Abuse and neglect of vulnerable children is not something in the past. This issue of the Virginia Child Protection Newsletter will discuss the specific risks of maltreatment for children diagnosed on the autism spectrum. Parts of the investigative process will be highlighted to help readers understand how investigators try to offer accommodations for the special needs of children with ASD or other disabilities. Prevention techniques will be considered. Separate articles will highlight specific prevention programs.

For readers who are not experienced in serving children on the autism spectrum, a separate article discusses the origins of the diagnoses, the differences between Autism and Asperger’s disorder, the prevalence rates, concurrent disorders, and early diagnosis.

Prevalence of Maltreatment

There is limited information about the prevalence of maltreatment in populations with disabilities and there is even less information about the incidence among those with Autism Spectrum Disorder (ASD). Some of the most comprehensive studies (such as Sullivan & Knutson, 2000) are fairly old, but may be preferred as estimates over some of the more recent research that uses convenience samples rather than representative samples (Horner-Johnson and Drum, 2006).

In addition to the paucity of research, the Child Welfare Information Gateway (2012) says that variations in the way States define and collect data on maltreated children makes it difficult to compare research and to accurately estimate the rates of maltreatment among children with disabilities. Studies that were located by VCPN staff are discussed below.

The most comprehensive study found was research by Sullivan and Knutson (2000). The researchers had done a prior study in 1998 based on 3,001 maltreated children and 880 comparison children using a hospital-based sample. That study had several limitations, but gave evidence that children with disabilities were at heightened risk for maltreatment, as well as some evidence that maltreatment could be important as a cause of developmental disabilities.

The study by Sullivan & Knutson published in 2000 used a sample of 50,278 children enrolled in Omaha, Nebraska schools in 1994-95. Of the sample, 3,262 children were identified by the school system as having a disability. Of those, 31% were identified as maltreated, using archival records from social services, the foster care review board, and law enforcement. Results indicated that 31% of children with disabilities had been maltreated while 9% of non-disabled children had been maltreated.

For all categories of disabilities except Autism, the rates of maltreatment for children with disabilities were considerably higher (3.76 times as high overall) than for children without disability. Children diagnosed with Autism had a slightly higher likelihood (1.3 times the risk) for neglect compared to children without disabilities but no increased risk for physical abuse, for sexual abuse, or for emotional abuse (Sullivan & Knutson, 2000).

For all maltreated children (with disability and without disability) Sullivan and Knutson found that neglect was the most prevalent form of maltreatment, followed by physical abuse, emotional abuse, and then sexual abuse. Children with disabilities were
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more likely to experience multiple episodes of maltreatment and multiple types of maltreatment than maltreated children without disability. Economic distress was associated with multiple forms of maltreatment, and neglect was linked to economic disadvantage. Males were more prevalent among maltreated children with disabilities (except that for sexual abuse only, females were predominant). For children without disability, females were more prevalent in all maltreatment types. For children with disabilities, family members were the primary perpetrators except for sexual abuse.

For children with disabilities, the lowest academic achievement scores were among those who were maltreated. There was also a clear pattern of an increasing number of missed school days among children who had experienced multiple forms of maltreatment (Sullivan & Knutson, 2000).

A more recently published study using slightly more recent data (from 1997 to 2000) and caregiver report, found higher rates of abuse for children diagnosed with Autism (26 children) or Asperger’s Disorder (156 children). From the total of 182 children on the autism spectrum, 156 completed interviews. There was no indication of how many of the 156 were in each diagnostic category (how many of the 156 were diagnosed with Autism and how many were diagnosed with Asperger’s Disorder). Of the sample of 156 on the autism spectrum, 108 reported no abuse (69.2%) while 22 (14.1%) reported physical abuse, 19 (12.2%) reported sexual abuse and 7 (4.4%) reported both physical and sexual abuse (Mandell, Walrath, Mantuvelki, Sgro, & Pinto-Martin, 2005).

Mandell et al. report that 70% of their subjects were male. Those who reported physical or sexual abuse had a greater incidence of sexually assaultive or sexual acting out behaviors, a higher incidence of suicide attempts, and a higher incidence of having run away.

Data from national studies of the incidence of maltreatment offers somewhat conflicting findings. A special analysis of data from Child Maltreatment 2004 revealed that children with disabilities were 1.68 times more likely to experience abuse or neglect than children without a disability (U.S. Department of Health and Human Services, 2006, cited in Child Welfare Information Gateway, 2012). In contrast, the Department of Health and Human Services National Incidence Study of Child Abuse and Neglect (NIS), using data from 2005 and 2006, found that children with disabilities had overall lower rates of maltreatment compared to the general population. However, children with disabilities were 1.5 times more likely to be seriously harmed by the abuse or neglect that they experienced (Sedlak et al., 2010, cited in Child Welfare Information Gateway, 2012).

An analysis of 2005 data from the National Child Abuse and Neglect Data System (NCANDS) found that children with disabilities were more likely to experience neglect than were children without disabilities.

