an upcoming test. *Long-term memory* is the ability to maintain storage and retrieval of the information over a longer period. When a child has difficulty with some facet of memory storage and retrieval, learning and processing information can be negatively impacted (Boudreau & Constanza-Smith, 2011).

It is important to remember that learning disabilities are not always apparent or reported. Indicators that a child may have learning disabilities and be struggling to process information include when the child:

- Struggles to follow directions
- Uses filler words such as "um," "thing," "stuff," and "like" while searching for correct words
- Has a poor grasp of abstract concepts such as time and dates
- Has difficulty relaying sequential narratives (first, second, last)
- Confuses the order of words, numbers, or sequence in a story
- Distracts to other topics, becomes agitated, or changes the subject

Attention deficit/hyperactivity disorder (ADHD)

According to the DSM-5 (APA, 2013), the essential diagnostic feature of attention deficit/hyperactivity disorder (ADHD) is a "persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development" (pg. 61). In the past, children received a diagnosis of ADHD if they presented with hyperactivity and/or impulsivity. If they showed no signs of hyperactivity, they received a diagnosis of ADD (attention deficit disorder). Now, ADHD is used as the primary diagnostic label (Johns Hopkins Medicine, n.d.), but it has three types:

- **ADHD, combined type:** Presentation of inattention/distractibility with hyperactivity/impulsivity
- **ADHD, impulsive/hyperactivity type:** Presentation of impulsive and hyperactive behaviors without deficits in attention or distraction
- **ADHD, inattentive and distractible type:** Presentation of inattention and distractibility without hyperactivity

This section discusses ways ADHD can impact a child's communication abilities. However, Chapter 4: Social and Emotional Disabilities—Socializing, Feeling, and Behaving also covers ADHD because this disorder can affect impulse control, social skills, and behavior.

Deficits with attention can interfere with communication (Staikova, Gomes, Tartter, McCabe, & Halberin, 2013). When a child lacks attentional skills, the child may have difficulty focusing on a sentence, paragraph, or conversation long enough to hear the entire message, let alone keep the message in mind long enough to develop a response, send a meaningful reply, and then wait for the next message. The multitude of stimuli in the environment also can compete for the child's attention during a conversation, thus causing the child to become easily distracted away from the topic and have difficulty being redirected back to the conversation at hand.

Attentional problems associated with ADHD manifest in different ways. Some common characteristics include:

- **Hyperactivity and impulsivity:** Hyperactive children struggle with maintaining attention while tuning out the stimuli surrounding them. They may be fidgety, loud, and fast moving. Children with hyperactive tendencies often have trouble sitting still in class and following appropriate public behaviors if movements are supposed to be suppressed. They also may be impulsive in nature and unable to process consequences before acting on the impulse.
- **Distractibility:** Children do not need to present with hyperactivity to struggle with attention. They may be easily distracted because their train of thought is interrupted by other thoughts or external stimuli. These children might seem lost in thought or be considered daydreamers.
- **Hyperfocus:** This attentional problem involves fixating (i.e., "getting stuck") on a topic or activity to the exclusion of all other stimuli (National Resource Center on ADHD, n.d.). With hyperfocus, children have difficulty changing their focus from one topic or activity to another. They may talk at length about very small and specific details of a topic and be unable to transition to different aspects of the topic. If a child's hyperfocus is prematurely interrupted, it can be very difficult for the child to transition to a different topic or activity.
- **Saliency:** Children with ADHD also struggle with the saliency (meaning and relevancy) of a detail. For example, an interviewer may ask an open-ended question to which the child provides numerous responses. However, the child who struggles with saliency has difficulty identifying the topic at hand (foreground) and knowing what is less relevant (background). Thus, the child may provide a non sequitur or off-topic response to the open-ended question asked.

Chapter 4: Social and Emotional Disabilities—Socializing, Feeling, and Behaving

Social and emotional development begins at birth and drives human behavior. It includes children's ability to understand and process their own experiences, manage their emotions, and develop positive relationships with others.

EMOTIONAL DEVELOPMENT

Emotional development includes the ability to understand one's own feelings as well as accurately perceive and relate to others' feelings and emotions. It also involves the ability to regulate one's emotions and behaviors, and to express them in a socially acceptable manner (Kids Matter, n.d.). For example, children learn that if they act out certain feelings, such as love, then generally this produces a positive response in others. Conversely, acting out feelings of selfishness or hate may create a negative response in others. Children learn that even when they *feel* a certain way, they should still *behave* in a socially acceptable manner, thus learning that feelings can be controlled by thinking before acting.

SOCIAL DEVELOPMENT

Social development involves learning values, knowledge, and skills that help children relate to others and contribute positively to their family, school, and community (Kids Matter, n.d.). In other words, children are able to integrate their personal needs and desires with the desires and needs of the group. Such behaviors include how one greets and treats others, and how one responds to authority.

Children learn social behaviors through imitation, instruction, and trial and error—and occasionally through traumatic events. Acceptable social behavior is also somewhat dependent on intellectual ability and communication skills. Social behaviors include behaviors that demonstrate:

- Respect for authority and others
- Understanding that at times the needs of a group are more important than one's individual needs
- An ability to delay instant gratification for a greater gain in the future
- Acceptance that there are rules to maintain social order so personal needs can be met within a social context

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

DEVELOPMENT OF SOCIAL AND EMOTIONAL DIFFICULTIES

Some children demonstrate atypical development in social and emotional domains. This can be due to biological and/or neurological differences, or it can stem from a child not receiving appropriate modeling and reinforcement of the social norms (Education.com, n.d.). Examples of the latter include:

- Children are exposed to and imitate socially unacceptable behavior.
- Children lack instruction about getting their needs met in a socially appropriate context.
- Children experience loss or trauma, creating feelings and needs that override their ability to moderate their behavior.
- Children are exposed to multiple stressors over a long period of time, including poverty, residential instability, abuse and neglect, oppression, and parental stress.
- Children experience a disturbance in brain biochemistry.
    - Negative behaviors caused by imbalances in brain chemistry can often be mitigated with medication, counseling, and/or cognitive behavioral therapies.

Behaviors that suggest social and emotional difficulties include (Education.com, n.d.):

- Externalizing behaviors (acting-out behaviors), such as noncompliance with directions or with people in authority, hitting and fighting, destroying property, and stealing
- Internalizing behaviors (opposite of aggression), such as depression, mood and anxiety disorders, somatic complaints, and self-harm
- Inability to self-regulate or calm when upset
- Poor social skills, including inability to make and maintain friends, and/or immature and atypical behavior for age (acting much older or younger than chronological age)
- Difficulty making or maintaining eye contact
- Impulsivity and hyperactivity

Of note, children with social and emotional difficulties are at much higher risk of poor academic achievement. Often, children with emotional disturbances perform below their academic grade level and have higher rates of dropping out of high school than their typically developing peers.

Useful resource information on children's mental health disorders and social and emotional disabilities can be found at www.cdc.gov, the Centers for Disease Control and Prevention (CDC) website (CDC, 2016).

COMMON DIAGNOSES AND PRESENTATIONS IN SOCIAL AND EMOTIONAL DIFFICULTIES

Anxiety disorders

Children with anxiety disorders may present with an elevated state of worry or tension even when there is little or nothing to trigger this response. The anxiety may also be accompanied by physical manifestations (somatic symptoms), including fatigue, headaches, insomnia, and irritability.

Some common anxiety disorders in children include (Anxiety and Depression Association of America [ADAA], 2016):

- **Generalized anxiety disorder:** This disorder includes general worries and concerns about numerous aspects of children's lives, including school, family, and impending disasters.
- **Panic disorder:** A child with a panic disorder experiences episodes of physical symptoms that accompany feelings of terror, including sweating or chills, tingling, numbness, dizziness, or fainting.
- **Social anxiety disorder:** This disorder involves persistent fear of negative experiences in social settings or with other children. It includes worrying about judgment by others or about doing something that causes embarrassment or shame.
- **Obsessive-compulsive disorder (OCD):** A child with OCD uses rituals (compulsions) to control anxiety, but over time the rituals end up controlling the child. Examples of rituals include counting objects, insisting on a specific order in a certain activity, and washing hands excessively.
- **Posttraumatic stress disorder (PTSD):** A child experiences or witnesses trauma, then re-experiences the trauma through images, sounds, and feelings associated with the trauma.

Trauma

As noted above, PTSD falls under anxiety diagnoses (APA, 2013). Not all children who experience trauma will develop PTSD. Trauma reactions are not homogeneous and can differ between two children who experienced the same traumatic event. However, a child who presents with trauma symptoms can present with social and emotional difficulties. Common signs and symptoms of trauma reactions in children include (National Child Traumatic Stress Network [NCTSN]):

- Difficulty regulating emotions and behaviors
- Excessive anger and/or agitation
- Regression in behaviors (reverting to immature behaviors such as thumb sucking and bed wetting)
- Imitation of the abusive/traumatic event
- Inaccurate thoughts about themselves or the abusive event
- Hypervigilance and rigidity
- Increased anxiety, fearfulness, and/or avoidant behaviors
- Disassociation (disengaging and "spacing out")

Depression

Depression is characterized by feelings of sadness, isolation, hopelessness, pessimism, guilt, and/or worthlessness that can interrupt enjoyable activities and interests. Other symptoms of depression include changes in appetite (overeating or loss of appetite), fatigue, insomnia, difficulty concentrating or maintaining attention, and difficulty making decisions. Children with

depression may demonstrate mood swings, resist going to school, and have increased irritability or aggressive behaviors (ADAA, 2016).

Attention deficit hyperactivity disorder (ADHD)

Children with ADHD often struggle socially due to the behaviors associated with this disorder (Holmber, 2014 as cited by ADHD Institute, n.d.). As a result of behavioral challenges, children are at risk of social isolation from peers, poor academic achievement, low self-esteem, substance abuse disorders, behavioral difficulties like delinquency and oppositional behaviors, and development of mood disorders such as depression or anxiety (National Resource Center on ADHD, n.d.). Examples of behaviors that interfere with social development include:

- Impulsivity (difficulty taking turns and/or following directions, interrupting)
- Inattention (not listening, acting withdrawn)
- Difficulty understanding social pragmatics (difficulty understanding or following the social norms, such as invading personal boundaries and space)

Oppositional defiant disorder (ODD)

The hallmark feature of oppositional defiant disorder is a persistent and frequent pattern of an angry, agitated, and/or irritable mood, often with the presence of argumentative, defiant behaviors and vindictiveness (APA, 2013). Children with this disorder often act stubborn, disobey, deliberately annoy others, and shift blame from themselves to others. Such behaviors can be present only in certain situations, such as at home or with family members, but the pervasiveness of symptoms across aspects of daily life (in public, at school, etc.) is indicative of the disorder's severity. Of note, ODD often co-occurs with ADHD.

Autism spectrum disorder (ASD)

In Chapter 3, *Project Ability* introduced autism spectrum disorder characteristics. Briefly summarizing, children with ASD present with difficulties in two domains of functioning: 1) social interaction and social communication, and 2) restricted interests and repetitive behaviors, which include sensory differences and challenges (APA, 2013).

Deficits in social interaction and communication pose challenges when interviewing children with ASD (Mattison, Dandon, & Ormerod, 2015). The deficits include:

- Difficulty providing and articulating personally experienced events (Brown, Morris, Nida, & Baker-Ward, 2012)
- Difficulty relaying episodic memories from free recall prompts (McCrory, Henry, & Frappe, 2007)
- Difficulty understanding socially relevant, salient details of events (Goldman S. , 2008).
- Inclusion of idiosyncratic language in the narratives that are out of context and/or confusing to others. (Suh, et al., 2014)
- Difficulty connecting emotions with an experience or an event (Brown et al., 2012)

Children with ASD also display emotions in a variety of ways. When overwhelmed, they may display increases in repetitive and/or restrictive behaviors, such as flapping their hands in front of their eyes. If they become increasingly agitated, stressed, or uncomfortable, then they might begin flapping their hands more frequently and intensely instead of using their words to express such feelings. Other children with ASD might disengage from the conversation or activity and retreat to something more desirable to them. For example, a child who has difficulty with interpersonal interactions but enjoys computer coding might stop in mid-conversation when distressed and revert to talking only about computer codes.

Such difficulty with social and emotional communication and behaviors does not mean a child cannot have a successful interview. A study by McCrory, et. al (2007) found that children with ASD can provide accurate narrative accounts of historical events, but they often require support, such as more focused and direct questions. Please refer to Chapter 10: Accommodations—Autism Spectrum Disorder (ASD) for accommodations interviewers can make to support children during forensic interviews.

