Kathy McNamara M.A., LMFT #33319
Licensed Marriage, Family and Child Therapist
16573 Los Gatos Almaden Rd., Los Gatos, CA. 95032
(408) 356-8200 x426

Licensed Marriage, Family, and Child Therapist #33319

Kathy's clients include: individuals, children, couples, and families and leads groups in her office in Los Gatos. I utilize my skills as a Process Therapist, implementing such modalities as Play Therapy, Gestalt Process, Sand Tray, and Art Therapy, to name a few. The Process Model is an active form of therapy. Kathy works with a variety of families who has children with Special Needs, i.e.: **Attention Deficit Hyperactivity Disorder, Learning Disabilities, Emotional/Behavioral issues, Delayed Development, Aspergers, Non Verbal Disorder, Autism, Sensory Integration Disorder** and/or **Fetal Alcohol Spectrum Disorder** She also assists the adults who work and live with them.

Private Consultant

Kathy is committed to enhancing the lives of children by providing trainings to the adults who work with them. Being the parent of her adult son with a variety of Special Needs, She is provided with first hand life experiences of parenting, which enhances her professional work. She is available for Consultation to schools, agencies, groups, and corporations in addition to offering presentations to those interested in: developing effective communication and positive discipline skills, parenting issues, working with children with Special Needs, day care provider training's, integrating children with Special Needs, support groups, menopause, couples communication and a variety of other subjects. She has been presenting through out Santa Clara for over 25 years on a variety of topics and providing trainings including and not limited for: a variety of schools, day cares, foster parents, colleges, conferences, private agencies, and public health nurses.

Parent Educator for the YWCA

Kathy began working as a Parent Educator in 1982, facilitating classes for parents of pre-school and school-age children using Systematic Training for Effective Parenting (STEP) as a model. After 5 years, she noticed her needs as a parent of a child who has Delayed Development, were not being fulfilled. She then developed and implemented a program designed to meet the needs of parents and those working with children who have a variety of Special Needs.

Milpitas School District

For 4 years, Kathy worked with at-risk children, their families and teachers, collaborating between home and school, providing individual, teacher and family support.

Prodigy Daycare Centers

Kathy has the experience of being a Consultant and Parent Educator for two of Prodigy's Centers. She ran brown bag lunches, parenting classes, supported the staff through trainings, as well as in the classrooms and worked with parents individually, including attending parent meetings with the staff.

Family Education Foundation

For two years, Kathy provided trainings through out Santa Clara and participated in a variety of committee's, all focusing on serving the population of children with Fetal Alcohol Spectrum Disorder and the adults who work and live with them.

University of California Santa Cruz Extension

In the Early Childhood Program for almost 20 years, Kathy has taught two classes:

1. Managing the Behaviors of Children Who Are Challenging and
2. Guidance and Discipline For Children.

"I LOOK FORWARD TO GUIDING YOU TOWARDS YOUR TRUEST DESIRES. YOUR ANSWERS LIE WITH IN. I SEE MYSELF ASSISTING YOU IN EXPERIENCING YOUR DEEPEST TRUTH FROM YOUR PLACE OF KNOWING." Kathy McNamara, M.A., LMFT

Sign and/or Symptoms of Abuse and/or Assault

A. Bissada, L. Miller, A. Wiper, M. Oya, 2000

Physical/Medical Signs of Abuse or Assault

Physical Abuse/Assault

Cuts or scrapes
Bruises, bite marks
Burns
Broken or missing teeth
Broken bones
Head injuries
Shaken Baby Syndrome
Welts

Sexual Abuse/Assault

Genital discharge
Genital and/or anal pain
Bruises, scratches, bites marks
Pain: stomach, head aches
Body aches
STD's
Torn underwear
Bloody underwear
Pregnancy

Behavioral/Emotional Signs Of Abuse and/or Assault

General Symptoms

Disclosure
Aggression
Depression
Anxiety
Not Listening
Impulsivity
Attention difficulties
Social difficulties
Regression
Trouble Sleeping
Eating disturbances
Self-mutilation
Drugs/alcohol
Suicidal Thoughts/ Ideation

Sexual Abuse/Assault

Aggressive sexual behaviors
Act out sexual themes
Detailed understanding of sex
Excessive masturbation
Inserting objects
Seductiveness
Very interested in sex

The Arc

Q&A

People with Intellectual Disabilities and Sexual Violence

By Leigh Ann Davis, M.S.S.W., M.P.A.
Assistant Director of Professional & Family Services

What is sexual assault/ sexual abuse?

Sexual assault is a crime of violence, anger, power and control where sex is used as a weapon against the victim. It includes any unwanted sexual contact or attention achieved by force, threats, bribes, manipulation, pressure, tricks, or violence. It may be physical or non-physical and includes rape, attempted rape, incest and child molestation, and sexual harassment. It can also include fondling, exhibitionism, oral sex, exposure to sexual materials (pornography), and the use of inappropriate sexual remarks or language.

Sexual abuse is similar to sexual assault, but is a *pattern* of sexually violent behavior that can range from inappropriate touching to rape. The difference between the two is that sexual assault constitutes a single episode whereas sexual abuse is ongoing.

Sexual violence occurs in the home (sexual abuse of children, sexual assault by partners or relative), outside the home (in group homes or institutions), on the job, on transportation systems (while riding the bus or a taxi) and virtually anywhere.

How often do adults and children experience sexual violence?

Studies consistently demonstrate that people with intellectual disabilities are sexually victimized more often than others who do not have a disability (Furey, 1994). For example, one study reported that 25 percent of girls and women with intellectual disabilities who were referred for birth control had a history of sexual violence (Sobsey, 1994). Other studies suggest that 49 percent of people with intellectual disabilities will experience 10 or more sexually abusive incidents (Sobsey & Doe, 1991).

Any type of disability appears to contribute to higher risk of victimization but intellectual disabilities, communication disorders, and behavioral disorders appear to contribute to very high levels of risk, and having multiple disabilities (e.g., intellectual disabilities and behavior disorders) result in even higher risk levels (Sullivan & Knutson, 2000).

Children with intellectual disabilities are also at risk of being sexually abused. A study of approximately 55,000 children in Nebraska found that children with intellectual disabilities were 4.0 times as likely as children without disabilities to be sexually abused. (Sullivan & Knutson, 2000).

Women are sexually assaulted more often when compared to men whether they have a disability or not, so men with disabilities are often overlooked. Researchers have found that men with disabilities are twice as likely to become a victim of sexual violence compared to men without disabilities (The Roeher Institute, 1995).

WHAT TO LOOK FOR

Physical Signs

Bruises in genital areas	Pain in genital areas
Sexually transmitted disease	Signs of physical abuse
Tearing of vaginal or anal area	Headaches/stomachaches

Behavioral/Psychological Signs

Depression	Substance abuse	Withdrawal
Avoids specific setting	Seizures	Phobias
Avoids specific adults	Crying spells	Regression
Sleep disturbances	Irritability	Guilt/shame feelings
Change in appetite	Resists physical exam	Change in prior mood
Self-destructive behavior	Feelings of panic	Change in habits
Learning difficulty	Sexually inappropriate behavior	Severe anxiety & worry

Possible Signs To Look For In An Abuser

Alcohol or drug abuse	Devaluing attitudes
Excessive or inappropriate eroticism	Socially isolated
Uses other forms of abuse	Previous history of abuse
Seeks isolated contact with children	Strong preference for children
Surrogate caregivers (particularly males)	Unresolved history of abuse
Pornography usage	

Adapted from *Violence and Abuse in the Lives of People with Disabilities* (1994), D. Sobsey.

Why is sexual violence so common among people with intellectual disabilities?

People with severe intellectual disabilities may not understand what is happening or have a way to communicate the assault to a trusted person. Others with a less severe disability may realize they are being assaulted, but don't know that it's illegal and that they have a right to say no. Due to threats to their well-being or that of their loved ones by the abuser, they may never tell anyone about the abuse, especially if committed by an authority figure whom they learn not to question. In addition, they are rarely educated about sexuality issues or provided assertiveness training. Even when a report is attempted, they face barriers when making statements to police because they may not be viewed as credible due to having a disability (Keilty & Connelly, 2001).

What risk factors contribute to the occurrence of sexual violence?

Some risk factors may include a feeling of powerlessness, communication skill deficits and inability to protect oneself due to lack of instruction and/or resources. Individuals may live in over-controlled and authoritarian environments, contributing to the feeling of powerlessness over their situation. In addition, they are not given enough experiential opportunities to learn how to develop and use their own intuition (those who are taught can often detect between safe versus unsafe situations.)

Other factors include the caretaker's failure to 1) request information on the background of all those involved in the person's life, such as professionals, paraprofessionals, ancillary and volunteer staff, 2) become familiar with the abuse-reporting attitudes and practices of the agency, and 3) assure there is a plan in place for responding to reports of abuse when they occur. Also, offenders are typically not caught and/or held accountable for these crimes, which allows abuse to continue.

Who is most likely to sexually assault?

As is the case for people without disabilities who experience sexual violence, perpetrators are often those who are known by the victim, such as family members, acquaintances, residential care staff, transportation providers and personal care attendants. Research suggests that 97 to 99 percent of abusers are known and trusted by the victim who has intellectual disabilities. While in 32 percent of cases, abusers consisted of family members or acquaintances, 44 percent had a relationship with the victim specifically related to the person's disability (such as residential care staff, transportation providers and personal care attendants). Therefore, the delivery system created to meet specialized care needs of those with intellectual disabilities contributes to the risk of sexual violence (Baladerian, 1991).