Social (pragmatic) communication disorder (SCD)

Chapter 3 also reviewed social (pragmatic) communication disorder (SCD). SCD is a condition in which children persist with difficulty with social verbal and nonverbal (pragmatic) communication (APA, 2013). In the past, children with SCD often were identified with ASD, PDD-NOS, or Asperger syndrome. This new disorder's important distinction from ASD is that children with SCD do not present with repetitive behaviors or restricted interests like children with ASD do. The DSM-5 (APA, 2013) indicates the following difficulties:

- Difficulty engaging in social conversations (greeting others, sharing information within a social context)
- Difficulty matching conversational style among different contexts or listeners' needs (e.g., not adjusting speech from the playground to the library)
- Difficulty following social communication rules and expectations (taking turns in conversation, rephrasing if misunderstood)
- Difficulty understanding abstract concepts or making inferences

Chapter 5: Intellectual Disabilities—Thinking and Reasoning

Intellectual disabilities (ID) are characterized by limitations in intellectual functioning and adaptive behavior. Intellectual functioning refers to one's general mental capacity (thinking, learning skills), IQ, and reasoning or problem-solving skills. Adaptive behavior is the development of conceptual, social, and practical skills utilized in daily life (American Association on Intellectual and Developmental Disabilities [AAIDD], 2013). ID typically occur during the developmental period (birth to age 18) and persist throughout one's lifetime.

ID are a heterogeneous condition that is either congenital (a condition present at birth) or acquired (e.g., a severe infection such as meningitis or a traumatic brain injury). Other terms that have been used previously for ID include mental retardation, cognitive disability, and cognitive impairment.

Often when referring to children with ID, there is mention of "mental age" or "developmental age" versus chronological age. For the purposes of *Project Ability*, a child's mental and/or developmental age is associated with current academic functioning as compared to peers who are the same chronological age. Sometimes, when a child is referred for a forensic interview and an intellectual disability or difficulty is noted, the child might be identified as functioning at a lower "mental age" than the child's chronological age. An example would be a 12-year-old who is working academically at the level of a kindergartener. ID-related information can be quite subjective and possibly inaccurate, depending on its source (an Individualized Education Program versus a quick assessment by someone who just met the child). However, such information can be helpful in assessing and planning the interview to accommodate the child's current communication abilities and conceptual (thinking/reasoning) abilities (Henry, Bettenay, & Carney, 2011).

Children with ID are particularly vulnerable to maltreatment due to a myriad of difficulties with their (APA, 2013):

- Social and communication skills
- Ability to assess for risk
- Reliance on others for daily care needs

Depending on the severity of the ID, the DSM-5 categorizes a person's intellectual and adaptive functioning as mild, moderate, severe, or profound. Table 4 describes these categories.

Severity Level	Thinking and Reasoning Abilities	Social Functioning	Practical Functioning
Mild	Difficulty with academic learning (reading, writing, math, problem solving) Difficulty with abstract concepts (time, money) Poor executive functioning skills (planning, organization, prioritizing) Short-term memory and working memory deficits	Immature interactions with others compared to same-aged typically developing peers, including: Difficulty understanding social cues from peers Simple, concrete language Immature emotional regulation and behaviors Gullible and at risk of being manipulated Able to develop strong friendships and relationships	May have age-appropriate personal care skills May need support with complex daily living tasks when older, such as: Grocery shopping Transportation Nutritious food preparation Banking/money management
Moderate	Throughout development, the child's intellectual functioning is noticeably behind peers. Academic progression develops slowly and is limited compared to peers. As an adult, the child's academic skill development is often at an elementary level.	Social judgment, decision-making skills, and social communication are markedly different and immature compared to peers. Simple, non-complex language skills Able to develop close relationships and develop romantic relationships when older	During childhood, may need adult assistance with daily care routines and hygiene Extended period of education and training needed to become self-sufficient in daily care routines Will need support from others for complex tasks
Severe	Limited ability to understand written language or numerical concepts (math, time, money)	Vocabulary and grammar are quite limited and simple. Verbal skills may include using single words or phrases. Use of augmentative communication may occur with simplistic representations of items or needs. Relationships with family and friends are very positive and a source of pleasure.	Caregivers provide extensive support for daily care routines and adaptive skills throughout lifetime.
Profound	Very limited capacity for learning and symbolic processing	Very limited language skills and ability for symbolic communication Expresses needs and desires through simple nonverbal gestures and sounds	Reliant on others for daily care routines and adaptive skills throughout lifetime

Table 4. Range of intellectual and adaptive capabilities as categorized by the *Diagnostic and Statistical Manual of Mental Disorders*

In general, children with mild and moderate ID can participate in forensic interviews. Research indicates that children with ID are able to recall forensically relevant, accurate accounts when best practices are utilized, including the use of open-ended, free-recall prompts but without the use of repeated, suggestible questions (Brown, Lewis, & Lamb, 2015). Unfortunately, biases against children with ID—including concerns about increased suggestibility and presenting as poor eyewitnesses—have led to underreporting and less prosecution of abuse cases against children with ID (Henry et al., 2011). For interviewing best practice and accommodations, please refer to Chapter 11: Accommodations—Intellectual Disabilities.

GENERAL PRESENTATION

As compared to typically developing, same-aged peers, common presentations of children with ID—depending on the severity of the condition—include:

- Immature conversation style (simple vocabulary, shorter sentences, concrete in thought)
- Immature social behaviors (seem younger in presentation than chronological age)
- Difficulty with abstract concepts (time, complex humor)
- Literal interpretation of words and gestures
- Limited or immature problem-solving skills
- Tendencies toward compliance and pleasing others
- Impulsivity in decision making due to intellectual capacity
- Difficulty with short-term memory and working memory
- May require more time to process and may take longer to learn new concepts (need for repetition to master skills)
- Normal sexual development, but may lack ability to perceive danger or manipulation in relationships

SPECIFIC DIAGNOSES ASSOCIATED WITH INTELLECTUAL DISABILITIES

Down syndrome

Down syndrome is a genetic condition with a duplication of chromosome 21. Physical characteristics include low muscle tone, flat nose, small mouth and ears, slanted eyes, short arms, and a large head. In addition, people with Down syndrome are at increased risk of heart disease and leukemia (National Institute of Child Health and Human Development [NICHD], 2014). Down syndrome may cause delays in physical development and intellectual functioning. However, functional capacities vary greatly among individuals with Down syndrome. Many people with this syndrome can live independently, build healthy, strong relationships, and maintain jobs.

Children with Down syndrome are likely to have expressive language difficulties, including limited vocabulary, shorter utterance length, simple sentence structure, and difficulty with articulation. They may also have difficulty with short-term memory and limited attention spans (NICHD, 2014). In contrast, their receptive language skills, including nonverbal skills, are an area

of strength. That said, their receptive language skills still may not be as strong as their same-aged typically developing peers' skills (Henry, et. al., 2011).

Autism spectrum disorder (ASD)

Autism spectrum disorder has been discussed throughout *Project Ability*. ASD can impact several domains of functioning, including communication, social/emotional behaviors, and intellect. It should be noted that approximately 50 to 80% of individuals with ASD have an ID (Shoemaker & Matson, 2009).

Chapter 6: Physical Disabilities—Hearing, Vision, Movement, and Health

The fourth category of disability identified in *Project Ability* involves physical functioning—hearing, vision, movement, and health. This category of disability is diverse and encompasses numerous chronic conditions that can affect children's performance in school and their ability to participate in an interview.

Definitions and classifications of physical disabilities vary widely. The Individuals with Disabilities Education Act (IDEA) categorizes disabilities that impact a child's movement or body structure as "orthopedic impairments," which typically include orthopedic and neuromuscular disorders (Smith, 2014). The IDEA uses the phrase "other health impairments" to describe conditions that cause special health care needs or health disabilities for children (Smith, 2014). These conditions affect a child's physical functioning and alertness to environmental stimuli, which ultimately influence the child's educational performance (Center for Parent Information and Resources, 2012). Conditions in this category include chronic heart problems, asthma, attention deficit hyperactivity disorder (ADHD), diabetes, traumatic brain injury, epilepsy, lead poisoning, sickle cell anemia, and Tourette syndrome. Other types of physical disabilities involve difficulties with seeing and hearing. Both visual impairment and hearing impairment are complex disorders with varying degrees of severity and support needs (e.g., assistive technology supports such as computer screen readers, hearing aids, and cochlear implants).

SELECTED DIAGNOSES AND PRESENTATIONS IN PHYSICAL DISABILITIES

Vision impairment and blindness

The vision impairment and blindness category in the IDEA includes difficulty with vision that adversely affects a child's educational experience and performance, even when visual correction (i.e., glasses) is used (Center for Parent Information and Resources, 2012). This phrase encompasses low vision (also referred to as partial sightedness) and total blindness.

- People with low vision have a severe reduction in vision that cannot be corrected with standard eyeglasses or contact lenses.
- People with total blindness cannot tell light from dark and/or have a total inability to see.

The majority of people experiencing vision impairment and blindness have some form of sight or ability to see light and dark, while approximately 15% of the visually impaired population in the United States experience total blindness (American Foundation for the Blind, 2016).

Deaf or hard of hearing

Deaf or hard of hearing includes the impairment of hearing, either permanent or fluctuating, that adversely affects a child's educational experience and performance (Center for Parent

Information and Resources, 2012). The IDEA notes that deafness involves hearing impairment so severe that the child's ability to process linguistic information through hearing, with and without amplification, is impaired (Special Education Guide, n.d.) Deafness is a term that generally refers to one's inability to hear speech without a hearing aid, while hearing loss describes reduced hearing acuity. Depending on the severity of hearing loss, deafness can range from mild to profound. Variations of deafness include the level of hearing, age of onset, communication methods, and cultural identity. The U.S. deaf and hard of hearing community is diverse, but its members share common history, values, language (American Sign Language), and morals (Benedict & Legg, 2014).

Children who are deaf or hard of hearing are at greater risk of abuse—including neglect, emotional abuse, physical abuse, and sexual abuse—than their typically developing peers (Schenkel, et al., 2014). There are a myriad of reasons for this increased vulnerability, including:

- Difficulty accessing appropriate educational resources
- Delays in communication due to lack of appropriate language and communication education
- Lack of support services and appropriate mental health services

As interviewers, it is important to understand how the child who is deaf or hard of hearing communicates and what accommodations are needed to enhance communication with that child. For details, please refer to Chapter 12: Accommodations—Physical Disabilities.

Cerebral palsy

Cerebral palsy is a group of disorders that affect movement, posture, and sometimes speech. Cerebral palsy is caused by abnormal development of the brain or damage to the developing brain. The degree of brain damage and impairment does not change over time, but complications or secondary conditions may result in decreased function over time (CDC, 2015).

Cerebral palsy's symptoms can range from mild to severe and most often affect the child's mobility. Many children with cerebral palsy can walk unaided and enjoy most activities of childhood. Other children who are affected more seriously may use braces or a wheelchair. A child with cerebral palsy may also present with:

- Speech and articulation difficulties, such as dysarthria (articulation problems caused by oral or facial muscle weakness)
- Drooling (due to difficulty with swallowing, not excessive saliva production)
- Learning disabilities or intellectual disabilities, due to the brain injury
- Difficulty with impulse control or focusing (associated with ADHD)
- History of feeding difficulty, resulting in poor nutrition (United Cerebral Palsy, 2016)

Chapter 7: General Accommodations for Children with Disabilities

All forensic interviewers should adhere to current best practices in order to conduct forensically sound interviews of children. Accommodations for children with disabilities build on the interview guidelines already established. In Oregon, interviewers should follow the Oregon Interviewing Guidelines (2012).

This chapter reviews important interview preparatory questions and considerations as well as universally helpful interview accommodations for children with disabilities. Subsequent chapters expand on these general accommodations with accommodations specific to the area of functioning (communication, social/emotional, intellectual, and physical) that is most impacted by the child's disability.

PREPARING FOR THE INTERVIEW

The goal of *Project Ability* is to help interviewers simplify their thinking about disability as it pertains to the four primary domains of development and focus on five questions to ask when preparing to interview children with disabilities. These questions prompt interviewers to rethink "disability" by emphasizing an understanding of and capitalizing on each child's strengths. By asking these five questions prior to interviewing a child with a disability, the interviewer can organize what is known about the child and determine what information is needed before proceeding to an interview.

The five interview preparation questions are:

1. **Does this child have a disability or difficulty with:**
    - *Speaking, understanding, and/or using language? (Communication)*
    - *Socializing, feeling, and behaving? (Social/emotional behavior)*
    - *Thinking and reasoning? (Intellectual)*
    - *Hearing, vision, movement, and health? (Physical)*
2. **How does the disability affect *this* child?**
3. **What strengths and abilities does this child have?**
4. **What else do I need to know about the disability and the child?**
    - Are there medical or educational records available for review?
    - Who might be available for a general consultation on this disability?
5. **How can I structure the setting and the questions for a successful interview?**

Question 1: *"Does this child have a disability or difficulty with …"* relates to the four domains of functioning discussed throughout *Project Ability*. Consider what areas are most impacted for the child.

Question 2: *"How does this disability affect this child?"* explores in more detail the child's current level of functioning, presentation, and effects of the disability. Such information can be found in various collateral reports, such as:

- **School records**—such as an Individualized Education Program (IEP)—that document level of functioning, current strengths, weaknesses, and academic/behavioral accommodations at school
- **Medical records**, including specific diagnoses, medications, and therapies received
- **Other collateral reports**, such as police reports or the Oregon Department of Human Services (DHS) reports
- **Histories** provided by caregivers and adults who work and interact with the child

Please note that IEPs often are long, complicated documents, broken into different sections related to testing (the child's current academic functioning), academic and behavioral challenges, goals, and accommodations. IEPs can provide information about the child's academic functioning, social and emotional challenges, and current accommodations in place in the school setting. Important information to glean from the IEP includes the child's:

- Current problem/disability
- Current academic functioning (i.e., "mental age" as compared to chronological age)
- Current strengths (whether the child is engaged, able to sit through class, etc.)
- Current accommodations used in class or with peers

Caregiver input should never be overlooked. Caregivers typically have the best understanding of how the child communicates and functions as well as the current accommodations already established for the child. Such input can also come from other adults who know the child, such as extended relatives, teachers, and therapists.

Question 3: *"What strengths and abilities does this child have?"* Always remember that children with disabilities rely on their strengths and abilities to overcome challenges, adversity, and prejudice every day. It is the interviewer's job to ask, seek, and acknowledge the child's strengths. Examples of strengths could be generic (e.g., the child is generally happy and easily engages with others) or more specific (e.g., the child utilizes gestures effectively to get needs met).

Question 4: ***"What else do I need to know about the disability and the child?"*** may involve gathering more person-specific information. Examples include:

- Does the child take any medications? How do they affect the child depending on the time of day? (Knowing when the medications are at peak performance may influence the interview time.) Is the child experiencing any side effects? Has the child been without medications for some time and experiencing any adverse effects?
- Does the child have a special stuffed animal that helps calm the child when upset? Can the child bring this stuffed animal into the interview?

Certain situations call for the interviewer to explore broader questions about the child's functioning. For example, if the child has a rare genetic disorder, inquire about common characteristics of people who have that same disorder.

Question 5: ***"How can I structure the setting and the questions for a successful interview?"*** relates to accommodations that can be made prior to meeting the child and during the interview.

CONSIDERATIONS FOR THE INTERVIEW SETTING

Important considerations that can be helpful in most circumstances for children with disabilities:

- The waiting room should adequately accommodate the child and family, including having age- and developmentally appropriate activities available if possible.
- Minimize distractions in the interview room, such as limiting the number of toys, objects, and obstacles in the room.
- Ideally, incandescent lighting and lamps are best in interview rooms because florescent lighting can be harsh and often have a distracting "humming" sound.
- Have access to writing tools (paper, crayons, markers) in case the child chooses to draw, write, or map during the interview.
- Sometimes, Play-Doh or other nontoxic molding materials can provide opportunities for children to stay busy and engaged during the interview. However, if the child becomes agitated or too distracted by this, then the interviewer should plan for how to remove this item.

INTERVIEW GUIDELINES

All forensic interviewers should adhere to current best practices in order to conduct forensically sound interviews of children. Accommodations for children with disabilities should build on the interview guidelines already established. Those best practices and guidelines should remain the foundation of any interview for a child; however, accommodations can be made at any time and as needed when the standard for the interview is not meeting the child's needs.

In Oregon, interviewers should follow the Oregon Interviewing Guidelines (OIG, 2012), which include:

- Begin the interview.
    - Role introductions/room explanation
    - Establishing rapport
    - Instructions and answer options
    - Narrative practice—encouraging the child to tell about a salient event from beginning to end
- Transition to the *topic of concern* in the most open-ended and non-suggestive way by using open-ended questions and prompts.
    - Interviewer transitions from neutral topic to topic of concern.
    - During this phase, follow the question continuum:
        - **Open-ended questions/prompts:** Use invitational prompts that allow the most spontaneous responses and provide the most accurate details. ("Tell me everything… beginning to end.")
        - **Focused questions:** These questions direct the child to a particular topic, place, or person but refrain from providing information about the subject.
            - Focused questions are used to elicit clarification and more specific detail regarding statements the child provided during the narrative.
            - Focused questions also provide sensorimotor and other details about the incident (e.g., "What did the hand feel like?").
        - **Direct** questions**:** Questions that specify actor and act. Direct questions can confirm or clarify information a child has already provided during the interview (e.g., "You said Dad hit you. What did Dad hit you with?").
            - The interviewer should always return to open-ended questions after direct and focused questions if possible.
        - **Multiple choice and close-ended questions:–**
            - Multiple choice questions should always include an open-ended option, such as "or something else". (e.g., "Was the door open, closed, or something else?").
            - Close-ended questions allow for one-word responses; they include yes or no questions.
            - Interviewers should follow multiple choice or close-ended questions with an open-ended question (e.g., "Tell me about the door being closed.").
- Conclude the interview.
    - End the interview after sufficient information has been obtained.

- End the interview if the child is unable to continue to participate.
- End the interview if the child requests to end the interview.

GENERAL ACCOMMODATIONS FOR CHILDREN WITH DISABILITIES

Prior to the interview, meet the child in the waiting room.

- Take time to explain roles and the evaluation process. For example:
  - "We take lots of turns here. First we are going to meet with your mom, then you have a checkup and talking time, then your mom has a turn again."
- Be flexible! Consider offering the child a tour of the center and the various rooms that will be used.

During the interview:

- Review roles, introductions, and room explanations again, even if these were reviewed when meeting the child in the waiting room.
- Use the child's name frequently throughout the interview to maintain attention and ground them.
- Spend time establishing rapport.
  - Use this time to evaluate the child's speech and language as well as the child's ability to respond to open-ended, more abstract questions.
  - Notice if the child has difficulty providing a lot of details and/or long-running narratives regarding neutral topics or interests.
  - Building rapport also allows the child to relax and feel safe.
- Review instructions/answer options one at a time.
  - Give the child time to process each instruction/answer option before moving to the next instruction/answer option.
  - Practice with the child if developmentally appropriate. For example:
    - Interviewer: "Mia, if I hear something you say and I hear it wrong, please tell me I'm wrong."
    - Mia: "Okay."
    - Interviewer: "Let's practice. What if I said your name was Mindy?" Pause.
    - Mia: "My name is Mia."
  - Reinforce accurate answers.
    - Interviewer: "That's right, you do that. Tell me I'm wrong and tell me the right answer."
- The narrative practice is a very important component of the interview.
  - If the child provides few responses and/or is unable to provide a narrative in response to an open-ended prompt (e.g., "Tell me everything"), you can scaffold questions, possibly using more focused and direct questions, to elicit more information. When scaffolding questions, use the child's words as cues. For example:

        - Interviewer: “Sam, tell me everything you did during your birthday party.”
        - Sam: “Ate cake and opened presents.”
        - Interviewer: “Okay, so tell me the first thing that happened at your birthday party.”
        - Sam: “My friends came over.”
        - Interviewer: “Your friends came over, then what happened next.”
        - Sam: “We played.”
        - Interviewer: “You played, then what did you do?”
        - Sam: “Mom got the cake.”
        - Interviewer: “After the cake, then what happened?”
- If scaffolding questions helped during the narrative practice, this structure most likely will be needed when exploring the topic of concern.
    - Utilize open-ended prompts/questions as much as possible. For example:
        - Interviewer: “Jake, how come your mom brought you to the clinic today?”
        - Jake: “Joey touched.” Jake points to genitals.
        - Interviewer: “What do you call that part where you are pointing?”
        - Jake: “My private.”
        - Interviewer: “Jake, tell me all about Joey touching your private.”
        - Jake: “He touched it with his hands.”
        - Interviewer: “Where were you when Jake touched your private?”
        - Jake: “I was in my bedroom.”
        - Interviewer: “Tell me all about Joey touching your private, from start to finish.”
        - Jake: “He came in, pushed me down, and touched it.”
- It may be necessary to introduce the topic of concern directly if the child does not transition to the topic of concern.
    - For instance, the interviewer may need to ask about a particular action without introducing the actor, or introduce the name of the person (actor) without stating the action. For example:
        - Interviewer: “Sue, how come you came to the clinic today?”
        - Sue: “I don’t know.”
        - Interviewer: “Sometimes kids come here if someone is worried about them. Is anyone worried about you?”
        - Sue: “No.”
        - Interviewer: “Sometimes kids come if someone is worried that a kid has been hit or hurt on their body. Is anyone worried about that happening to you?”
        - Sue: “No.”

        - Interviewer: “Okay, so you know I talked with your mom today. She said she was worried about a bruise on your arm.”
        - Sue: “Oh yeah, this one.” Sue shows upper arm bruise.
        - Interviewer: “Tell me about the bruise.”
- Using tools during the interview can help elicit more details about the concerns. Tools include maps, drawings, anatomically detailed dolls or body drawings, and asking the child to use gestures or show body positioning.
    - **Maps** help organize location and can ground a child. Ask the child to draw a map, then refer to the map and use it to help structure questions, including where the child and/or alleged perpetrator were, who else was there, and peripheral details of the surroundings (sounds, smells).
        - Reassure the child that the maps (or drawings) can be simple and do not need to be perfect.
        - Asking the child to articulate what they are drawing can elicit additional details.
    - **Drawing pictures** of the abuse incident after the child has disclosed information can help provide additional clarification and details. Periodically, ask the child about the picture being drawn (e.g., “What is this?” “Bed.”) Or have the child tell you what they are drawing, if able. Ask open-ended questions regarding the drawing. For example:
        - Interviewer: “John, you drew the bed. Tell me about the bed.”
        - John: “I on it.” John then draws an X on the bed and a bigger X by the bed.
        - Interviewer: “John, tell me about this big X.”
        - John: “That uncle.”
        - Interviewer: “Tell me about uncle.”
    - **Anatomically detailed dolls and/or body drawings** can be helpful for a child to show what happened, such as body positioning, clothing positioning, force, body movement, etc. (Hlavka, Olinger, & Lashley, 2010). Dolls should be used only after a disclosure has been made. Note that different jurisdictions and multidisciplinary teams (MDTs) may not support the use of dolls or body drawings. If dolls/body drawings are to be utilized:
        - The interviewer should be trained on appropriate protocols within the jurisdiction on the use of anatomically detailed dolls and body drawings before utilizing these tools.
    - **Gestures** include having the child show how something occurred (e.g., the child holds up a fist to show how they were hit), pointing to a body part (e.g., pointing to the genitals when referencing where touching occurred), and showing body positioning (e.g., the child lies face down on the floor to show body positioning).
- Introducing evidence is another consideration for cueing a child’s memory and transitioning to the topic of concern. However, interviewers should review appropriate

protocols and discuss the plan with MDT partners before introducing evidence. Trainings are available on the introduction of evidence, such as the Homeland Security Prepare and Predict Method (Levi, Siegel, Allen, & Gregory, n.d.). Examples of evidence include: police reports, text messages, journals, and photographs.
    - If evidence is introduced, the child still may not discuss the concerns. (If this is the case, respect where the child is in the disclosure process.)
- Be patient and *pause* often!
    - Give the child time to speak, process questions, and express everything the child wants to share before posing the next question.
    - Resist filling in the blanks for a child if the child is not speaking in full sentences.
    - Pause after a child's narrative; then use part of the child's statement without adding more words. For example:
        - Child: "Steve had the belt, and it was black."
        - Interviewer: "Steve had the belt…" Pause.
        - Child: "Yeah, and then he started whipping it around."
- When posing questions, remember:
    - Use short sentences with only one idea per sentence.
    - Start with open-ended questions and prompts. If these are difficult for the child, then move toward focused and direct questions. Move back to open-ended prompts whenever possible.
    - Use yes/no (closed-ended questions) as a last resort. Always follow up with an open-ended question/prompt.
    - Avoid using double negatives.
    - Avoid asking "why" or "if" questions.
    - Use the child's words whenever applicable and clarify terms the child uses. For example: "You said Daddy was mean. Tell me about Daddy being mean."
    - Allow the child to express feelings or no emotions at all.
    - Allow for long silences.
    - Avoid infantilizing the child (e.g., "baby talk").
- As best practices dictate, avoid asking the number of times an incident occurred. Focus on a specific event, which can anchor the child and help the child provide additional details of that event.
    - If a child uses descriptive words indicative of multiple events (e.g., "always," "every time," etc.), ask about a time when something different happened.
    - Instead of asking about dates and times, ask about locations (e.g., what house, what rooms, any other home).
- Pay attention to the child's responses to questions. Are they patterned? (For example, the child always responds with, "I don't know" or always chooses the last option if multiple choice/forced-choice questions are posed.) Patterned responses could indicate that the child is fatiguing or avoiding the topic. Consider checking in with the child by asking if they do not know an answer or if it is hard to talk about.