What are the effects of sexual violence on someone with intellectual disabilities?

Sexual violence causes harmful psychological, physical and behavioral effects (see chart on front page). The individual may become pregnant, acquire sexually transmitted diseases, bruises, lacerations and other physical injuries. Psychosomatic symptoms often occur, such as stomachaches, headaches, seizures and problems with sleeping. Common psychological consequences include depression, anxiety, panic attacks, low self-esteem, shame and guilt, irrational fear, and loss of trust. Behavioral difficulties include withdrawal, aggressiveness, self-injurious and sexually inappropriate behavior (Sobsey, 1994).

What type of treatment or therapy is available for victims of sexual violence?

In the past the benefit of psychotherapy for people with intellectual disabilities was questioned, as well as the impact of sexual violence (whether or not it impacts people with intellectual disabilities as strongly as others without disabilities). Today, however, it is widely acknowledged that all people who experience sexual violence are affected and do require therapeutic counseling, even if they are non-verbal.

Locating a qualified therapist may be difficult since the person should be trained in child/adult sexual abuse and sexual assault treatment as well as intellectual disabilities. The therapist should also be trained in non-verbal mind-body healing modalities that do not require an intellectual processing component of the therapy. Payment for the therapy can be obtained through victim witness programs, community mental health centers or developmental disability centers.

How can sexual violence of people with intellectual disabilities be prevented?

The first step is recognizing the magnitude of the problem and facing the reality that people with intellectual disabilities are more likely to be assaulted sexually than those without disabilities. Also, societal attitudes must change to view victims with disabilities as having equal value as victims without disabilities, and giving them equal advocacy. Every sexual assault, regardless of who the victim is, must be taken seriously.

Secondly, sexual violence must be reported in order for repeat victimization to stop. While few people ever disclose sexual violence for a variety of understandable reasons, such non-disclosure promotes an environment ripe for continued victimization. Reporting can be increased by educating individuals with disabilities and service providers about sexual violence, improving the investigation and prosecution of this crime, and creating safe environments that allow victims to disclose.

In addition, employment policies must change to increase safety. For example, background checks on new employees should be conducted on a routine basis and those with criminal records should not be hired. Routine checks should consistently be conducted for current employees as well.

Sex education must be provided on a regular, on-going basis, and self-determination and relationship-building skills taught so individuals with intellectual disabilities can learn how to develop safe relationships. Classes on sexual violence should be provided to teach individuals how to respond and protect themselves when they become sexual assault victims.

What should I do if I suspect sexual abuse/assault of someone I know?

All states have laws requiring professionals, such as case managers, direct care workers, police officers and teachers to report abuse. Some states require the general public to report abuse as well. If you suspect a child is being sexually abused, contact your local child protective agency. If the person is an adult, contact adult protective services. These are also referred to as "Social Services", "Human Services" or "Children and Family Services" in the phone book. ***You do not need proof to file a report.*** If you believe the person is in immediate danger, call the police. After a report is made, depending on how serious the abuse is, the incident is referred for investigation to the state social services agency (who handles civil investigations) or to the local law enforcement agency (who handles criminal investigations).

For more information on how you can help prevent sexual assault/abuse, contact Prevent Child Abuse America at 1-800-555-3748 (200 S. Michigan Ave., 17th floor, Chicago, IL 60604) or visit their web site at www.preventchildabuse.org and The Arc Riverside's CAN DO! Project at www.disability-abuse.com

The Arc thanks Nora Baladerian,Ph.D., Shirley Paceley, and Dick Sobsey, R.N., Ed.D. for reviewing this document.

References

Balderian, N. (1991). Sexual abuse of people with developmental disabilities. *Sexuality and Disability, 9*(4), 323-335.

Furey, E. (1994). Sexual abuse of adults with mental retardation: Who and where. *Mental Retardation*, 32, 3, p. 173-180.

Keilty, J & Connelly, G. (2001). Making a statement: An exploratory study of barriers facing women with an intellectual disability when making a statement about sexual assault to police. *Disability & Society*, 16 (2), 273-291.

Sobsey, D. (1994). *Violence and abuse in the lives of people with disabilities: The end of silent acceptance?* Baltimore: Paul H. Brookes Publishing Co.

Sobsey, D. & Doe, T. (1991). Patterns of sexual abuse and assault. *Sexuality and Disability, 9* (3), 243-259.

Sullivan, P.M. & Knutson, J.F. (1994). *The relationship between child abuse and neglect and disabilities: Implications for research and practice*. Omaha, NE: Boys Town National Research Hospital.

The Roeher Institute (1995). *Harm's way: The many faces of violence and abuse against persons with disabilities in Canada.*

The Arc Q&A

Abuse of Children with Intellectual Disabilities

By Leigh Ann Davis, M.S.S.W., M.P.A.

Are children with disabilities at higher risk of being abused?

Children with disabilities of any kind are not identified in crime statistic systems in the U.S., making it difficult to determine their risk for abuse (Sullivan, 2003). A number of weak and small-scale studies found that children with all types of disabilities are abused more often than children without disabilities. Studies show that rates of abuse among children with disabilities are variable, ranging from a low of 22 percent to a high of 70 percent (National Research Council, 2001). Although the studies found a wide range of abuse prevalence, when taken as a whole, they provide consistent evidence that there is a link between children with disabilities and abuse (Sobsey, 1994).

One in three children with an identified disability for which they receive special education services are victims of some type of maltreatment (i.e., either neglect, physical abuse, or sexual abuse) whereas one in 10 nondisabled children experience abuse. Children with any type of disability are 3.44 times more likely to be a victim of some type of abuse compared to children without disabilities. (Sullivan & Knutson, 2000).

Looking specifically at individuals with intellectual disabilities, they are 4 to 10 more times as likely to be victims of crime than others without disabilities (Sobsey, et al., 1995). One study found that children with intellectual disabilities were at twice the risk of physical and sexual abuse compared to children without disabilities (Crosse et. al., 1993).

Why are these children more likely to be abused?

According to researchers, disability can act to increase vulnerability to abuse (often indirectly as a function of society's response to disability rather than the disability in itself being the cause of abuse). For example, adults may decide against making any formal reports of abuse because of the child's disability status, making the abuse of those with disabilities easier for the abuser (Sullivan, 2003). Parents fear if they report abuse occurring in the group home, they may be forced to take their child out of the home with few options for other safe living arrangements. Often the abusers are parents or other close caregivers who keep the abuse secret and do not report out of fear of legal and other ramifications.

Children may not report abuse because they don't understand what abuse is or what acts are abusive. Communication problems that are inherent in many disabilities also make it difficult for children to understand and or verbalize episodes of abuse (Knutson & Sullivan, 1993). Those with limited speaking abilities have had no way to talk about or report abuse. Only recently have pictures demonstrating acts of abuse and sexual anatomy been added to communication boards to help non-communicative children and adults (or those with limited communication) report acts of abuse.

Are children with different types of disabilities more at risk for being abused?

A number of studies have found that different types of disabilities have differing degrees of risk for exposure to violence. For example, Sullivan (2003) reported that those with behavior disorders face greater risk of physical abuse, whereas those with speech/language disorders are at risk for neglect.

Sullivan & Knutson (1998) also found that out of all the types of disability, children with behavior disorders and children with intellectual disabilities were both at increased risk for all three forms of abuse (neglect, physical abuse and sexual abuse) compared to those children with other types of disabilities (speech/language disorders, hearing impairments, learning disabilities, health impairments and Attention Deficit Disorder).

There are no differences in which form of child maltreatment occurs the most often between disabled and nondisabled children. For both groups, neglect is the most prevalent, followed by physical abuse, sexual abuse and emotional abuse (Sullivan & Knutson, 2000).

How can I tell if a child with disabilities is being abused?

Children with and without disabilities share similar indicators of abuse. Along with physical signs (bruises, broken bones, head injuries, or other outward marks) two primary indicators are reports from the child that abuse has occurred and changes in the child's behavior. Children with disabilities face greater risk of abuse going unnoticed if their behavior change can be attributed to their disability instead of the abuse. Also, children with intellectual disabilities may be viewed as easily suggestible or untrustworthy, especially when the report involves abuse that seems improbable. Any time abuse is suspected, it is the adult's responsibility to carefully monitor the child's behavior, ask the child about his or her safety and follow through by reporting any suspected abuse. State laws vary regarding who is considered a mandated reporter, although usually professionals who have regular contact with children are included, such as teachers, physicians, dentists, speech pathologists, etc. (see "To report abuse" in the box on the back page for more information).

1010 Wayne Ave., Suite 650, Silver Spring, MD 20910, (301) 565-3842, (301) 565-5342 FAX
Web Site: www.thearc.org E-mail: info@thearc.org

What are the consequences of being abused?

Consequences of abuse may be physical in nature, such as damage to the central nervous system, fractures, injury to internal organs of the abdomen, burns, malnutrition, and trauma to the head (such as in the case of Shaken Baby Syndrome). Other consequences reap havoc on the heart and in the mind of a child, with abuse resulting in long-term emotional trauma and behavioral problems.

Another possible consequence of being abused is to become disabled. Some children who had never had a disability before become disabled due to abuse. For example, a one-year study of children with firearm injuries identified an 11.7% mortality rate and a 10% permanent disability rate. (Dowd, et.al., 1994).

How can I help prevent abuse of children with intellectual disabilities?