- If a child is showing signs of fatigue or waning attention, consider having the child return for a follow-up interview.

ADDITIONAL INTERVIEWS

Additional child abuse forensic interviews are potentially beneficial for some children who have been abused, including for children who experienced multiple types of maltreatment, children who are reluctant to disclose, and children with disabilities (Williams, Nelson-Gardell, Coulborn Faller, Cordisco-Steele, & Tishelman, 2013). And additional interviews about an abusive event can elicit more details for a more complete account of the event (Brown, Lewis, & Lamb, 2015) (LaRooy, Katz, Malloy, & Lamb, 2010).

Additional interviews should follow best practice guidelines (open-ended questions, narrative prompts, etc.) and avoid leading and suggestive interviewing techniques (La Rooy et al., 2010) (Coulborn Faller, Cordisco-Steele, & Nelson-Gardell, D., 2010).

Additional interviews can be especially beneficial for children with anxiety, limited attention, intellectual disabilities, and communication difficulties. Some benefits of additional interviews for children with disabilities include:

- The interviewer can spend more time building trust and rapport with the child.
- The child spends less time in any single interview, thus accommodating for attentional issues and potential fatigue.
- Additional interviews, when conducted with open-ended and free-recall prompts, tend to elicit more recall of new information about abuse.

Reasons a follow-up interview might be contraindicated include:

- The child is too stressed or experiences trauma reactions when having to talk about the incident.
- If multiple suggestive, leading questions were asked during the first interview and again in the follow-up interview (LaRooy, Katz, Malloy, & Lamb, 2010), then this can lead to the child being more suggestible and at risk of changing answers.

For successful multiple session interviews, the interviewer should assure that the interview center and MDT support this plan. As well, it is important to discuss with the community providers and the caregiver any contamination issues that may have occurred. (For example, continued contact with the alleged offender or family members continuing to interview the child at home.) The following accommodation chapters discuss additional considerations for additional interviews of children with disabilities.

Chapter 8: Accommodations—Communication Difficulties

The accommodations discussed below are based on current best practices for forensic interviews. In Oregon, interviewers should follow the Oregon Interviewing Guidelines (2012). The information contained in this chapter also builds on the accommodations discussed in Chapter 7: General Accommodations for Children with Disabilities.

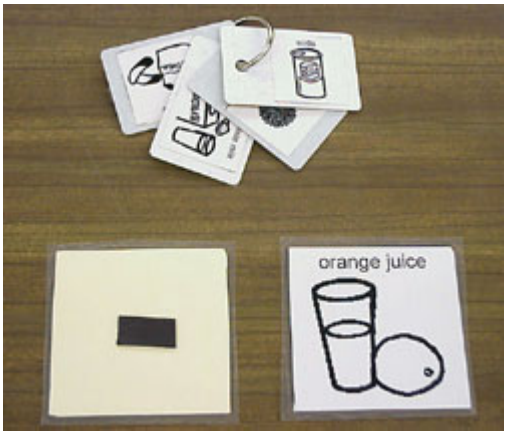
The interview approach for children with communication disorders will depend on the type and extent of the disorder. *Use the five interview preparation questions from Chapter 7* to help identify what difficulties the child experiences and what additional information may be helpful when interviewing the child.

PREPARATION CONSIDERATIONS SPECIFIC FOR COMMUNICATION DISABILITIES

Particularly with communication difficulties and/or disabilities, it is important to consider *what type of communication* is impacted (speech versus language). Interview preparation questions include:

- Does the child have *speech or articulation* problems?
    - If so, ask for clarification on the speech or articulation difficulty, what it sounds like, and if the child compensates for the difficulty. If so, how?
    - Ask how the child typically responds when misunderstood. Will this child become frustrated and try to correct the adult or not?
- Does this child have *receptive or expressive language* difficulties? How will the interviewer know if something said is not understood (either by the interviewer or the child)?
- Does this child communicate in other ways (gestures, writing) and/or need extra time to process?
    - Explore this question for insight about the child's personal adaptations to their challenges and their strengths.
- Does this child use communication tools or aids, known as *augmentative and alternative communication (AAC)* devices? If so, try to familiarize yourself with the device the child uses.
    - **AAC devices:** These can range from simple systems (pictures) to highly complex computer programs that generate speech from typed words or images (ASHA, n.d.)(Cooperative Educational Service Agency 7 [CESA 7], n.d.). Examples include:
        - **Picture point communication systems:** These systems use pictures, photos, or other visual aids—on boards or computer applications—that the child can refer and point to. They help children express themselves.

- **Picture Exchange Communication Systems (PECS):** With these systems, children use visual representations (pictures or photos) to indicate something they want. For instance, if a child has several images of food and/or drinks available, the child can gesture to one or pick it up and hand it to someone in order to ask for specific item.



- **Break cards:** Break cards help children indicate when they need a break from an activity or some quiet time. The child uses this card to communicate this message rather than becoming increasingly anxious or frustrated.

- **Facilitated communication:** In this assisted communication scenario, an individual with a severe communication problem has a facilitator who physically assists by guiding that person's hand to either type or write so that the individual can provide responses to questions and relay desires/needs. Facilitated communication is controversial, and it has been discredited as a reliable form of communication by numerous experts and in much literature. Therefore, *do not conduct a forensic interview using facilitated communication.*

INTERVIEW ACCOMMODATIONS FOR COMMUNICATION DIFFICULTIES

Interviews involving children with disabilities should begin and progress in a similar manner as interviews with typically developing children. The accommodations discussed in this chapter should occur as needed and when the interviewer notices that the standard protocol for the interview is not meeting the child's needs. Even with the accommodations recommended, interviewers should attempt to use open-ended prompts as much as possible, because these allow the child to relay a story in the most accurate and fruitful manner. However, focused and/or direct questions may provide some children with the organization and structure needed to help them tell their experience in a cohesive and concise way (McCrory et al., 2007; Goldman & DeNigris, 2015).

Accommodations for speech and articulation difficulties

- Look at the child when they speak. Notice if the child seems to use hand gestures with words when speaking.
- At the beginning of the interview, explain that you might repeat the child's words to ensure that you understood what was said. Also, explain that your job is not to guess about what the child says.
    - For example, tell the child, "Susie, it's my job to make sure I don't guess about your words. I may repeat words you say to make sure I heard you correctly."
- Provide positive reinforcement if the child corrects you when misunderstood.
- Offer the child the option to write or draw a picture in response to a question.
- Allow the child to stutter, stammer, and pause.
- Resist the temptation to fill in the word that the child is trying to say.
- If the child's articulation is difficult to understand, offer the child the option to write a word or narrative, if developmentally appropriate.

Accommodations for receptive and expressive language difficulties

Receptive difficulties

- After any question posed, pause! Pausing gives a child with processing difficulties time to understand the question and formulate a response.
- Use the child's name. This helps ground the child in the moment.
- Ask one question at a time. Give the child a chance to answer the question before moving to another question.
- When reviewing instructions/answer options, stress the importance of the child stating if they do not know an answer. Practice by asking a question the child might not know. For example:
    - Set up the practice by clearly stating, "It's okay to tell me if you do not know an answer. Let's practice that. What if I asked, 'What's my cat's name?'" Pause to give the child a chance to answer.
    - If the child guesses a name, it is fine to clarify that the child actually does not know the cat's name. Then consider practicing again. Ask the same question. If

the child says, “I don’t know,” then positively reinforce this answer. (For example, “That’s right, thank you for telling me you don’t know. My cat is Cleo.”)
    - If the child guesses again, remind them of the cat’s name and reinforce that it is okay to say, “I don’t know.” Then move on to the next topic.
- Pay attention to the child’s eye contact, body language (squirming, grimacing), and other cues, such as changing the subject or responding with a non sequitur, which might indicate the child does not understand the question.
- Periodically check in with the child to make sure the question was understood. For example:
    - “Sam, was that a hard question to understand?” If he says yes, then offer to ask the question in a different way. Or you can say, “That was a hard question. Let me ask it in a different way.”
    - Consider having the child repeat your question in their own words, but avoid sounding punitive. If the child cannot do this, then they might not have processed the question. Regardless, thank the child for trying and rephrase the question.

Expressive difficulties

- After any question posed, pause! The child may require extra time to formulate thoughts and responses to questions before being able to state them.
- If the child has difficulty expressing thoughts, ask if writing or drawing would be easier than speaking. Offer the child different communication methods, such as writing a response, drawing a picture, drawing a map, using anatomically detailed dolls or body drawings, or using gestures to show what happened.
    - For details regarding these methods, please refer to Chapter 7: General Accommodations for Children with Disabilities.
- Repeat the child’s statements periodically to make sure you understood, and use positive reinforcement if the child corrects you.
- Clarify pronouns and use identifiers and/or proper nouns whenever possible.
    - If the child continually says “he” when talking about an incident, ask who “he” is, then use the name of that person during follow-up questions. (“You said Uncle John hit. Then what did Uncle John do?”)
- Not all children will speak in full sentences. Resist the temptation to fill in the blanks. If the child did not finish the sentence, it is okay to repeat what was said and then pause. For example:
    - Child: “Then Aunt Becky did…” Pause.
    - Interviewer: “Then Aunt Becky did…” Wait for the response. If no response, try saying, “Aunt Becky did what?”
- If a child answers multiple questions with automatic responses such as “I don’t know,” then check in with the child. Ask if the question was a hard one. Offer to state the question differently. For example:

    - Interviewer: “You said Fred hit you. Tell me all about Fred hitting you.”
    - Child: “I don’t know.”
    - Interviewer: “Is that a hard question?”
    - Child: “Yes.”
    - Interviewer: “Okay, let me ask it differently. Where did Fred hit you?” Child points to arm. “Show me how Fred hit you.” Child punches arm.
    - Interviewer: “What did Fred hit your arm with?” Child shows a fist.
- Another option for addressing a child who frequently responds to questions with, “I don’t know” is to say, “Tell me what you do know.”
- Pay attention to signs of fatigue, agitation, or frustration. If the child is showing signs of fatigue, consider bringing the child back for a follow-up interview.
- Before concluding the interview, check in privately with community partners/teammates. The partners might hear information said by the child differently than you did, which is important to know. They also may have helpful suggestions on rewording difficult questions or other communication accommodations that would be helpful for the child.

Learning disabilities

Interviewers should be cognizant of any learning disability identified for the child. Depending on the learning difficulty, interviews can be tailored to avoid pitfalls such as asking a child with dysgraphia (difficulty with writing or drawing) to draw a map.

Accommodations for children with learning disabilities

- Offer different modes of communication for relaying narratives (verbalizing the narrative as well as showing what happened by gestures, positioning, pointing).
- Allow for silence. The child may need additional time to process.
- Ask one question at a time.
- Avoid asking the number of times any incident occurred. Focus on specific events, because that can help the child provide idiosyncratic details of each event.
- If the child uses nondescript words during narratives (e.g., “that,” “there,” “those,” “thingy,” etc.), ask for clarification on each nondescript word. For example:
    - Alex: “He hit me with that and then those things happened.”
    - Interviewer: “Who hit you?”
    - Alex: “Joe.”
    - Interviewer: “Joe hit you with what?”
    - Alex: “He hit me with the belt.”
    - Interviewer: “Joe hit you with the belt, then what happened?”
    - Alex: “Those things happened.”
    - Interviewer: “Tell me what the things were that happened?”
    - Alex: “You know, those things.”
    - Interviewer: “Alex, it’s my job not to guess. I wasn’t there, so help me understand what you mean when you say, ‘those things.’”