Encourage training and continuing education about violence against children with disabilities for those with disabilities themselves, their families, legal professionals, judges, prosecutors, victim advocacy agencies, Guardians ad Litem, public defenders and police officers. Children with disabilities need early education about the risks of abuse and how to avoid it in a way that they can understand.

Parents can get to know all persons working with their child and observe interactions closely for any signs of abuse. Parents and other caregivers may be the abusers, so other adults in the child's life should also be able to identify possible abuse and know how to go about reporting the abuse.

Parents of children with disabilities and the organizations they are a part of (such as local chapters of The Arc or state Developmental Disability Councils) can form relationships with local victim assistance or child abuse agencies, share each other's expertise and partner together in serving children with disabilities in their local communities.

Obtaining (or advocating for the funding of) family support programs, such as respite care, that have a direct impact on families with disabilities can help prevent abuse by giving families breaks from day-to-day caregiver responsibilities that can seem overwhelming.

What legislation exists to help children with disabilities?

Although there is no single public policy initiative that addresses abuse of children with disabilities, there have some attempts to address the issue. The Crime Victims with Disabilities Awareness Act of 1998 mandated the inclusion of disability status in the U.S. National Crime Victim Survey. It also mandated that research be conducted to address crimes against individuals with disabilities, including children. See the report at http://www.nap.edu/catalog/10042.html.

The Child Abuse Prevention and Treatment Act (CAPTA) is a law that helps prevent children from being abused, including those with disabilities. Since 1974, this law has been part of the federal government's effort to help states and communities improve their practices in preventing and treating child abuse and neglect. CAPTA provides grants to states to support child protective services (CPS) and community-based preventive services, as well as research, training, data collection, and program evaluation. (see http://www.cwla.org/advocacy/2003legagenda09.htm for more information).

***Contact for more information*:**

National Clearinghouse on Child Abuse and Neglect Information
1-800-FYI-3366
www.happinessonline.org/LoveAndHelpChildren/p7.htm

Prevent Child Abuse America
1-800-244-5373
www.preventchildabuse.org

***To report abuse*:**

Contact your local child protection or law enforcement agency. State laws vary regarding who is a mandated reporter. If you need assistance with reporting or have questions about reporting abuse, contact ChildHelp USA's 24-hour hotline at **1-800-4-A-CHILD**

References

Crosse, S., Elyse, K. & Ratnofsky, A. (1993). *A report on the maltreatment of children with disabilities*. Washington, DC: National Center on Child Abuse and Neglect, U.S. Department of Health and Human Services.

Dowd, M.D., Knapp, J.P. & Fitzmaurice, L.S. (1994). *Pediatric firearm injuries, Kansas City, 1992: A population-based study*. Pediatrics, 94, 867-873.

Knutson, J. & Sullivan, P. (1993). Communicative disorders as a risk factor in abuse. *Topics in Language Disorders*, *13* (4), 1-14.

National Research Council (2001). *Crime victims with developmental disabilities: Report of a workshop*. Committee on Law & Justice. Joan Petersilia, Joseph Foote, and Nancy A. Crowell, editors. Commission on Behavioral and Social Sciences and Education. Washington, D.C: National Academy Press.

Sobsey, D. (1992). *Violence and abuse in the lives of people with disabilities: The end of silent acceptance?* Paul H. Brookes Publishing Co: Baltimore, MD.

Sobsey, D., Wells, D., Lucardie, R. & Mansell, S. (1995). *Violence & disability: An annotated bibliography*. Baltimore: Brookes Publishing.

Sullivan, P.M. (2003). *Violence against children with disabilities: Prevention, public policy, and research implications*. Conference Commissioned Paper for the National Conference on Preventing and Intervening in Violence Against Children and Adults with Disabilities (May 6-7, 2002), SUNY Upstate Medical University, NY

Sullivan, P. & Knutson, J. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse & Neglect, 24* (10), 1257-1273.

Sullivan, P. & Knutson, J. (1998). The association between child maltreatment and disabilities in a hospital-based epidemiological study. *Child Abuse & Neglect, 22* (4), 271-288.

Revised August 2009

CHILD ABUSE AMONG, CHILDREN WITH SPECIAL NEEDS (CSN)

More than five children will die each day in the U.S. from child abuse or neglect. According to **Child Maltreatment 2007**, the most recent report of data from the **National Child Abuse and Neglect Data System**, approximately 794,000 children were found to be victims of child abuse or neglect in Federal fiscal year 2007 alone. It is alarming to realize that the U.S. death rate is more than double the rate in France, Canada, Japan, Germany, Great Britain and Italy. **Children with disabilities are the most likely to suffer abuse.**

The Center for Infants and Children with Special Needs at Cincinnati Children's Hospital Medical Center recommends resources where parents and caregivers can turn for support when facing the challenges of child abuse or neglect.

Overview

Child abuse involves ***doing*** something or ***failing to do*** something that results in harm to a child or puts a child at risk of harm. **Child abuse can be physical, sexual or emotional. Neglect, or not providing for a child's needs, is also considered, to be a form of abuse**. **Munchausen's by Proxy Syndrome** is a unique form of abuse where a parent or caregiver misleads others into thinking that the child has medical problems by deliberately creating or exaggerating the child's symptoms in several ways. They might lie, falsify medical records, or induce symptoms by giving the child medicine or toxic substances. As a result, doctors usually order tests, try different types of medications, and/or, may even hospitalize the child or perform unnecessary surgery.

Most child abuse occurs within the family, often by parents or relatives who themselves were abused as children. Neglect and mistreatment of children is also more common in families living in poverty and among parents who are teenagers or are drug or alcohol abusers. According to the **American Bar Association**, child protective services agencies received nearly 3.2 million reports of child maltreatment, but were only able to investigate a little more than half of these cases. The recession is inflicting a further hit, with many states imposing budget cuts that affect child welfare programs. Inadequate resources are stretching state child protection agencies too thin to properly serve at risk children and their families.

Children with Special Health Care Needs: (C/SHCN)

Children with disabilities are the most likely to suffer abuse. Some children who have never had a disability before may become disabled due to abuse. Children with disabilities may be more at risk because of parent or caregiver stress and frustration in caring for them, combined with being more vulnerable because of the disability. Lack of caregiver knowledge and ability, along with inadequate community supports, can also contribute to this population, being abused..

Children, especially those with developmental disabilities, may not or can not report abuse because they do not understand what abuse is or what acts are abusive. Communication delays, limited communication and or no communication, also make it difficult for children to understand and then express themselves about episodes of abuse. Only recently, have pictures demonstrating acts of abuse and sexual anatomy, been added to communication boards and assistive technology devices

Child Abuse and Reporting;

Children with Special Needs

For children with special education needs, the usual risk factors for child abuse such as dependence, vulnerability and family stress are intensified.

In fact, a study from the National Center on Child Abuse and Neglect (NCCAN) found that children with special needs are maltreated at 1.7 times the rate of other children and indicate that underreporting is a major concern due to communication issues and negative myths about disabilities.

Parents of children with disabilities come from every social class and value system. However, these parents may feel very much on their own and may be stressed by:

* Ongoing health care needs,

* Difficulties in finding suitable child care, thus not able to hold down a job,

* Feeling overwhelmed and exhausted

* Sibling rivalry,

* Financial burdens and/or

* Social isolation,

* Feeling depression and/or

* Marital discord.

Several research studies indicate that caregivers of children with special needs who perceive themselves as severely stressed, are more likely to commit abuse.

Unfortunately, many families lack the necessary social supports or networks, to work through the many concerns and situations that arise in providing care for their children **plus** the rest of the family.

REPORTING <u>SUSPECTED</u> ABUSE

REMEMBER IT IS AGAINST THE LAW TO HURT ANY CHILD!!!!

1. **You must report ABUSE when you <u>SUSPECT</u> a child is being abused with in 36 hours.**
2. **Have the phone number for Child Protective Services (CPS) at your immediate disposal.**
3. **After you report abuse, wait a week and then call again to see what has been done.**
4. **Watch for new signs of abuse and report each one. Each time you call, write down: the time, date and who you spoke with.**
5. **Write down the child's name and what evidence you have that the child MAY be being abused.**
6. **You only have to report what you suspect a child is being abused. You do not have to PROVE that the child is being abused. It is the job of CPS, to decide if the child is being abused.**

OVERVIEW OF ABUSE OF PEOPLE WITH DEVELOPMENTAL DISABILITIES

By Nora Baladerian, Ph.D.
Presented at the AAMR Conference, Orange County, 1985
(Author's Note: Although this article was written in 1985, much of the material is still pertinent today. Please accept my apology for any non Aperson-first@ language errors, as I may have been unaware of them or they did not exist at the time of this writing.)

Introduction

I have worked since 1973 as a Certified Sex Educator in the area of sexuality and people with developmental disabilities. Since 1983 I have worked intensively on abuse of people with disabilities, including sexual abuse. Prior to this I worked in family planning clinics as a health educator.

Abuse is one of the "hidden" areas of life of the disabled person with a developmental disability. Most of us professionals have trouble dealing with sexuality and developmental disability, much less acknowledging the existence and even pervasiveness of sexual abuse of people with developmental disabilities.

As we begin to open this can of worms, we realize the can has been available for study and attention for years. We just have been, for the most part, unaware of its existence. Perhaps it is too horrible for us to contemplate. In fact, it is.

However, professional/parent repulsion does not, unfortunately, magically dissolve the problem. The victims of abuse continue to suffer the short and long term effects, suffer ongoing abuses, and multiple abuses, whether or not we choose to see it. The time has come to acknowledge and address the problem, and, most importantly, take direct action to stop abuses that are occurring, prevent further or initial abuses, and provide treatment for those who are victims of current or past abuse.

I will review 7 areas:

l.. Define Abuse and Identify Types of Abuse
2. Identifying the Perpetrators
3. Incidence and Prevalence
4. Identification
5. Prevention
6. Treatment
7. Recommendations

DEFINING ABUSE AND IDENTIFYING TYPES OF ABUSE

There are many definitions, legal and operational, of abuse. Overall, abuse is the

nonaccidental injury or committing of acts that could result in injury, through acts of omission or commission. The seriousness and nature of the injury require discretion, on the part of the reporter, to determine if the real or potential injury is "serious", and if the acts or omissions that cause the injury are nonaccidental. Those who cause these abuses may be individuals, institutions or society as a whole.

Who "individuals" are, is clear. Institutional abuse includes approved or nonconsequated (new word!!) abuse of children in schools, juvenile courts, and other agencies. Societal abuse refers to approved or nonconsequated abuse of children by society as a whole, for example the fact that only in 1962 was "child abuse" even recognized by professionals who work with children, after centuries of preferring to turn away from acknowledging the plight of children...to the detriment of children, and in the endeavor to "protect" parents from embarrassment.

The types of abuse experienced by children (with disabilities or not) fall into the following categories:

Physical abuse: Any nonaccidental physical injury or injuries to a child by a caretaker. This includes: drug use, drug use by infants/children, burning, whipping, scalding, hitting with objects such as hammers, slamming into walls, stomping over, kicking, shaking; resulting in abrasions, lacerations, bruises, scars, fractures, brain damage, sensory impairment (blindness, deafness). Satanic or cult ritual torture, mutilation or murder of children. Other types of homicide (drowning, stabbing).

Physical neglect: Failure to provide adequate food, shelter, clothing, protection, supervision and medical and dental care. Signs are: starving, child always sleepy or hungry, unsanitary conditions in the home (garbage, animal or human excrement), lack of heating, fire hazard, abandonment.

Emotional abuse: A pattern of verbal assaults or coercive measures against a child destructive of his selfesteem. For example, belittling, blaming, sarcasm; unpredictable responses (child never knows when the next emotional outburst is coming, and the outbursts are unrelated to child's behavior); constant discord in the home, humiliating the child. (You dummy, you'll never amount to anything; what's the matter with you?; why do you always...; you're nogood now, and you never will be; I wish you had never been born...I didn't want you anyhow.) Emotional abuse is always a component of the other types of abuse, as a consequence of their occurrence. Viewing the cult ritual torture/mutilation/murder of other children and animals takes its toll emotionally. The perpetrators almost always threaten the children if they tell someone about what is going on, and these threats seem real...and often are...to the children. They say, " if you tell, noone will believe you anyway"; "you can't live at home anymore" ...or, "you're dog will die", "you'll get me in trouble, and then mommy will be mad at you".

Emotional neglect: The failure to provide the nurturing or stimulation needed for the child's social, intellectual and emotional growth. This includes: ignoring the child, rare demonstration of affection to child (or none).

Sexual abuse: Any sexual contact, between an adult and a child 16 years of age and under.

This includes: exploitation (using the child for one's own sexual excitement through taking pictures, showing pictures), incest, rape, fondling, oral sex, anal sex, penetration with objects, exposure, forcing child to commit sexual acts on other adults and children, forcing a child to masturbate self or others (adults/children), and satanic sexual rituals including sexual mutilation, and torture.

Murder: This really falls under physical abuse, but as it is so important, I like to create a separate category for this. Two examples. Ray Walker, a profoundly retarded man, 28 years old, was found dead in a box that was nailed shut. He had been missing for more than 7 days. He had been living in a licensed residential home for 6 disabled men. This is an example of an individual perpetration of abuse. His murderer was found and prosecuted. The license for the home was revoked for 2 years. Baby Doe Bloomington was also murdered, the perpetrator being both an individual (his physician) and society. He was born with an esophageal fistula, a condition that sent food right back up from the stomach, inhibiting the processing of food. This is an easily correctable condition, and standard procedure, as this happens to a large number of newborns. However, Baby Doe Bloomington also had Down's Syndrome, which indicates a high probability of retardation, but the level cannot be known until the child is at least 3 to 5 years of age. The physician recommended, and the parents agreed, that the corrective surgery not be performed, that the child not be given any medical treatment at all, which includes food and water, so that he would die. The nurses refused to comply, so private nurses were hired, and the child removed to a private room at the hospital. Appeals to the court upheld the doctors's orders. He starved to death. This case, however, was not considered abuse, nor reported as abuse. He was considered to have died of natural causes.

Financial abuse: The misuse of the funds of another, including the keeping of funds from it's due recipient. This has more application for dependent adults, and frequently goes along with physical and emotional neglect.

The state laws on child abuse apply to children with a developmental disability as well as all other children. The State recognized the continuing vulnerability of adults with developmental disabilities, and created the Dependent Adult Abuse Law. As a parenthetical statement, no money was provided for implementation of adult abuse protections. Guidelines for investigation, prosecution, and intervention have not yet been developed. Apparently guidelines development will occur during this year (1986), with a team from the State Departments of Developmental Services, Social Services and Adult Protection. This law includes the dependent elderly person as well as the adult who is dependent due to a disability.

IDENTIFYING THE PERPETRATORS

In the case of children with disabilities and dependent adults, 99% of the perpetrators are well known to and trusted by the victim.(1) So who are they: they are parents, extended family members, special education teachers, aides, bus drivers, psychologists, psychiatrists, physical therapists, occupational therapists, medical doctors (pediatricians, gynecologists), recreational specialists: boy/girl scout leaders, camping leaders, residential care providers and aides...in short, any category of person who deals with disabled children and dependent adults has been charged and convicted of abuse of their clients.

Examples: President of a sheltered workshop for 20 years; chief psychiatrist of the adolescent unit for mentally ill children (also 20 years); physical therapist for children with cerebral palsy; camp leader for young adults with developmental disabilities..

INCIDENCE AND PREVALENCE

Although one would think that data would be kept on such an important item, very little has been done to document abuse of people with disabilities. Some feel this reflects the strong repulsion from the knowledge of the problem. Others believe that children and adults with disabilities represent such a small number percentagewise it isn't all that important. Some believe the disabled themselves aren't that important (A high ranking staff member of the Los Angeles County Department of Children's Services stated, "I just can't get excited about this issue!") Others, I believe just never thought of it. Whatever the reasons, the following are the accomplishments to date on data collection.

(1) The United Cerebral Palsy organization estimates that 11% of their constituents have cerebral palsy as a result of physical abuse.(2) Eleven per cent!!!!

(2) We have some data available to us, reported in the pamphlet, "Child Abuse and Developmental Disabilities" published by the Regional Developmental Disabilities Offices in Boston. It includes the following data: In an examination by David Gil in 1970 of confirmed cases of child abuse, 29% of the children had demonstrated a developmental disability prior to the abuse. A national survey conducted of Parents Anonymous members showed that 58% of the member's abused children had developmental problems prior to abuse incidents In a study conducted by the Denver Department of Welfare, nearly 70% of the children exhibited either a mental or physical deviation prior to their reported abuse.

(3) California Association for Retarded Citizens reported in its 10/12/84 newsletter, that two to two and a half million children a year are born with some effects of Fetal Alcohol syndrome (FAS), which makes it the third most common cause of mental retardation

(4) The Seattle Rape Relief Project on the Developmentally Disabled (1) for 197779 found of their program participants 70% had had at least 1 incident of sexual abuse (remember the

definitions). None of these had been reported prior to involvement in the program. Their estimates are that of the population, of individuals with developmental disabilities approximately 75% experience abuse, prior to age 18.

(5) Other estimates on sexual abuse put the number at approximately 10 times the rate in the general population. Estimates in the general population are l in 4 girls, l in 6 boys will be molested prior to age 18. Ten times l in 4 indicates 99% will experience up to 4 incidents of sexual abuse. This is closer to the experience of Sex and Developmental Disability

professionals. As yet, there is not a data backup on this.

Which raises another issue..why not? Why is data on the disability of the abuse victim not collected? To remedy this in California, last year the Los Angeles Committee on Abuse of Disabled Persons lobbied very hard with the following result: The Suspected Child Abuse Investigator Report now has a box which asks for identification of the victim and suspect as Adevelopmentally disabled@ We felt this was a major accomplishment. Data will be available in the State of California effective this year.

It is interesting/devastating to note that the Department of Developmental Services document "Prevention Plans to 1990" does not address abuse as a cause of disability, even though simply for cerebral palsy we know 11% is due to abuse. What is the percentage for other types of disability? i.e. mental retardation, seizure disorder, brain damage, etc.?

I believe that abuse is a significant contributor to disability and cannot fathom why it is not addressed by the Prevention department. Certainly much of it is preventable.

In a paper I presented at CANHC last year, I have outlined some "Family Reactions to the Disability of a Child", which describes a series of reactions and difficulties all family members experience. Some of these can contribute to increased stress which we know is a factor in abusing families. This is a reference you would like to have. Another resource on this topic is the report of the Senate Subcommittee Hearings held by Senator George Miller last year on Families with Handicapped Children.

Incidence of dependent adult abuse is really unknown, as laws regarding its remediation and reporting are so new and the guidelines are not even written. Other states are equally delayed in this area of knowledge.