- Alex: “Like tying me up and yelling at me.”
- Interviewer: “Okay, I see. Tell me all about being tied up.”

Attention deficit hyperactivity disorder (ADHD)

As stated previously, children who have attentional issues do not necessarily present with hyperactive traits. Therefore, it is important for the interviewer to explore details about the child’s attentional challenges. The following accommodation strategies relate to how the attentional challenges affect communication.

Often, children with ADHD experience behavioral challenges related to impulsivity and self-regulation. Refer to Chapter 9: Accommodations—Social and Emotional Disabilities for additional interviewing strategies and accommodations when such behavioral difficulties are present.

Accommodations for children with hyperactivity

- Limit distractions in the interview room.
- If the child speaks loudly and at a quick pace, be patient. The child might not possess the self-awareness necessary to regulate voice or pace in the moment. If the child’s pace or loudness is not disrupting the narrative, then sit patiently and listen.
    - If the child speaks so quickly that the narrative is difficult to track, check in with the child to make sure you understand what’s being said.
        - Take notes of salient details in the narrative. When the child pauses or finishes a narrative, relay any pieces of salient detail and ask the child to clarify.
        - You can also paraphrase the child’s narrative afterward. Always remind the child to correct you if you get something wrong. Use the language from the child’s narrative when paraphrasing. Paraphrasing can help organize and direct the child to continue with a more cohesive narrative. For example:
            - Hazel: “I went into the room. It was dark and spooky. Things seemed to be everywhere and I was totally freaked out. I am running around, bumping into things, and I kept hearing them. They were crazy loud. I didn’t know what to do and bumped into the bed, then fell on some shoes. I was crying and my leg hurt. There was crashing and I kept trying to find my phone. I couldn’t because it was dark. I get freaked in the dark. It still was loud and I was scared.”
            - Interviewer: “Okay, Hazel, let me make sure I understood you. You said you went into a dark room and heard them. Who did you hear?”
            - Hazel: “Mom and Dad.”

        - Interviewer: "So you heard Mom and Dad and they were loud. You said you were trying to find your phone in the dark, then you heard crashing. Is that correct?"
        - Hazel: "Yes."
        - Interviewer: "Tell me all about the crashing."
- Allow opportunities for the child to move and squirm in the seat or move about the room as long as the child is safe. It is okay to remind the child not to jump off things or move in a way that compromises their safety. Children with hyperactive tendencies often struggle with the internal need for movement (kinesthetic energy) versus having to expend mental energy to focus on a conversation. When children have opportunities to release the kinesthetic energy inside them, they are actually able to attend better to conversations.
    - Offer Play-Doh, so the child can play with it while talking.
    - Consider giving the child a pillow or something else to sit on that allows for movement in the seat.
    - Have the child draw or color a picture during the interview.
- If you sense that a child is too distracted, say the child's name and ask the child to look at you. Repeat your question when the child looks at you.
    - Interviewer: "Jimmy." The child continues to run around the room and does not respond.
    - Interviewer: "Jimmy, please look at me." Interviewer pauses and waits for him to look. Jimmy continues to move, but he looks at the interviewer.
    - Interviewer: "Jimmy, how did X make you feel?"
- Pick your battles. Having a child moving around the room may be distracting to you as an interviewer, but having the child sit still—especially when talking about something distressing—could negatively affect the productivity of the interview.

Accommodations for children with attention issues without hyperactivity

- Provide clear interview instructions.
- Check in with the child to make sure they are following you and understand the interview expectations. This allows a chance to assess how well the child is attending.
- Pay attention to how much you speak versus the child speaks. If you are speaking more than the child, the child may lose interest or become distracted.
- Use the child's name to ground them and retain their attention.
- Ask the child to repeat a question if there are concerns about inattention. For example:
    - Interviewer: "Dylan, I want to make sure you understood my question. Tell me in your words what I just asked."
- Do not use compound questions. Try to keep questions to one thought at a time.
- Listen for patterned responses from the child, which may indicate the child is tuned out of the interview and/or disengaged from the process. If you sense patterned responses,

pause and ask the child how they are doing. Reinforce that they can state if they do not know an answer or ask for clarification if needed.

- Consider concluding the interview if you feel the child has disengaged. Ask if the child wants to come back on a different day to talk more about the concerns.

Chapter 9: Accommodations—Social and Emotional Disabilities

The accommodations discussed below are based on current best practices for forensic interviews. In Oregon, interviewers should follow the Oregon Interviewing Guidelines (2012). The information contained in this chapter also builds on the accommodations discussed in Chapter 7: General Accommodations for Children with Disabilities.

The interview approach for children with social and emotional disabilities will depend on the type and extent of the disability. *Use the five interview preparation questions from Chapter 7* to help identify what difficulties the child experiences and what additional information may be helpful when interviewing the child.

PREPARATION CONSIDERATIONS FOR SOCIAL AND EMOTIONAL DISABILITIES

Helpful questions to consider if the child has behavioral challenges include:

- What are the child's baseline behaviors at home or when in neutral settings?
- Does the child present with specific difficulties and/or behaviors? For example:
    - Verbal perseverations
    - Compulsive behaviors
    - Self-harming behaviors
    - Assaultive behaviors (to self or others)
    - Sexualized behaviors
    - Hyperactive behaviors
    - Oppositional behaviors
    - Withdrawal
    - Sensitivity to environmental stimuli (noises, mirrors, crowded rooms, etc.)
- What behaviors and/or reactions does the child have when stressed or anxious?
    - Does the child articulate feeling stressed or anxious?
    - Does the child act aggressive when upset, or does the child regress or shut down?
- What coping mechanisms does the child use when upset? Can these techniques be used during the interview?
    - Does the child have a calming object, like a stuffed animal, that they can bring to the interview?
    - Does the child use gestures to signal when getting fatigued or ready to stop?
- Does the child take medications for this disability? If so, when are the medications administered and when do they tend to wear off?
    - Consider scheduling the interview when the medications are at peak performance.

- Can the child tolerate sitting still for the interview, or will the child do best if given the opportunity to move about the room?

ACCOMMODATIONS DURING THE INTERVIEW

Beginning the interview:

- After completing introductions in the waiting area and explaining the interview process, allow the child to ask questions about what to expect and provide details about the interview room.
    - Before starting the interview, consider giving the child a tour of the interview room and the rooms where MDT partners will monitor the interview. This can alleviate anxiety.
- Once the interview starts, clearly review roles, instructions, and answer options.
    - Slowly review the instructions/answer options, one at a time.
    - Practice the instructions/answer options if developmentally appropriate. Positively reinforce the child for answering, "I don't know" and correcting you.
        - If the child corrects you during the interview, thank the child for making the correction.
- Spend time building rapport.
- Conduct the practice narrative.

During the interview, consider the following:

- If the child provides rambling narratives, remain patient. Listen for salient details during the narrative that you can address in a follow-up question. Use the child's words when possible.
- Allow for silences between questions or after the child provides a narrative. Silence can evoke additional details from the child.
- Be patient and flexible with the child. Follow the child's lead and structure questions accordingly.
- Allow the child to move, crawl, wiggle, or fidget because kinetic activity may be the child's attempt to calm down.
    - If the movement or behavior becomes disruptive for you or the child, set limits with the child in a gentle but firm manner and redirect the child if necessary. For example, if the child attempts to jump off the chair during the interview:
        - Interviewer: "Sage, please don't jump off the chair. I don't want you to hurt yourself. It's okay to move around the room if you want."
- Power struggles with children who have behavioral challenges tend to shut down any productive interaction.
    - Pick your battles; set clear and reasonable boundaries.
- If the child is teary, seems distressed, or is very quiet, consider acknowledging the difficulty by asking, "How does it feel to talk about this?" Consider taking a break from

the subject to talk about something less difficult, then return to the subject when the child seems composed.

- If the child seems agitated, offer other communication methods, such as mapping a room, drawing a picture of the event, or gesturing.
- If available, consider using a facility or therapy dog. This dog should be certified and the interviewer should be trained on proper use of the dog. The facility/therapy dog can help a child with behavioral or emotional difficulties regulate and focus.
- If the child is too distracted, too anxious or upset, or is fatiguing, consider offering the child an opportunity to come back for a second interview. Please refer to Chapter 7: General Accommodations for Children with Disabilities for more information about additional interviews.

CONSIDERATIONS FOR SPECIFIC DISABILITIES

Anxiety disorders and trauma reactions

If the child has a history of anxiety, gather as much information as possible about the child's presentation when anxious and what techniques help the child calm down if anxiety escalates. Trauma reactions can occur with or without a diagnosis of posttraumatic stress disorder (PTSD). Interviewers should have a basic understanding of common trauma reactions in children.

Even if a child does not have a diagnosed anxiety disorder, that child could become anxious. If the child exhibits visual or verbal signs of anxiety, then consider the following:

- Encourage the child to take several deep breaths before continuing.
- Say the child's name and ask for eye contact. This can help ground the child if they are disassociating or experiencing emotional numbing.
- Ask the child how they are doing. Also, ask if it is okay to continue talking about what happened.
    - If the child can continue, consider moving away from the abusive or traumatic event and instead asking more neutral questions, such as peripheral questions about the room or other location where the incident occurred. Return to abuse-related questions if the child seems calm.
    - If the child expresses feeling too distressed to talk about the incident, or it is apparent that the child is experiencing difficulty, consider changing the subject to an unrelated topic. For example, if the child talks about sexual abuse by the father but becomes overwhelmed, seems flooded by emotion or memory, etc., ask what the child liked about the father. Or change the subject totally to a neutral topic. Return to the abuse concern if the child calms and/or articulates that it is okay to talk more about the topic.
- Consider bringing the child back on a different day to continue the interview. Ask the child if this is something they could do. Please refer to Chapter 7: General Accommodations for Children with Disabilities for more information about additional interviews.

Oppositional defiant disorder (ODD)

If a child has oppositional behaviors, avoid power struggles during the interview. Follow interviewing best practices (reviewing roles and the interview process, building rapport, reviewing answer options, etc.) to provide the child with clear information and expectations. Additional considerations include:

- Allow the child to move around the room as long as the child remains safe.
- Do not emotionally react to oppositional behaviors. Pick your battles; set clear and reasonable boundaries.
    - For example, if the child is throwing Play-Doh hard against the mirror but is not damaging the mirror, consider allowing this to continue as long as it is not too distracting. If the child throws Play-Doh at you, ask them not to do this as it could cause an injury. Redirect the child to coloring.
    - If the child continues to be disruptive and/or is unsafe, consider ending the interview and rescheduling for a different day.

Autism spectrum disorder (ASD) and Social (Pragmatic) Communication Disorder (SCD)

Social and emotional accommodations as well as communication accommodations for children with ASD and SCD are discussed in Chapter 10: Accommodations—Autism Spectrum Disorder (ASD), because difficulties with both communication and social/emotional functioning are hallmarks for these disorders.

Chapter 10: Accommodations—Autism Spectrum Disorder (ASD)

The accommodations discussed below are based on current best practices for forensic interviews. In Oregon, interviewers should follow the Oregon Interviewing Guidelines (2012). The information contained in this chapter also builds on the accommodations discussed in Chapter 7: General Accommodations for Children with Disabilities.

Children with ASD can have a wide range of abilities, challenges, and presentations. Regardless, children who have been diagnosed with ASD present with difficulties in two domains of functioning: communication and social/emotional. Thus, the interview accommodations for children with ASD discussed in this chapter are related to both communication difficulties as well as social and emotional difficulties.

PREPARATION CONSIDERATIONS SPECIFIC FOR ASD

Prior to interviewing, *use the five interview preparation questions from Chapter 7* to learn about the child's communication abilities and social and emotional functioning abilities as well as any additional information that may be helpful when interviewing the child.

If *communication* is noted to be difficult for the child, explore how communication is difficult. For example:

- Does the child engage in conversations, or does the child speak in short sentences and/or utterances?
- Does the child present with echolalia? If so, how does the echolalia occur?
    - Does the child repeat questions several times but provide a response if given time? Or does the child utter repeated statements that are unrelated to the topic discussed and fail to provide any additional information during conversations?
- Does the child use augmentative and alternative communication (AAC) devices and services for communication? If so, please refer to Chapter 8: Accommodations—Communication Difficulties for more information on the use of AAC.
- What is the functioning capacity of the child (e.g., higher-functioning versus lower-functioning ASD)? If the child is at a higher-functioning capacity, then a successful interview is likely. Interviewing a child with a lower-functioning capacity may be more difficult and require significant accommodations, and/or it may not be possible due to the severity of the disorder.