Regional Centers for the Developmentally Disabled vary greatly in their approach to abuse of their clients. Some, for example, Lanterman and San Diego, are rigorous in their reporting and followup...others state they NEVER report abuse as a matter of policy. They do not specifically track abuse of their clients as a separate "incident report", and cannot provide any data on the number of incidents of abuse reported, type of abuse, or any demographics for any given time period. Of any agency, it seems to me the Regional Centers should be a major source of information on this topic. I do understand that, if requested, the Regional Centers could provide information on the number of cases they carry that are disabled due to abuse. I have not investigated this yet, but have been told that it is available information for the asking.

IDENTIFICATION

One major difficulty is obviously in identifying victims of abuse. Part of the difficulty

lies in the Regional Center's role, that does not include intensive daytoday contact with clients and families, which would obviously make identification easier. But this is the job of those who do have this intensive contact: special education programs, day programs, workshops, residential care programs. So, two roles appear for the Regional Centers: First, direct involvement, when AT INTAKE, direct questions are asked of parents and clients regarding sexual activity, physical discipline practices, verbal discipline practices, to gain a "profile" on how daily life works. Direct questions about history of abuse often "open" an opportunity for parents and/or clients to talk, where they may not do so without the openness of the counselor. Second, indirect involvement, assisting through formal and informal training of providers in the area of abuse identification (signs and symptoms), what reporting guidelines and requirements are, and that the Regional Center supports and will help in reporting processes.

Regional Center counselors should be thoroughly knowledgeable about Client Rights and what these mean. They should do a thorough (rather than cursory) discussion with each client of what these mean, and assure that the client has actually been receiving these rights. The monitoring of programs/providers is not adequate as we know. More intensive technical training is really needed at this levelthe most critical level as this is where monitoring actually takes place.

San Diego regional Center has a SCAN (Suspected Child Abuse and Neglect) Team which meets biweekly. At this team are the special Regional Center consultants (nurse, psychologist, sexuality educator), and local experts (hospital pediatrician, SCAN expert). Regional Center counselors come here to discuss cases, to determine if a report should be made, if more questioning by the client program coordinator should be done, or if none is required. This provides both technical assistance and moral support to those "on the line", and has tremendously strengthened identification skills and practices, and helped numbers of children who otherwise might still be undiscovered or unreported victims of abuse.

TREATMENT PROGRAMS

Often my referrals are for offenders, who have developmental disabilities. On these cases, I always ask, who is treating the victim. Ninety percent of the time, I find that no referral has been made for the victim. Why not? Many times, no one has thought of it. Sometimes even developmental disabilities professionals believe the victim didn't "really" suffer, due to the retardation. TREATMENT IS STILL REQUIRED! People have feelings. Not to mention the greatly increased vulnerability of a victimized person.

The State Departments of Mental Health and Developmental Services have a memorandum of understanding regarding provision of mental health services to individuals with a developmental disability. This should be used at the County level, to assure that victims of abuse with developmental disabilities receive the same level of treatment as their Ageneric@ counterparts. Again, it takes perserverance and action to reify the agreement, but the abuse victim with a disability is hardly the appropriate agent for advocacy at that point in time...it is up to the Stateassigned advocates, namely Regional Center staff.

Regional Centers should also enter into a mutual training and technical assistance program with local State Mental Health programs, to assist in providing specialized posttrauma
counseling to children and adults with developmental disabilities.

PREVENTION PROGRAMS

There are scattered Prevention training projects throughout the State and nation. One of these is the previously noted Seattle Project, which continues to provide rape and sexual assault prevention training to adults with developmental disabilities.

The Waters Child Abuse Prevention Training Act specifies that programs be offered to ALL children at various grade levels. In response, some programs simply provide the more basic program to children with developmental disabilities, without particular understanding of or effort for the particular disabilities. Others, for example in Contra Costa County are creating several curricula to meet the needs of various disability types, learning level, and ages of the children.

Los Angeles County Office of Education is completing a Preschool Abuse Prevention Program for Disabled Children , that addresses Teachers, Parents and Children. It addresses learning styles and need for repetition and reinforcement, and is sensitive to disability issues. It offers training in regard to physical, emotional and sexual abuse, as well as neglect.

It is a safe statement that most Special Education program staff have not received sufficient or appropriate training and support to recognize and act, to report suspected abuse. Many
special education teachers and other disability specialists believe they must PROVE abuse prior to reporting. This is not correct. The belief, however, impedes action. It is reasonable suspicion that is required, not proof.

Dependent Adults also need training on what abuse is, how to recognize and report it to someone who can help. Many programs mistakenly focus on stranger danger, which, for those with a developmental disability, represent 1% of the perpetrators of abuse...I suppose these appear more "palatable" to community members who might complain. But, since we know that 99% of the time the perpetrator is well known to and trusted by the person with a disability, a more appropriately focused program is indicated.

Many professionals are unaware of the reporting law for dependent adults, and fail to secure help that can be made available.

SUMMARY AND RECOMMENDATIONS

Laws are new, but abuse is not. The child and dependent adult depend for their safety on external protectors, i.e., Regional Center Counselors, Special Education teachers, etc. It is imperative that these "protectors" know and understand abuse issues and feel they have the support they need to help these disabled victims of abuse.

In this paper, there are many issues that have not been addressed: following the report, how is the investigation handled by an investigator who may or may not have training and experience with people with developmental disabilities? Many reports of abuse are simply "shelved" because the witness is disabled and is deemed unable to give a report that can be substantiated.

Many disabled victims are deemed not to be credible witnesses, once the case has been filed, and the case is dropped at that point. Even in court, the prejudices of judge, jury, and others invalidate the case. What are the prevention training techniques that have been found effective with children and adults with developmental disabilities? What are the treatment needs and techniques recommended for this population?

This paper was designed as a brief overview, to illuminate some of the issues and problems faced by the abuse victim with a developmental disability and the helping professional. Certain recommendations flow from it:

1. Begin to add "Disability" to the categories such as race, and age, to report forms for child abuse.

2. Create and attend training programs on the identification of abuse, prevention, intervention and treatment, for this population.

3. Create an awareness among your colleagues, of this problem, and put some energy into the organizations that exist to combat this problem.

For more information about this topic, please feel free to contact me.

Nora J. Baladerian, Ph.D., M.F.C.C.
MENTAL HEALTH CONSULTANTS
2100 Sawtelle Blvd. #303-1
Los Angeles, CA 90025
Office: 310 473 6768
FAX: 310 996 5585
Email: Nora@disability-abuse.com

American Academy of Pediatrics
Dedicated To The Health Of All Children

CHILD ABUSE & NEGLECT

Each year approximately 3 million children are reported abused or neglected in the U.S.; 3 children die each day from abuse and neglect.

Below is information to assist healthcare providers, families and the community to recognize child abuse and neglect and prevent it from happening.

Physical Abuse is when a child is hit, slapped, beaten, burned, or otherwise physically harmed. Like other forms of abuse, physical abuse usually continues for a long time.

Sexual Abuse is when a child is engages in a sexual situation with an adult or an older child. Sometimes this means direct sexual contact, such as intercourse, other genital contact or touching. But it can also mean that the child is made to watch sexual acts, look at an adult's genitals, look at pornography or be part of the production of pornography. Children many times are not forced into the sexual situation, but rather they are persuaded, bribed, tricked or coerced.

Emotional/Psychological Abuse is when a child is regularly threatened, yelled at, humiliated, ignored, blamed or otherwise emotionally mistreated. For example, making fun of a child, calling a child names, and always finding fault are forms of emotional/psychological abuse.

Neglect, is when a child's basic needs are not met. These needs include nutritious food, adequate shelter, clothing, cleanliness, emotional support, love and affection, education, safety, and medical and dental care.

COMMON CHARACTERISTICS OF CHILDREN WITH EMOTIONAL/BEHAVIORAL ISSUES:

*1. Lack of social skills

*2. Impairment in communication skills, processing information, expressive and/or receptive language

*3. Restricted repertoire of activities and interests

*4. Abnormalities in cognitive skills; splinter skills

*5. Hyperactivity; on the move, restless, accident prone, OR inattentive, by being quiet as though all is well, while not listening to a word you are saying

*6. Short attention span, distracted easily

*7. Impulsive; acts first, then ***may*** think of the correct behavior instead

*8. Confused sense of time and space

*9. Memory lapses; knew something one day (math) and then forgets it the next day

*10. Concrete thinkers and learners (have to see, feel and touch to learn) vs. abstract thinking

*11. Often lose their temper

*12. Often argues with adults

*13. Deliberatively does things to annoy people, thinking when they get attention people like him/her

*14. Often blames others for their mistakes

*15. Sensitive and/or easily annoyed by others (“I didn’t do it.”) even though you saw the act.)

*16. Often can be depressed, angry, and/or resentful

*17. Many emotional ups and downs, (mood swings) through out the day

*18. Poor coordination; team sports may be difficult OR may be really good in sports

*19. Actively defies adult requests or rules often

*20. Unorganized, loses things, breaks things, absent minded

*21. Difficulty waiting their turn and following rules; though others find safety in rules and thrive on them

*22. Talks excessively

*23. Often engages in physically dangerous activities without considering the consequences, of their behavior.