If *socializing, expressing emotions,* and *regulating behaviors* are difficult for the child, explore how these difficulties present for the child. For example:

- Does the child have difficulty expressing emotions? Can they express simple emotions such as mad, sad, or happy? Or is the child able to use narratives to provide more detailed accounts of their feelings?
- Does the child become agitated by different sensory input from the environment (e.g., florescent lighting that makes a "humming" sound or ticking clocks)?
- Does the child have difficulty with crowded rooms or loud children, which the child could experience in the waiting room?
- If the child becomes agitated or fatigued, how does this present (e.g., the child rocks back and forth, increases echolalia, verbalizes feeling stressed)?

Gather history and current information about the child's strengths and abilities. These may include:

- The child attends a mainstream classroom with little adult support.
- The child performs at their grade level.
- The child uses communication aids for self-expression.
- The child does best in one-on-one interactions, so a quiet interview room may be suitable for the interview.
- The child has an object (such as a "pet rock") that they can hold to help them feel calm.
- The child has a special interest or expertise on a certain subject. This might be a nice neutral topic to discuss first in the interview when building rapport.
- The child needs extra time to understand processes and routines. Once the child understands these, then stress decreases.

Prepare the interview room to minimize potential distractions as much as possible. For example:

- Use a room that is simply decorated with as little visual stimuli as possible.
- Use lamps for lighting instead of overhead florescent lighting.
- Avoid having loud clocks in the room.

Ideally, introduce yourself to the child and explain your role briefly before transitioning to the interview room. Consider offering a tour of the interview room and observation room before beginning the interview, which could help alleviate anxieties or difficulty with transitions or unknown situations.

THE INTERVIEW

Follow forensic interviewing best practices, such reviewing roles, aspects of the room, and interview expectations. In particular, consider being very concrete and specific about the interview process. Allow the child to ask lots of questions about the room or about your role. Then do the following with the child:

- Clearly review instructions/answer options.
    - Consider having the child practice answering questions if developmentally appropriate.
- Build rapport and attempt to discuss a neutral topic.
    - If the child is able to do this, then capitalize on the opportunity to ask open-ended questions and prompts. Ask clarifying questions to determine the communication style, ability, and any difficulties the child may have.
- Conduct a practice narrative focusing on a discrete event.
    - Start with an open-ended prompt (e.g., "Tell me everything that happened on your birthday, from start to finish.") Keep in mind that children with ASD may not provide lengthy narrative responses to open-ended prompts or questions—they may require more general and focused questions to elicit more details (McCrory et al., 2007) (Henry et al., 2011).
    - If the child does not provide narratives that include a beginning, middle, and end, then help guide the child through narratives by using more focused, non-suggestive questioning. For example:
        - Interviewer: "Joey, tell me everything you did today from the moment you opened your eyes until you got to this doctor's office."
        - Joey: "I got up and then came here."
        - Interviewer: "Tell me the first thing you did when you got up."
        - Joey: "I got up and peed."
        - Interviewer: "After you got up and peed, then what did you do?"
        - Joey: "I got dressed."
        - Interviewer: "You got dressed, then what did you do?"
        - Joey: "I ate breakfast then did computer codes."
        - Interviewer: "You did computer codes, then what?"
        - Joey: "We drove here."
- Avoid use of metaphors, sarcasm, and slang. Children with ASD and SCD are literal and often lack skills associated with understanding language nuances. For instance:
    - The saying "It's raining cats and dogs outside" might be literally interpreted by the child, who would question how cats and dogs could be falling from the sky.

Transitioning to a topic of concern:

- Always invite the child to provide narratives in whatever capacity the child is able by asking open-ended questions/prompts. The child might include irrelevant details within the narrative about the abuse. If this happens:

- Refrain from interrupting the narrative.
- Listen for the salient details about the topic of concern.
- If the child seems unable to move beyond special interest topics (such as talking about every decoration on the desk in the child's bedroom instead of discussing the touching that happened in the bedroom), allow the child to complete that thought and description before moving on. This may take a lot of patience.
- Once the child completes the narrative, bring the child back to the topic at hand using direct or focused questions that can help cue the child to salient details.
    - For example, Susie, a 10-year-old girl with high-functioning ASD, was referred due to sexual abuse by her father that occurred two days prior. When the interviewer asked Susie why her mom brought her to the clinic, she replied, "My daddy licked my private." Susie identified her private as the part she pees from. Upon being asked focused questions about where the touching happened (she said it happened in her bedroom on the bed), and who was there (she said only her dad), the interviewer asked the following questions:
        - Interviewer: "Susie, tell me everything that happened when Daddy licked your private."
        - Susie: "He licked it, then he left."
        - Interviewer: "Okay, so you told me that the licking happened on your bed. Tell me what you were doing before Daddy licked your private."
        - Susie: "I was asleep and then Daddy came in and woke me. He made me cold. I don't like cold."
        - Interviewer: "Tell me about Daddy waking you."
        - Susie: "I get cold at night. I get cold in the morning. I need my blanket. I don't like cold."
        - Interviewer: "You don't like being cold."
        - Susie: "No, I hate cold. It is cold in Antarctica. I could not live in Antarctica."
        - Susie continues to relay how cold it gets in Antarctica and various details of its weather. This takes several minutes, while the interviewer listens patiently. Susie pauses after her last detail about Antarctica, as does the interviewer.
        - Interviewer: "Okay, Susie, you do not like feeling cold. You said Daddy made you cold when he woke you. Tell me how Daddy made you cold."
        - Susie: "Daddy sat on my bed and took off my covers. I was cold. I don't like it cold. Cold bothers me. Cold makes me sick."
        - Interviewer: "Daddy took off your covers and you were cold. Then what happened?"

- Susie: “Daddy pulled off my pants. That made me cold too. I don’t like that.”
- Interviewer: “Then what happened after Daddy pulled off your pants?”
- Susie: “Daddy licked my private and I was cold.”

Additional considerations

High-functioning ASD (includes children formerly diagnosed with Asperger syndrome)

Children with high-functioning ASD typically can have successful interviews, but challenges may include:

- Although they may have strong vocabulary skills and factual knowledge, they may have difficulty providing autobiographical narratives that connect relevant events in meaningful ways, struggling to articulate salient details of the event that an interviewer might find important.
    - This does not mean that these children cannot provide salient details. Instead, they may benefit from guided, general questions to elicit those details in a cohesive manner.
- They may provide fewer responses to open-ended questions.
- Their responses to questions may include details that are not socially salient to the topic discussed.
    - For example, when discussing a recent trip to Walt Disney World, a child with high-functioning ASD may provide few details about what they liked about the trip and instead focus on the minute mechanics of a particular roller coaster.

Lower-functioning ASD

Children with lower-functioning ASD may present with limited verbal skills and may only speak a few words. These children may only be able to engage minimally in interviews, possibly answering focused and direct questions, but not necessarily able to provide running narratives or peripheral, sensory, or other clarifying details.

Consider structuring an interview of a child with lower-functioning ASD in a very targeted way. Some suggestions include:

- Have pictures of family members and relevant individuals in the child’s life, including pictures of the alleged offender. The child could point to people to explain who is in their family. If the child makes a statement of abuse, consider asking them to also point to the picture of that person.
- Ask the child to show what happened, including by pointing to body parts.
- Allow the child to speak in short utterances.
    - Include the child’s phrases or utterances in follow-up questions to help guide questioning or ask for clarification.

  - For example, if the child says, “Bobby hurt,” the interviewer could ask “How did Bobby hurt?” or “Show how Bobby hurt.”
- Assess if the child seems to comprehend questions.
- Stop if the child does not seem to understand the process or questions.

Chapter 11: Accommodations—Intellectual Disabilities

The accommodations discussed below are based on current best practices for forensic interviews. In Oregon, interviewers should follow the Oregon Interviewing Guidelines (2012). The information contained in this chapter also builds on the accommodations discussed in Chapter 7: General Accommodations for Children with Disabilities.

The interview approach for children with intellectual disabilities (ID) will depend on the type and extent of the disability. *Use the five interview preparation questions from Chapter 7* to help identify what difficulties the child experiences and what additional information may be helpful when interviewing the child.

PREPARATION CONSIDERATIONS SPECIFIC FOR INTELLECTUAL DISABILITIES

Particularly for children with ID, it is very important to gather information about the child's mental age, which relates to the child's current academic functioning as compared to peers who are the same chronological age (Brown, Lewis, & Lamb, 2015) (Henry, Bettenay, & Carney, 2011). Henry et al. (2011) summarized bodies of research and noted that ***children with mild to moderate intellectual disabilities can recall forensically accurate and useful information, and the child's mental age is a helpful indicator for the child's performance***. Thus, the mental age can be a good indicator for the interviewer's approach and questioning of the child.

Keep in mind that the child's presentation during the interview can differ, sometimes drastically, from what might be expected upon reading past reports or developmental testing. As stated in previous chapters, children's development can vary across developmental domains.

- For example, the interviewer receives records indicating that a 10-year-old girl functions like a 5-year-old. During the interview, the child's language skills are much better than those of a typically developing 5-year-old, but this child cannot read. Therefore, the interviewer may not need to make as many accommodations when interviewing the child as first anticipated.

Information about the child's mental age and/or current academic performance can be gathered in several ways, such as:

- If the child has an IEP, the first few pages of that document should include summaries of the child's current academic skills for reading, writing, and math.
- Ask the caregiver and/or school staff:
    - What are the child's interests?
    - How does the child play?
    - Is that play age appropriate or younger?
    - What comparable age group plays in the same manner?

Other important information to ascertain prior to the interview includes:

- What are the child's expressive language abilities?
    - Does the child speak in full sentences?
    - Is the child able to be understood?
    - Does the child use an augmentative communication device? If so, can this device be used during the interview?
- Does the child have any co-occurring disabilities? If so, how do these impact the child's functioning?
    - For example, children who have Down syndrome can also present with some hearing loss. Hearing loss can affect the child's receptive language skills, so additional accommodations may be necessary.

GENERAL ACCOMMODATIONS FOR INTELLECTUAL DISABILITIES

Interviews of children with ID should begin and progress in a similar manner as interviews with typically developing children. The accommodations discussed in this chapter should occur when the interviewer notices that the standard protocol for the interview is not meeting the child's needs. Always attempt to use open-ended prompts/questions during interviews, but scaffold questions using focused and/or direct questions as needed to accommodate the child.

THE INTERVIEW

- Spend time providing the child with clear introductions and a full explanation of the interview process.
    - Speak at a slow pace.
    - Explain that it is okay for the child to take a break at any time.
- Do not use "baby talk" with a child even if the child has a much lower mental age than chronological age. Talking down to children is disrespectful. Use plain language.
- Assess the child's language skills throughout the interview. This will help guide how interview questions are posed.
    - Children with ID have been found to provide less-detailed, shorter narratives in response to open-ended prompts such as "Tell me all about the touching." But the information tends to be accurate as compared to children with the same mental age (Henry et al., 2011) (Brown, Lewis, & Lamb, 2015).
    - Asking general questions that are more focused or direct ("What happened after Johnny touched?") can elicit more details about an event.
    - Using open-ended questions and prompts that include the child's words can help structure the child's narrative and still allow for free recall. For example:
        - Interviewer: "Quinn, tell me about Nanna."
        - Quinn: "Nanna hit me. It hurt. I cried."
        - Interviewer: "Tell me all about Nanna hitting you."
        - Quinn: "Nanna got the spanking stick and hit me here and here." Points.

    - If the child has trouble providing narratives, then use statements such as "And then what happened?" or "Tell me more about X." Or "What did X do?" For example:
        - Interviewer: "Tell me more about the spanking stick."
        - Quinn: "It's brown and hard and has writing on it."
- Limit the use of closed-ended (yes/no) and multiple choice questions.
    - These questions can help provide clarifying information, but the interviewer should always follow up with an open-ended prompt/question. For example:
        - Interviewer: "When Nanna hit, was Nanna happy, sad, or something else?" Always make the last answer option open-ended in a multiple choice question.
        - Quinn: "She was mad."
        - Interviewer: "Tell me about Nanna being mad."
    - Children with ID have been found to be more suggestible when specific or suggestive questions are repeated several times (Cederborg, Danielsson, La Rooy, & Lamb, 2009).
- Ask one question at a time.
- Pause after asking questions. Do not rush children if they take a long time to respond. Give children time for processing and finding the words needed to relay their experiences.
- Check in with the child periodically and ask if the child understood the question. Children with ID may not readily tell you when they do not comprehend a question.
- Avoid asking "why" questions.
    - The child likely will not know the answer and may feel bad about not being able to answer you.
- Offer breaks during the interview. A break can include changing the subject to a neutral topic or stepping out to use the restroom.
    - Breaks are beneficial if the child is showing signs of stress, fatigue, or discomfort.
    - The child may not articulate the need for a break, so watch for possible signs of stress or fatigue and offer a break if appropriate. Signs of stress or fatigue include:
        - Withdrawal and/or not answering questions
        - Distraction (looking around, changing topics)
        - Fidgeting, hand wringing, rocking in the chair
        - Humming/groaning
        - Covering face, hiding
- Consider ending the interview and having the child return for a follow-up interview on a different day. Brown, Lewis, and Lamb (2015) found that children with mild and moderate ID can benefit from follow-up interviews. The researchers found that children with mild ID provided more informative and accurate information in a follow-up interview, and the children were less suggestible. Children with moderate ID recalled

fewer details, but those details were still accurate (Brown, Lewis, & Lamb, 2015). Benefits for having the child return for another interview include:

- The first interview established the interview process and expectations (open-ended prompts to elicit free recall). The child is now familiar and comfortable with this process for the follow-up interview.
- The child has built rapport with you and may feel more comfortable trusting you. Feeling more at ease with the process may help the child access memories without extensive prompting.

- Reasons a follow-up interview might be contraindicated include:
  - The child is too stressed or experiences trauma reactions when having to talk about the incident.
  - If multiple suggestive, leading questions were asked during the first interview and again in the follow-up interview (LaRooy, Katz, Malloy, & Lamb, 2010), then this can lead to the child being more suggestible and at risk of changing answers.
- If the child comes back for a follow-up interview, it is important to discuss with the community providers and the caregiver any contamination issues that may have occurred. Please refer to Chapter 7: General Accommodations for Children with Disabilities for more information about additional interviews.

Chapter 12: Accommodations—Physical Disabilities

The accommodations discussed below are based on current best practices for forensic interviews. In Oregon, interviewers should follow the Oregon Interviewing Guidelines (2012). The information contained in this chapter also builds on the accommodations discussed in Chapter 7: General Accommodations for Children with Disabilities.

The interview approach for children with physical disabilities will depend on the type and extent of the disability. *Use the five interview preparation questions from Chapter 7* to help identify what difficulties the child experiences and what additional information may be helpful when interviewing the child.

PREPARATION CONSIDERATIONS SPECIFIC FOR PHYSICAL DISABILITIES

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

Prior to the interview

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

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

INTERVIEW STRATEGIES FOR SPECIFIC DIAGNOSES

Deaf and hard of hearing

Gather information about the child's means of communication:

- When did the child acquire the hearing loss (e.g., at birth, after an infection in the recent past, etc.)?
- Are the child's parents deaf or hard of hearing, or are the parents without hearing impairment?
    - Nine out of ten children who are born with hearing impairment are born to parents who hear, so language delay due to lack of language (e.g., use of American Sign Language [ASL]) exposure can occur.
    - Children who are deaf or hard of hearing born to parents who are deaf or hard of hearing and who already use ASL in the home will acquire ASL as quickly as

hearing children acquire spoken language (National Institute on Deafness and other Communication Disorders, 2015).

- What communication does the child use at home and/or at school?
    - ASL may be the preferred choice, or the child may prefer to verbalize or write words instead of using ASL.
- Does the child have hearing aids or cochlear implants? With these devices, is the child fluent with spoken language, or does the child use sign language as well?
- If the child is learning sign language (ASL or other), how fluent are they?
- Does the child and/or the family use idiosyncratic or special signs (name or home signs) that are not included in ASL?

Children who use ASL to communicate ideally should be interviewed by a forensic interviewer who is fluent in ASL. Unfortunately, those interviewers are not typically available in most situations. If the child's primary language is ASL, then a certified ASL interpreter should be used. Children's family members or friends should not be used as interpreters even if they know sign language.

Another type of interpreter is a Certified Deaf Interpreter (CDI). CDIs are interpreters who are deaf or hard of hearing and have knowledge and understanding of deafness, deaf communication, and deaf culture. They can bring insight and expertise to the special considerations required when working with this population. CDIs should have general interpreter training, and they also will have specialized training in the use of gestures, mime, props, drawings, and other communication tools. Often, an ASL interpreter works in tandem with a CDI. Circumstances in which to consider using a CDI include (Cassady, Kellogg, MacDonald, Mounty, & Northrop, 2005):

- The child is not fluent in ASL and uses nonstandard signs/gestures to communicate.
- The child uses a foreign sign language, and a certified interpreter for that particular sign language is not available.
- The ASL interpreter is unfamiliar with deaf culture, which the child and family have embraced.
- The child is experiencing trauma reactions and is having difficulty communicating via ASL.

Additional strategies include:

- Face the child so that the child and you see each other.
- If an interpreter is being used, ensure that the child is able to see both the interpreter and you.
- Speak in a normal voice; yelling may distort words or interfere with lip reading.
- If the child draws an answer, pause and wait to respond or ask questions until the child finishes.

- Touching the child's arm or shoulder to get the child's attention is culturally appropriate and acceptable.
- Check in with the child to ensure that they understand the questions posed.

Vision impairment and blindness

Do not assume that the child has no usable vision; many people who experience visual impairment can see shapes, colors, and light (American Foundation for the Blind, 2016). To accommodate children with visual impairments:

- Ask where the child would like to sit in the room.
- Use natural or lamp lighting if possible. Fluorescent lights can be distressing and/or distracting.
- Announce yourself when you enter or leave the room.
- Always ask before petting a service animal, as this animal is not a pet; it is working.
- Do not take the child's arm without permission to guide the child. Instead, verbally offer the child your arm for guidance to a destination. State where you are going and what is in front of you as you move.
- If possible, have written materials in other formats, such as large print, pictures, audio recordings, and Braille.
- Offer Play-Doh or molding clay for the child to use instead of drawing or coloring during the interview.

Cerebral palsy

Cerebral palsy affects movement, posture, and sometimes speech, but it does not necessarily affect intellectual functioning. Do not assume that a child with cerebral palsy has intellectual delays based on the child's involuntary movements or speech. Appropriate accommodations during the interview include:

- Allow for movement in the interview room or at any time during the interview.
- If the child uses a wheelchair, do not touch the wheelchair or maneuver it without the child's permission.
- Pay attention to the child's comfort and respiratory efficiency; the child may need repositioning during the interview.
- If the child is drooling, see if there is something the child uses to wipe away saliva. If not, have appropriate towels available.

If speech and articulation are difficult for the child, consider asking the child how they prefer to communicate. The child might use picture/word boards or augmentative communication devices, but these devices can be time consuming and exhausting. The child may prefer to talk. If so, then the interviewer should respect that preference and be patient. Accommodations and strategies for speech and articulation difficulties are described in Chapter 8: Accommodations—Communication Difficulties.

Conclusion

This *Project Ability* reference guide aims to demystify disabilities for professionals who interview children with disabilities about abuse. A huge amount of information has been distilled into four areas where problems can result from almost all disabling conditions: difficulties with communication, intelligence, social/emotional behavior, and physical functioning.

This reference guide is a "drop in the bucket" of information about disabilities. Resources that provide additional details and insights about disabilities include the child's caregivers, educational and medical records, and reputable websites.

The best advice for any interviewer is to remember that the child with a disability is first and foremost a child. As with all children, that child has strengths and limitations. Build on the child's strengths and make accommodations for the things that are difficult or challenging. The child and family will be grateful.

Bibliography

ADHD Institute. (n.d.). *Social Impact*. Retrieved from www.adhd-institute.com: http://www.adhd-institute.com/burden-of-adhd/impact-of-adhd/social-impact/

American Association on Intellectual and Developmental Disabilities [AAIDD]. (2013). *Definition on Intellectual Disability*. Retrieved from aaidd.org: http://aaidd.org/intellectual-disability/definition#.V8CnCE-V-Uk

American Foundation for the Blind. (2016). *Low Vision and Legal Blindness Terms and Descriptions*. Retrieved from www.visionaware.org: http://www.visionaware.org/info/your-eye-condition/eye-health/low-vision/low-vision-terms-and-descriptions/1235

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5).* Arlington, VA: American Psychiatric Association.

American Speech-Language-Hearing Association. (n.d.). *What is Language? What is Speech?* Retrieved from www.asha.org: http://www.asha.org/public/speech/development/language_speech/

Anxiety and Depression Association of America (ADAA). (2015, September). *Childhood Anxiety Disorders*. Retrieved from www.adaa.org: https://www.adaa.org/living-with-anxiety/children/childhood-anxiety-disorders

Anxiety and Depression Association of America [ADAA]. (2016, May). *Anxiety and Depression in Children*. Retrieved from www.adaa.org: https://www.adaa.org/living-with-anxiety/children/anxiety-and-depression

Autism Speaks. (n.d.). *How are Asperger Syndrome and High Functioning Autism Different?* Retrieved from www.autismspeaks.org: https://www.autismspeaks.org/sites/default/files/documents/as-hfa/diff_as-hfa_tool_kit.pdf

Benedict, B. S., & Legg, J. (2014). *Communication Considerations A-Z: Deaf Culture & Community.* Retrieved from www.handsandvoices.org: http://www.handsandvoices.org/comcon/articles/pdfs/deafculture.pdf

Boudreau, D., & Constanza-Smith, A. (2011). Assessment and Treatment of Working Memory Deficits in School-Age Children: The Role of the Speech-Language Pathologist. *Language, Speech, and Hearing Services in Schools, 42*, 152-166.

Bowman, C. (2016, July 02). *Ages and Stages Summary - Language Development 0-5 years*. Retrieved from speech-language-therapy dot com: http://www.speech-language-therapy.com/index.php?option=com_content&view=article&id=34:ages&catid=11:admin&Itemid=117

Brown, B. T., Morris, G., Nida, R. E., & Baker-Ward, L. (2012). Brief Report: Making Experience Personal: Internal States Langague in the Memory Narratives of Children with and Without Asperger's Disorder. *Journal of Autism & Developmental Disorders, 42*, 441-446.

Brown, D. A., Lewis, C. N., & Lamb, M. E. (2015). Preserving the Past: An Early Interview Improves Delayed Event Memory in Children with Intellectual Disabilities. *Child Development, 86*(4), 1031-1047.

C. Harrington, M. F. (2013). Engaging young people with Autism Spectrum Disorder in research interviews. *British Journal of Learning Disabilities, 42*, 153-161.

California Department of Education: Early Education and Support Division. (2016, January 12). *Social-Emotional Development Domain*. Retrieved from www.cde.ca.gov: http://www.cde.ca.gov/sp/cd/re/itf09socemodev.asp

Cassady, C., Kellogg, N., MacDonald, M., Mounty, J., & Northrop, K. (2005). *Guidelines on Children's Advocacy Center Services for Children who are Deaf/Hard of Hearing.* Hartford, CT: National Children's Alliance.

Cederborg, A. C., Danielsson, H., La Rooy, D., & Lamb, M. E. (2009). Repetition of contaminating question types when children and youths with intellectual disabilities are interviewed. *Journal of Intellectual Disability Research, 53*(5), 440-449.