*24. Gets into a lot of physical fights

*25. Does better with one on one; needs explanations, encouragement, goes on overload with too much stimulation and needs grounding provided by this person

*26. Low self esteem; few friends, though others have a lot of friends and have high self esteem

*27. Enjoys children younger than they are, as their social skills are often 2-3 years or more delayed

*28. Thrives on structure and routine

*29. Often has an average or above average I.Q. Their behaviors are not due to an **intellectual issue,** they are due to a **performance issue.**

Support For Parents:
Helping Them to Feel More Connected
With Other Parents Who Have
A Child With Special Needs and/or Themselves

1. Share some of your child's functional problems. This might include problems with dressing, eating, toileting, sleeping, playing with others, transitioning, going out in the community, school issues, sibling issues, family issues (e.g., walking on eggshells, feeling like you are in jail because you can't go anywhere).

2. Share some of your child's social-emotional issues such as: anxiety, depression, aggression, negative behaviors, controlling behaviors, temper tantrums, impulsivity, poor sustained attention, school rejection, social isolation, etc.

3. Share the difference it made when your extended family finally "knew" what was causing your child's behaviors.

4. Share he effect of your child's condition on the opportunity to participate in a full range of childhood activities, e.g., Scouting, birthday parties, play groups, etc.

5. Share specific types of therapy that have helped your child and your family and in what way did these therapies help?

6. Share the social impacts of your child's condition, including how extended family and others, including peers and teachers, perceive/treat your child.

7. Share your own feelings (e.g., loneliness, isolation) before you found out your child’s diagnosis.

8. Share your own feelings (e.g., relief, hopefulness) once you had an explanation for your child's condition and knew it could be treated. How did you treat your child differently, knowing there was a reason why he/she had behaviors?

9. What was the impact on your family, schools, and others once you reframed your child's behavior as being physiological in source, not behavioral or the result of your parenting style

10. In what ways did a recognized diagnosis of your child's disorder, improve his/her educational conditions or opportunities.

11. Share your family's assessment/diagnosis story. If assessment was long or complicated, include how many professionals you saw before an accurate diagnosis was made, how long it took, any misdiagnoses along the way, etc.

12. What are the effects, of your child, on other children and/or family members?

13. What have you and the adults in your child's circle of care, done to learn ways to discipline a child with Special Needs, to feel more in control of yourself while creating harmony with in the family?

14. Have you experienced that raising a child with Special Needs is counter intuitive in comparison to raising a child who is developing typically?

15. In what ways do you find that parenting is different with a child that has Special Needs that your typically developing children?

16. What are willing to share with others about how taking care of yourself has enhanced your life and the lives of those around you? (i.e., getting a massage , going out with friends, seeing a movie, doing nothing, going to bed early, burying yourself in a good book, buying a new outfit, etc.)

17. What lessons have you learned from your child that has made you a better person?

18. How has your child been your Teacher?

19. What else would you like to share that has not been addressed here? Share it with the group/person.

20. Share how you are feeling in this moment, having discussed these question/comments, out-loud with someone.

"The Reality of Abuse Among Children with Special Needs: The Vulnerable Ones"

I. Introduction: Let Us Talk About Children With Disabilities

II. How To Define Abuse:

a. Cultural Values, b. Styles of Discipline, c. Sexual, d. Emotional, e. Physical

III. The Population of Children with Special Needs and Their Vulnerability; Targets Of Abuse

IV. An Inside View Into The Lives Of Children Who Have:

A. Children who are: Visually Impaired, Hearing Impaired, and/or Physically Impaired,
Those who require Special Assistance in every day life i.e.: those in a wheelchair and/or a walker for mobility or those who require a cane to get around with, those who need hearing aides, those with Cerebral Palsy, Muscular Dystrophy and those who need crutches to assist them in walking, and on and on and on.

B. Common Diagnosis that Parents, Teachers, Sitters, Families, Drs Deal With Day to Day also include:
Autism Spectrum Disorder, (ASD), Aspergers, Non Verbal Learning Disorder (NLD),
Attention Deficit Hyperactivity/Inattentive Disorder, (ADHD, ADD),
Learning Disabilities (LD), Sensory Integration Disorder (SID),
and Fetal Alcohol Spectrum Disorder (FASD), etc.

V. What Are Some Of The Indicators Of Abuse?

What are some signs and symptoms to look for of:
physical, emotional and/or sexual abuse,
in Children with Special Needs?

VI. What To Do Next After Seeing Indicators Of Abuse Helping Victim and the Family:

Teach appropriate sexual boundaries, who are strangers, effective communication skills with:
children, parents, teachers, sitters, other professionals, and paraprofessionals.

V. Resources:

CPS: Child Protective Services in San Jose

PHP: Parents Helping Parents in San Jose

SARC: San Andreas Regional Center in Campbell

NORA BALADERIAN: Ph.D., M.F.C.C.,
MENTAL HEALTH CONSULTANTS:
2100 Sawtelle Blvd. #303-1, Los Angeles, CA 90025,
Office: 310/473 6768 **Fax:** 310 996 5585, **Email:** Nora@disability-abuse.com

PEDIATRICS; Hibbard et al. 119 (5): 1018. **(95K)**
An online newsletter with a variety of topics and an in depth bibliography on the subject of Abuse, Related to Children with Special Needs.
http://pediatrics.aappublications.org/cgi/content/full/119/5/1018

A Class For Parents Of Children With Special Needs That Will Assist You In "Feeling Empowered As A Family"

Do You Have A Child With Challenging Behaviors or Who May Have:

Autism, Aspergers, Non Verbal Learning Disorder, Sensory Integration Disorder, Reactive Attachment Disorder, Oppositional Defiant Disorder Fetal Alcohol Spectrum Disorder, Pervasive Developmental Disorder, Attention Deficit Disorder, and/or Delayed Social Skills? If you answered "yes," then this class is for you!

Being A Parent Of A Child With Special Needs Requires:

*SHARING WITH OTHERS WHO HAVE EMPATHY AS THEY HAVE CHILDREN WITH SPECIAL NEEDS TOO

*A PLETHORA OF EFFECTIVE COMMUNICATION TOOLS THAT WORK TO HELP US TO STAY CALM

*LEARNING HOW TO INCREASE OUR PATIENCE OVER AND OVER THROUGH "CONCRETE SKILLS"

*A HUGE "BAG" FULL OF NEW IDEAS TO USE WHEN ALL THE OTHERS WE KNOW DO NOT HELP

* POSITIVE DISCIPLINE SKILLS THAT HELP TO TEACH OUR CHILD APPROPRIATE BEHAVIORS

*CONTINUALLY FOCUSING ON, "HOW AM I FEELING? I MUST TAKE APPROPRIATE ACTION"

*UNDERSTANDING OUR CHILDREN'S PERSPECTIVE OF LIFE

*CONSISTENCY, STRUCTURE AND ROUTINE

*A COUNTER INTUITIVE PARENTING STYLE

*A HUMUNGOUS AMOUNT OF SELF CARE

*POSITIVE BEHAVIOR MODIFICATION

*WAYS TO "ACT VS, REACT"

"PHEW! NO WONDER WE NEED:
SUPPORT, GUIDANCE, SKILLS AND CLASSES!

THERE IS SO MUCH TO LEARN ABOUT CREATING THE BEST ENVIRONMENT FOR OUR FAMILY THAT INCLUDES RAISING A CHILD WITH BEHAVIORS THAT ARE CHALLENGING!"

WE DO NOT HAVE TO PARENT ALONE!

IT REALLY DOES TAKE A VILLAGE TO RAISE OUR CHILDREN WITH SPECIAL NEEDS!" *Kathy McNamara*

What Can You Expect From This Class You Ask?

**Below You Will See A "Sampling" Of Practical and Concrete Skills Being Offered,
That Will Change Your Life When You Learn and Practice Them Consistently!**

PERSONAL VALUES

*** Having realistic expectations- for yourself and your child.**
***Self-acceptance for your strengths and weaknesses.**
Where did you learn to be a parent?

*AVOIDING PROBLEMS

*** Making transitions smooth from one activity to the next.**
*** Goals of Behavior- also known as a reaction to unmet needs.**
*** Limited choices by providing two choices (at least) whenever possible.**
*** Foreshadowing by preparing the child for what is going to happen.**
*** Use fewer words, as processing information is usually difficult for our children.**
*** Shaping is breaking large tasks into smaller steps, so child can experience success.**

PROBLEM SOLVING TOOLS

*** What is the problem, behaviorally?**
*** Who has the problem?**
*** Brainstorm solutions**

POSITIVE DISCIPLINE

*** Active Listening - understanding the feelings and facts of what your child is saying.**
*** I Messages – own your problem, your feeling, why, solve your problem; "When... I feel... because..."**
***Ways to teach your children to take responsibility for their behaviors**
*** Reinforcing appropriate behavior**
*** Modifying inappropriate behavior**
*** Natural and logical consequences**

COMMENTS FROM PREVIOUS CLASS PARTICIPANTS

"Being in the class has let me know I am not alone as a Special Needs Parent."
"I came into this class frustrated, depressed, frightened, lost. I came out feeling more in control of myself."
"I feel relaxed revived, and things are more possible, instead of impossible. Thanks for giving me back to me."
"If you have a difficult (trying) child and nothing seems to work and you feel guilty that you are some how the cause of his problems, then this class can offer you options that really work!"

FOR FRIENDS OF THE HANDICAPPED

BY ANN LANDERS

Blessed are you, who take the time to listen to difficult speech, for you help me to know that if I persevere, I can be understood.

Blessed are you, who never bid me to hurry or take my tasks from me and then do them for me, For I often need time rather than help.

Blessed are you who stand beside me as I enter new and untried ventures, for my failures will be Outweighed, by the times I surprise you and myself.

Blessed are you who asked for my help, for my greatest need is to be needed.

Blessed are you who understand that it is difficult for me to put my thoughts into words.

Blessed are you who with a smile encourage me to try once more.

Blessed are you who never remind me that today I asked the same question twice.

Blessed are you who respect me and love me JUST AS I AM.

The Arc

Q&A

People with Intellectual Disabilities and Sexual Violence

By Leigh Ann Davis, M.S.S.W., M.P.A.
Assistant Director of Professional & Family Services

What is sexual assault/ sexual abuse?

Sexual assault is a crime of violence, anger, power and control where sex is used as a weapon against the victim. It includes any unwanted sexual contact or attention achieved by force, threats, bribes, manipulation, pressure, tricks, or violence. It may be physical or non-physical and includes rape, attempted rape, incest and child molestation, and sexual harassment. It can also include fondling, exhibitionism, oral sex, exposure to sexual materials (pornography), and the use of inappropriate sexual remarks or language.

Sexual abuse is similar to sexual assault, but is a *pattern* of sexually violent behavior that can range from inappropriate touching to rape. The difference between the two is that sexual assault constitutes a single episode whereas sexual abuse is ongoing.

Sexual violence occurs in the home (sexual abuse of children, sexual assault by partners or relative), outside the home (in group homes or institutions), on the job, on transportation systems (while riding the bus or a taxi) and virtually anywhere.

How often do adults and children experience sexual violence?

Studies consistently demonstrate that people with intellectual disabilities are sexually victimized more often than others who do not have a disability (Furey, 1994). For example, one study reported that 25 percent of girls and women with intellectual disabilities who were referred for birth control had a history of sexual violence (Sobsey, 1994). Other studies suggest that 49 percent of people with intellectual disabilities will experience 10 or more sexually abusive incidents (Sobsey & Doe, 1991).

Any type of disability appears to contribute to higher risk of victimization but intellectual disabilities, communication disorders, and behavioral disorders appear to contribute to very high levels of risk, and having multiple disabilities (e.g., intellectual disabilities and behavior disorders) result in even higher risk levels (Sullivan & Knutson, 2000).

Children with intellectual disabilities are also at risk of being sexually abused. A study of approximately 55,000 children in Nebraska found that children with intellectual disabilities were 4.0 times as likely as children without disabilities to be sexually abused. (Sullivan & Knutson, 2000).

Women are sexually assaulted more often when compared to men whether they have a disability or not, so men with disabilities are often overlooked. Researchers have found that men with disabilities are twice as likely to become a victim of sexual violence compared to men without disabilities (The Roeher Institute, 1995).

WHAT TO LOOK FOR

Physical Signs

Bruises in genital areas	Pain in genital areas
Sexually transmitted disease	Signs of physical abuse
Tearing of vaginal or anal area	Headaches/stomachaches

Behavioral/Psychological Signs

Depression	Substance abuse	Withdrawal
Avoids specific setting	Seizures	Phobias
Avoids specific adults	Crying spells	Regression
Sleep disturbances	Irritability	Guilt/shame feelings
Change in appetite	Resists physical exam	Change in prior mood
Self-destructive behavior	Feelings of panic	Change in habits
Learning difficulty	Sexually inappropriate behavior	Severe anxiety & worry

Possible Signs To Look For In An Abuser

Alcohol or drug abuse	Devaluing attitudes
Excessive or inappropriate eroticism	Socially isolated
Uses other forms of abuse	Previous history of abuse
Seeks isolated contact with children	Strong preference for children
Surrogate caregivers (particularly males)	Unresolved history of abuse
Pornography usage	

Adapted from *Violence and Abuse in the Lives of People with Disabilities* (1994), D. Sobsey.

Why is sexual violence so common among people with intellectual disabilities?

People with severe intellectual disabilities may not understand what is happening or have a way to communicate the assault to a trusted person. Others with a less severe disability may realize they are being assaulted, but don't know that it's illegal and that they have a right to say no. Due to threats to their well-being or that of their loved ones by the abuser, they may never tell anyone about the abuse, especially if committed by an authority figure whom they learn not to question. In addition, they are rarely educated about sexuality issues or provided assertiveness training. Even when a report is attempted, they face barriers when making statements to police because they may not be viewed as credible due to having a disability (Keilty & Connelly, 2001).

What risk factors contribute to the occurrence of sexual violence?

Some risk factors may include a feeling of powerlessness, communication skill deficits and inability to protect oneself due to lack of instruction and/or resources. Individuals may live in over-controlled and authoritarian environments, contributing to the feeling of powerlessness over their situation. In addition, they are not given enough experiential opportunities to learn how to develop and use their own intuition (those who are taught can often detect between safe versus unsafe situations.)

Other factors include the caretaker's failure to 1) request information on the background of all those involved in the person's life, such as professionals, paraprofessionals, ancillary and volunteer staff, 2) become familiar with the abuse-reporting attitudes and practices of the agency, and 3) assure there is a plan in place for responding to reports of abuse when they occur. Also, offenders are typically not caught and/or held accountable for these crimes, which allows abuse to continue.

Who is most likely to sexually assault?

As is the case for people without disabilities who experience sexual violence, perpetrators are often those who are known by the victim, such as family members, acquaintances, residential care staff, transportation providers and personal care attendants. Research suggests that 97 to 99 percent of abusers are known and trusted by the victim who has intellectual disabilities. While in 32 percent of cases, abusers consisted of family members or acquaintances, 44 percent had a relationship with the victim specifically related to the person's disability (such as residential care staff, transportation providers and personal care attendants). Therefore, the delivery system created to meet specialized care needs of those with intellectual disabilities contributes to the risk of sexual violence (Baladerian, 1991).

What are the effects of sexual violence on someone with intellectual disabilities?

Sexual violence causes harmful psychological, physical and behavioral effects (see chart on front page). The individual may become pregnant, acquire sexually transmitted diseases, bruises, lacerations and other physical injuries. Psychosomatic symptoms often occur, such as stomachaches, headaches, seizures and problems with sleeping. Common psychological consequences include depression, anxiety, panic attacks, low self-esteem, shame and guilt, irrational fear, and loss of trust. Behavioral difficulties include withdrawal, aggressiveness, self-injurious and sexually inappropriate behavior (Sobsey, 1994).

What type of treatment or therapy is available for victims of sexual violence?

In the past the benefit of psychotherapy for people with intellectual disabilities was questioned, as well as the impact of sexual violence (whether or not it impacts people with intellectual disabilities as strongly as others without disabilities). Today, however, it is widely acknowledged that all people who experience sexual violence are affected and do require therapeutic counseling, even if they are non-verbal.

Locating a qualified therapist may be difficult since the person should be trained in child/adult sexual abuse and sexual assault treatment as well as intellectual disabilities. The therapist should also be trained in non-verbal mind-body healing modalities that do not require an intellectual processing component of the therapy. Payment for the therapy can be obtained through victim witness programs, community mental health centers or developmental disability centers.

How can sexual violence of people with intellectual disabilities be prevented?

The first step is recognizing the magnitude of the problem and facing the reality that people with intellectual disabilities are more likely to be assaulted sexually than those without disabilities. Also, societal attitudes must change to view victims with disabilities as having equal value as victims without disabilities, and giving them equal advocacy. Every sexual assault, regardless of who the victim is, must be taken seriously.

Secondly, sexual violence must be reported in order for repeat victimization to stop. While few people ever disclose sexual violence for a variety of understandable reasons, such non-disclosure promotes an environment ripe for continued victimization. Reporting can be increased by educating individuals with disabilities and service providers about sexual violence, improving the investigation and prosecution of this crime, and creating safe environments that allow victims to disclose.

In addition, employment policies must change to increase safety. For example, background checks on new employees should be conducted on a routine basis and those with criminal records should not be hired. Routine checks should consistently be conducted for current employees as well.

Sex education must be provided on a regular, on-going basis, and self-determination and relationship-building skills taught so individuals with intellectual disabilities can learn how to develop safe relationships. Classes on sexual violence should be provided to teach individuals how to respond and protect themselves when they become sexual assault victims.

What should I do if I suspect sexual abuse/assault of someone I know?

All states have laws requiring professionals, such as case managers, direct care workers, police officers and teachers to report abuse. Some states require the general public to report abuse as well. If you suspect a child is being sexually abused, contact your local child protective agency. If the person is an adult, contact adult protective services. These are also referred to as "Social Services", "Human Services" or "Children and Family Services" in the phone book. ***You do not need proof to file a report.*** If you believe the person is in immediate danger, call the police. After a report is made, depending on how serious the abuse is, the incident is referred for investigation to the state social services agency (who handles civil investigations) or to the local law enforcement agency (who handles criminal investigations).

For more information on how you can help prevent sexual assault/abuse, contact Prevent Child Abuse America at 1-800-555-3748 (200 S. Michigan Ave., 17th floor, Chicago, IL 60604) or visit their web site at www.preventchildabuse.org and The Arc Riverside's CAN DO! Project at www.disability-abuse.com

The Arc thanks Nora Baladerian,Ph.D., Shirley Paceley, and Dick Sobsey, R.N., Ed.D. for reviewing this document.

References

Balderian, N. (1991). Sexual abuse of people with developmental disabilities. *Sexuality and Disability, 9*(4), 323-335.

Furey, E. (1994). Sexual abuse of adults with mental retardation: Who and where. *Mental Retardation*, 32, 3, p. 173-180.