Center for Parent Information and Resources. (2012, March). *Categories of Disability Under IDEA*. Retrieved from www.parentcenterhub.org: http://www.parentcenterhub.org/repository/categories/#ohi

Center for Parent Information and Resources. (2015, July). *Speech and Language Impairments*. Retrieved from parentcenterhub.org: http://www.parentcenterhub.org/repository/speechlanguage/

Centers for Disease Control and Prevention (CDC). (2015, July 9). *Facts about Developmental Disabilities*. Retrieved from Developmental Disabilities: https://www.cdc.gov/ncbddd/developmentaldisabilities/facts.html

Centers for Disease Control and Prevention [CDC]. (2015, June 13). *Cerebral Palsy (CP): Facts About Cerebral Palsy*. Retrieved from www.cdc.gov/ncbddd: https://www.cdc.gov/ncbddd/cp/facts.html

Centers for Disease Control and Prevention [CDC]. (2016, March 28). *Autism Spectrum Disorder (ASD); Facts about ASD*. Retrieved from www.cdc.gov/ncbddd: http://www.cdc.gov/ncbddd/autism/facts.html

Centers for Disease Control and Prevention [CDC]. (2016, January 6). *CDC 24/7: Saving Lives, Protecting People (TM)*. Retrieved from www.cdc.gov/ncbddd: http://www.cdc.gov/ncbddd/adhd/conditions.html

Centers for Disease Control and Prevention [CDC]. (2016, August 8). *Children's Mental Health*. Retrieved from www.cdc.gov: http://www.cdc.gov/childrensmentalhealth/basics.html

Centers for Disease Control and Prevention [CDC]. (2016, August 18). *Developmental Milestones*. Retrieved from www.cdc.gov/ncbddd: http://www.cdc.gov/ncbddd/actearly/milestones/index.html

Centers for Disease Control and Prevention [CDC]. (2016, February 23). *Facts about Child Development*. Retrieved from www.cdc.gov/ncbddd: http://www.cdc.gov/ncbddd/actearly/milestones

Centers for Disease Control and Prevention [CDC]. (n.d.). *Attention-Deficit/Hyperactivity Disorder (ADHD): Facts About ADHD*. Retrieved from www.cdc.gov/ncbddd: http://www.cdc.gov/ncbddd/adhd/facts.html

Child Welfare Information Gateway. (2012, March). *The Risk and Prevention of Maltreatment of Children with Disabilities*. Retrieved from The Child Welfare Information Gateway: www.childwelfare.gov/pubs/prevenres/focus

Cooperative Educational Service Agency 7 [CESA 7]. (n.d.). *Expressive Communication Skills*. Retrieved from www.cesa7.org: https://www.cesa7.org/sped/autism/assist/asst13.htm

Coulborn Faller, K., Cordisco-Steele, L., & Nelson-Gardell, D. (2010). Allegations of Sexual Abuse of a Child: What to Do When a Single Forensic Interview Isn't Enough. *Journal of Child Sexual Abuse, 19*, 572-589.

Daymut, J. A. (2009). *Super Duper Handy Handouts! Types of Articulation Errors — A Simple Guide*. Retrieved from www.superduperinc.com: https://www.superduperinc.com/handouts/pdf/201_typesofarticulationerrors.pdf

Early Childhood Learning & Knowledge Center (ECLKC); U.S. Department of Health & Human Services; Administration for Children & Families; Office of Head Start. (2015, November 18). *Early Childhood Development, Teaching, and Learning*. Retrieved from https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/teaching/Disabilities/Services%20to%20Children%20with%20Disabilities/Disabilities/disabl_fts_00012_061105.html#characteristics

Education.com. (n.d.). *5 Signs of Emotional Disturbance*. Retrieved from www.education.com: http://www.education.com/slideshow/characteristics-children-emotional/4-intelligence/

Education.com. (n.d.). *9 Basics of Emotional and Behavioral Disorders*. Retrieved from www.education.com: http://www.education.com/slideshow/basics-emotional-behavioral-disorders/cause-2-home-community/

Goldman, S. (2008). Brief Report: Narratives of Personal Events in Children with Autism and Developmental Language Disorders: Unshared Memories. *Journal of Autism & Developmental Disorders*, 1982-1988.

Goldman, S., & DeNigris, D. (2015). Parents' Strategies to Elicit Autobiographical Memories in Autism Spectrum Disorders, Developmental Language Disorders and Typically Developing Children. *Journal of Autism & Developmental Disorders, 45*, 1464-1473.

Henry, L., Bettenay, C., & Carney, D. (2011). Children with Intellectual Disabilities and Developmental Disorders. In D. J. Michael E. Lamb, *Children's Testimony: A handbook of Psychological Research and Forensic Practice, second edition.* (pp. 251-283). Chichester, West Sussex: John Wiley & Sons, Ltd.

Holmberg, K. B. (2014). Do Symptoms of ADHD at Ages 7 and 10 Predict Academic Outcome at Age 16 in the General Population? *Journal of Attention Disorders*, 635-645.

Johns Hopkins Medicine. (n.d.). *Health Library; Attention-Deficit/Hyperactivity Disorder (ADHD) in Children*. Retrieved from www.hopkinsmedicine.org: http://www.hopkinsmedicine.org/healthlibrary/conditions/mental_health_disorders/attention-deficit_hyperactivity_disorder_adhd_in_children_90,P02552/

Jones, L., Bellis, M. A., Wood, S., Hughes, K., McCoy, E., Eckley, L., . . . Officer, A. (2012). Prevalence and Risk of Violence Against Children with Disabilities: A Systematic Review and Meta-analysis of Observational Studies. *Lancet*, 889-907.

Kaneshiro, N. K. (2014, May 14). *Expressive language disorder - development*. Retrieved from medlineplus.gov: https://medlineplus.gov/ency/article/001544.htm

Kids Matter. (n.d.). *Emotional Development*. Retrieved from www.kidsmatter.edu.au: http://www.kidsmatter.edu.au/mental-health-matters/social-and-emotional-learning/emotional-development

Kids Matter. (n.d.). *Social Development*. Retrieved from www.kidsmatter.edu.au: http://www.kidsmatter.edu.au/mental-health-matters/social-and-emotional-learning/social-development

Kistin, C. J., Tompson, M. C., Cabral, H. J., Sege, R. D., Winter, M. R., & Silverstein, M. (2016). Subsequent Maltreatment in Children with Disabilities after an Unsubstantiated Report for Neglect. *Journal of the American Medical Association (JAMA)*, 85-87.

LaRooy, D., Katz, C., Malloy, C., & Lamb, M. E. (2010). Do We Need to Rethink Guidance on Repeated Interviews? *Psychology, Public Policy, and Law, 16, number 4*, 373-392.

Learning Disabilities Association of America [LDA]. (2016). *Learning Disabilities Association of America (LDA)*. Retrieved from Types of Learning Disabilities: https://ldaamerica.org/types-of-learning-disabilities/

Levi, A., Siegel, D., Allen, A., & Gregory, C. (n.d.). Presenting Evidence in Forensic Interviews: The HSI Prepare and Predict Method. Washington DC: Immigration and Customs Enforcement (ICE)/Homeland Security Investigations (HSI).

Malekpour, S., Aghababaei, S., & Abedi, A. (2013). Working Memory and Learning Disabilities. *International Journal of Developmental Disabilities, 59*(1), 35-46.

Mattison, M., Dandon, C., & Ormerod, T. (2015). Sketching to Remember: Episodic Free Recall Task Support for Child Witnesses and Victims with Autism Spectrum Disorder. *Journal of Autism & Developmental Disorders, 45*, 1751-1765.

Mayo Clinic. (2014, June 3). *Diseases and Conditions; Autism spectrum disorder*. Retrieved from www.mayoclinic.org: http://www.mayoclinic.org/diseases-conditions/autism-spectrum-disorder/basics/definition/con-20021148

McCrory, E., Henry, L. A., & Happe, F. (2007). Eye-witness Memory and Suggestibility in Children with Asperger Syndrome. *Journal of Child Psychology and Psychiatry*, 482-489.

National Child Traumatic Stress Network. (2006, October 10). *White paper on addressing the trauma treatment needs of children who are deaf or hard of hearing and the hearing children of deaf parents. Revised.* Retrieved from www.NCTSN.org: http://www.nctsnet.org/sites/default/files/assets/pdfs/Trauma_Deaf_Hard-of-Hearing_Children_rev_final_10-10-06.pdf

National Institute of Child Health and Human Development [NICHD]. (2014, January 17). *What are common symptoms of Down syndrome?* Retrieved from NIH: Eunice Kennedy Shriver National Institute of Child Health and Human Development: https://www.nichd.nih.gov/health/topics/down/conditioninfo/pages/symptoms.aspx

National Institute on Deafness and other Communication Disorders. (2015, June 24). *National Institute on Deafness and Other Communication Disorders [NIDCD] American Sign Language*. Retrieved from www.nidcd.nih.gov: https://www.nidcd.nih.gov/health/american-sign-language

National Institute on Deafness and Other Communication Disorders [NIDCD]. (2010, June 7). *Apraxia of Speech*. Retrieved from https://www.nidcd.nih.gov: https://www.nidcd.nih.gov/health/apraxia-speech

National Institute on Deafness and Other Communication Disorders [NIDCD]. (2016, March 21). *Autism Spectrum Disorder: Communication Problems in Children*. Retrieved from www.nidcd.nih.gov: https://www.nidcd.nih.gov/health/autism-spectrum-disorder-communication-problems-children

National Resource Center on ADHD. (n.d.). *About ADHD*. Retrieved from www.help4adhd.org: http://www.help4adhd.org/Understanding-ADHD/About-ADHD.aspx

National Resource Center on ADHD. (n.d.). *Glossary of Terms*. Retrieved from National Resource Center on ADHD: http://www.chadd.org/Understanding-ADHD/About-ADHD/Glossary-of-Terms.aspx

Rollins, P. (2014). Personal Narratives in Individuals with High-Functioning ASD: A Lens into Social Skills. *Perspectives on Language, Learning & Education, 21*(1), 13-20.

Schenkel, L. S., Rothman-Marshall, G., Schlehofer, D. A., Towne, T. L., Burnash, D. L., & Priddy, B. M. (2014). Child Maltreatment and Trauma Exposure Among Deaf and Hard of Hearing Young Adults. *Child Abuse & Neglect, 38*, 1581-1589.

Shoemaker, J. L., & Matson, M. (2009). Intellectual disability and its relationship to autism spectrum disorders. *Research in Developmental Disabilities, 30(6)*, 1107-1114.

Smith, D. D. (2014, 10 02). *Physical or Health Disabilities Defined*. Retrieved from www.education.com: http://www.education.com/reference/article/physical-health-disabilities-defined/

Special Education Guide. (n.d.). *Deafness*. Retrieved from www.specialeducationguide.com: http://www.specialeducationguide.com/disability-profiles/deafness/

Special Education Support Service (SESS). (n.d.). *Receptive Language Disorder*. Retrieved from www.sess.ie: http://www.sess.ie/categories/specific-speech-and-language-disorders/receptive-language-disorder

Staikova, E., Gomes, H., Tartter, V., McCabe, A., & Halberin, J. (2013). Pragmatic deficits and social impairment in children with ADHD. *Journal of Child Psychology and Psychiatry 54:12*, 1275-1283.

Strine, T. L. (2006). Emotional and behavioral difficulties and impairments in everyday functioning among children with a history of attention-deficit/hyperactivity disorder. *Prevention of Chronic Disorders*, A52.

Suh, J., Eigsti, I.-M., Naigles, L., Barton, M., Kelley, E., & Fein, D. (2014). Narrative Performance of Optimal Outcome Children and Adolescents with a History of an Autism Spectrum Disorder (ASD). *Journal of Autism & Developmental Disorders*, 1681-1694.

The American-Speech-Language-Hearing Association (ASHA). (n.d.). *Augmentative and Alternative Communication (AAC)*. Retrieved from http://www.asha.org/public/speech/disorders/AAC/

The National Child Traumatic Stress Network [NCTSN]. (n.d.). *Symptoms and Behaviors Associated with Exposure to Trauma*. Retrieved from www.nctsn.org: http://www.nctsn.org/trauma-types/early-childhood-trauma/Symptoms-and-Behaviors-Associated-with-Exposure-to-Trauma

U. S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2009). *Child Maltreatment 2009*. Retrieved from www.acf.hhs.gov: http://www.acf.hhs.gov/sites/default/files/cb/cm2009.pdf

U.S. Department of Education. (n.d.). *http://idea.ed.gov*. Retrieved from Building the Legacy: IDEA 2004: http://idea.ed.gov/explore/home

U.S. Department of Education, National Center for Education Statistics. (2016). *Fast Facts: Students with Disabilities*. Retrieved from https://nces.ed.gov/fastfacts: https://nces.ed.gov/fastfacts/display.asp?id=64

U.S. Department of Education, National Center for Education Statistics. (2016, May). *The Condition of Education: Children and Youth with Disabilities*. Retrieved from IES-NCES National Center for Education Statistics: http://nces.ed.gov/programs/coe/indicator_cgg.asp

United Cerebral Palsy. (2016). *Common Health Problems Associated with Cerebral Palsy*. Retrieved from www.mychildwithoutlimits.org: http://www.mychildwithoutlimits.org/understand/cerebral-palsy/cerebral-palsy-common-health-problems/

Victoria State Government, Better Health Channel. (2016, September). *Expressive language disorder*. Retrieved from www.betterhealth.vic.gov: https://www.betterhealth.vic.gov.au/health/healthyliving/expressive-language-disorder

Williams, J., Nelson-Gardell, K., Coulborn Faller, L., Cordisco-Steele, A., & Tishelman, A. (2013). Is There a Place for Extended Assessments for Evaluating Concerns About Child Sexual Abuse? Perceptions of 1,294 Child Maltreatment Professionals. *Journal of Forensic Social Work, 3*, 88-105.