Keilty, J & Connelly, G. (2001). Making a statement: An exploratory study of barriers facing women with an intellectual disability when making a statement about sexual assault to police. *Disability & Society*, 16 (2), 273-291.

Sobsey, D. (1994). *Violence and abuse in the lives of people with disabilities: The end of silent acceptance?* Baltimore: Paul H. Brookes Publishing Co.

Sobsey, D. & Doe, T. (1991). Patterns of sexual abuse and assault. *Sexuality and Disability, 9* (3), 243-259.

Sullivan, P.M. & Knutson, J.F. (1994). *The relationship between child abuse and neglect and disabilities: Implications for research and practice*. Omaha, NE: Boys Town National Research Hospital.

The Roeher Institute (1995). *Harm's way: The many faces of violence and abuse against persons with disabilities in Canada.*

THOUGHTS TO PONDER

Peace Comes Not From
The Absence Of Conflict,
But From The Ability
To Deal With It!

****

Where Did We Ever Get The Crazy Idea
That In Order To Get Our Children
To Do Better, First We Have To
Make Them Feel Worse?

****

When Adults Change Their Attitude First,
Children Have The Opportunity
To Change Their Attitude!
Expect This Miracle!

****

Parenting A Child With Special Needs
Is A Process, Not A Destination!

****

Did You Know That The Word Discipline,
Comes From The Word Disciple,
Which Means To Teach?
Therefore, When We Discipline Our Children,
We Need To Remember That
We Are Teaching Them.

****

Actually, Be Aware Of What Is Being Taught,
Because Our Children Learn From Us
In Every Moment; Yes, In Every Moment,
Even Lessons We Do Not Intentionally Mean To Teach.

****

SOME STATISTICS TO BE AWARE OF

The Federal Maternal and Child Health Bureau defines; "Children with Special Health Care Needs" (CSHCN) as:

"Those who have or are at increased risk for a chronic: physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally"

This definition is used to guide the development of family-centered, coordinated systems of care for children and families with special needs served by the state Title V block grants administered by the **Maternal and Child Health Bureau. The National Survey** of CSHCN (NS-CSHCN) and the National Survey of Children's Health (NSCH) – two child health prevalence surveys – use a validated non-condition specific, consequences based screening tool, to identify children meeting the Maternal and Child Health definition of CSHCN with the exception that the "at risk" component is not included.

Demographic Profile

• Compared to children not meeting CSHCN criteria (non-CSHCN), CSHCN are more likely to be male: (59% vs. 50%) and older, 12–17 years (42 % vs. 33%).

• CSHCN and non-CSHCN are equally likely to live in low-income families.

• While estimated by the NS-CSHCN to be about 14% of the child population, CSHCN account for 40% or more, of medical expenditures for children overall.

Prevalence Profile

Source: 2005-2006 National Survey of Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN):

• Approximately 10.2 million children ages 0–17 years in the United States (13.9%) have special health care needs.

• Prevalence of CSHCN ranges from 10% to 18.5% across the 50 states and the District of Columbia.

• 1 in 5 households with children in the United States have at least, one child with special health care needs. This translates into over 8.8 million households nationally.

Health Status Profile:

91% of CSHCN have **1** or more conditions on the list of **16** shown below and
25% of CSHCN have **3** or more of these conditions

Conditions: % OF CSHCN:

Allergies; **53%**

Asthma; **38%**

ADD/ADHD**; 30%**

Depression, Anxiety, or Emotional Problems; **21%**

Migraine/Frequent Headaches; **15%**

Mental Retardation; **11%**

Autism or Autism Spectrum Disorder; **5%**

Joint Problems; **4%**

Seizure Disorder; **4%**

Heart Problems; **4%**

Blood Problems; **2%**

Diabetes; **2%**

Cerebral Palsy; **2%**

Down Syndrome; 1%

Muscular Dystrophy; **0.3%**

Cystic Fibrosis; **0.3%**

85% of CSHCN experience **1** or more of the following functional difficulties and **28% of CSHCN** have **4** or more of the difficulties listed:

Functional Difficulties: % Of CSHCN

Respiratory Problems; **43%**

Learning, understanding, or paying attention (ages 2–17 yrs old);

Feeling anxious or depressed; **29%**

Behavior problems; **28%**

Speaking, communicating or being understood; **23%**

Making & keeping friends (ages 3–17 yrs old); **20%**

Chronic pain; **18%**

Gross motor; **14%**

Self care (ages 3-17 yrs old); **12%**

Fine motor; **11%**

Swallowing, digesting food, or metabolism; **10%**

Difficulty seeing even with glasses; **4%**

Blood circulation; **2%**

Uses a hearing aid; **1%**

Source:

*2005-2006 National Surveys of Children with Special Health Care Needs

*The Data Resource Center is, a project of the Child and Adolescent Health Measurement Initiative at Oregon Health & Science University.

*The Data Resource Center is sponsored by, the Maternal and Child Health Bureau, Health Resources and Services Administration.

A CLASS THAT PROMOTES, "FEELING EMPOWERED AS A FAMILY."

♥Parenting The Child With Behaviors That Are Challenging♥

The Process Therapy Institute, a non-profit since 1972, proudly sponsors this class facilitated by:

Kathy McNamara, M.A., LMFT

Licensed Marriage, Family and Child Therapist, #33319

Do You Have A Child Who Is Challenging Or Who May Have:

Learning Disabilities, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Aspergers, Non Verbal Learning Disorder, Autism, Fetal Alcohol Spectrum Disorder, Sensory Integration Disorder, Developmental Delays and/or Reactive Attachment Disorder**?**

This program is designed to support you as a parent of a child who is challenging, by providing: positive discipline tools and effective communication skills, to reduce the time spent nagging, yelling and in conflict with your child. Learn how to develop healthy family relationships, see the world through the child's eyes and better understand their behavior.

Kathy created this class and has facilitated it for close to 30 years. She has offered her services to over a thousand people: including parents, and professionals, She is the proud parent of a son who has Special Needs, thus familiar with the unique problems, concerns and joys, surrounding this population. She has a private practice in Los Gatos, where she sees: children, siblings, couples, families and individuals.

SOME TOPICS COVERED DURING THE "COMPLETE" CLASS

Positive Discipline, Effective Communication, Self Esteem for the entire family, Realistic Expectations, Avoiding Problems, Problem Solving, Problem Ownership, Coping Skills, Modifying Behavior (yours and your child's), Acceptance (of yourself and your child) and so much more!

LOCATION FOR BOTH CLASSES

16573 Los Gatos Almaden Rd., Los Gatos, 95032

Take Highway 17 to Lark Ave. Right on Los Gatos Blvd. Left @1st light, Gateway. Right at the stop sign on Carlton Ave. Right @ last driveway.

DATES and TIMES

Tuesday, 5/11/2010, 10:00 AM-12:00 PM**

*First class begins at 9:45 AM.

You must come to the first or second session to be in the class.

OR

Thursday, 5/13/2010, 7:00 PM*-9:00 PM

**First class begins at: 6:45 PM.

You must come to the first or second session to be in the class.

****Be Sure To Read This:** This class is designed to be a 9-week class. Come **ONLY** to the first 5 weeks **OR** attend the complete 9-week class. The next 4 weeks begin immediately after the 5th session. The location & time remain the same. Pay for only 5 weeks or the full 9 weeks. If you want to continue after the 5th week, the additional fee is due: the 4th week of class. Only those who have taken the first 5 weeks are eligible to continue in the 9-week class.

COST FOR CLASS***:

$150/Individual, $280/Couple for the 5-week class
$270/Individual and $360/Couple for the 9-week class
A couple is 2 people raising the same child.

QUESTIONS? CALL KATHY MCNAMARA @ (408) 356-8200 X426.

REGISTRATION FORM

PRE-REGISTRATION REQUIRED! Send Registration Form to the Above "Class Location" Address.

==========Please fill out and return this bottom portion with your payment, to hold your place in the class. ==========

REFUND POLICY

Refunds will be given only if the class is canceled or postponed, Please initial to indicate that you understand and agree to the refund policy. _____

NAME: _____ **ADDRESS:** _____

CITY & ZIP CODE: _____ **#of people attending:** _____

PHONE: ( ) _____ _____**CELL: ( )**_____**FAX:**_____

WE PREFER CHECKS: PLEASE MAKE YOUR CHECK OUT TO: THE PROCESS THERAPY INSTITUTE.

PAYMENT: ___ CHECK ____VISA _____MASTERCARD TOTAL PAID: _____ WHICH CLASS? _____TUES? _____ THURS?

CARD #: _____ EXPIRES: _____SIGNATURE: _____

♥ ***Peace comes not from the absence of conflict, but from the ability to deal with it!*** ♥
♥ ***This class will improve all your relationships.*** **Expect a miracle!** ♥
♥♥ **What people want most is to love and to be loved for who they are.**♥ ♥

ABUSE AMONG CHILDREN WITH DEVELOPMENTAL DELAYS

Bossada, L.Miller, M.oya

There are more than 3,000,000 cases of child abuse/neglect among the general population.

Children with Developmental Delays are 1.5 to 10 times more likely to be abused than the general population.

Often the abuse happens more than once.

Children with Developmental Delays are 2-10 times more often, to be sexually abused.

39%-68% of Girls and 16%-32% of Boys with Developmental Delays are sexually abused by the age of 18 years old.

99% of those who abuse Children and Adults with Developmental Delays are people who they know.