Stalker and McArthur (2012) published a review of research on the association between maltreatment and children with disabilities. They report that research in the United States provides “clear and reliable” evidence of a higher incidence of abuse among children with disabilities. However, they cite only the two studies by Sullivan and Knutson (1998; 2000) reviewed above. They review studies in the United Kingdom and other countries which are limited but seem to support a greater risk of maltreatment for children with disabilities.

Other findings from Stalker and McArthur (2012) include: weak evidence for any role of age in the abuse of children with disabilities; strong but not undisputed evidence that boys with disabilities are at greater risk than girls with disabilities; no standardized approach to child protection for children with disabilities; few agencies with written policies on accommodating maltreated children with disabilities.

A review by Govindshenoy and Spencer (2007) examined 107 studies on the association of maltreatment and disabilities and found only four that met their criteria for inclusion in their review. They concluded that some, but not all disabling conditions were associated with an increased risk of abuse or neglect. Based on a single study (Spencer et al., 2005) they concluded that Autism and sensory disorders did not show an increased risk for maltreatment. They conclude that there is relatively poor evidence for the commonly held view that a disability predisposes a child to a higher risk of maltreatment.

It is worth noting that the phrase ‘children with disabilities’ encompasses a vast spectrum. It is unreasonable to assume that all children with disabilities have equal risk for child maltreatment. For example, two studies have suggested that children with milder impairments are at higher risk for maltreatment than those with more severe impairments (Fisher, Hodapp, and Dykens, 2008; Helton & Cross, 2011). Children with particular types of disabilities, as noted by the Sullivan and Knutson (2000) and others (studies cited in the Child Welfare Information Gateway, 2012) likely have different risks for various forms of maltreatment.

Characteristics of the Maltreatment of Children with Disabilities

The most comprehensive study to examine the types and characteristics of reported offenses and the disclosure patterns of children with disabilities was undertaken in Israel. Herschkowitz, Lamb, and Horowitz (2007) examined the forensic interview data from 40,430 children interviewed between 1998 and 2004 using the National Institute of Child Health and Human Development (NICHD) Investigative Interview Protocol (see resource reviews, this issue for more information). Of the total sample, 11% of the children (4,461) were considered to have minor disabilities (such as Asperger’s Disorder; hearing impairments; severe emotional problems; developmental delay) and 1.2% (476) were considered to have severe disorders (such as Autism; deafness; mental illness such as childhood schizophrenia; mild to severe mental retardation which is now termed intellectual disability).

The researchers found a number of differences between the children with disabilities and the typically-developing children. Children with disabilities, regardless of age, were overrepresented among suspected victims of sexual abuse and were underrepresented among suspected physical abuse victims.

Children diagnosed with disabilities who were suspected victims of sexual abuse suffered more severe and intrusive abuse, were more likely to be repeatedly victimized, and were more likely to have physical injuries, and had more occasions of force and threat than did typically-developing children.

Higher levels of disability were associated with increased risks for sexual abuse. The risks for those with minor disabilities were greater than for typically-developing children and the risks for those with severe disabilities were greater than for those with milder disabilities (Herschkowitz et al., 2007).

Compared to typically-developing children, alleged victims with disabilities disclosed maltreatment less frequently and delayed disclosure longer and more frequently. For the children with disabilities, the alleged perpetrators were more often found to be parents or parental figures. Children with severe disabilities appeared to have trouble understanding the sexual incidents under investigation. Overall, risk of sexual victimization was greatest for the children with severe disabilities (Herschkowitz et al., 2007).

An examination of research studies by Algood et al. (2011) found that boys with disabilities were at higher risk of maltreatment than were girls with disabilities. In
were 10 times more likely to be maltreated again when compared to peers without disability (Jaudes & Mackey-Bilaver, 2008).

**What Percentage of Maltreated Children Have Disabilities?**

According to Child Maltreatment 2009 (U.S. Department of Health and Human Services, 2010), 11 percent of identified child maltreatment victims had a known disability. The estimate is based on about 484,000 victims in 42 states that submitted information about child disability status (cited in Child Welfare Information Gateway, 2012). This estimate is similar to the findings of Hershkowitz et al. (2007) using a sample of 40,430 children which represented the entire population of alleged abuse victims in Israel over the 7-year period from 1998 to 2004. They found 11 percent of their sample characterized as having minor disabilities and 1.2% with severe disabilities.

**Why ASD May Increase Risk for Maltreatment**

There is conflicting information about heightened risk of maltreatment for children on the autism spectrum, reviewed above. This section reviews information from researchers that theoretically could cause an increased risk of maltreatment for children diagnosed as ASD.

According to Tantam (2012), youth with ASD can be rigid and lack empathy for others. The reduced empathy can result in poor relationship quality which can increase stress for caregivers. Children and adolescents with Autism Spectrum Disorder may be aggressive or perceived as deliberately disobedient. The child’s intensity and rigid adherence to rituals can be perceived as oppositional. Children with ASD lack compromise or negotiation skills, so they withdraw from conflict or react with hostility (Little, 2003; Tantam, 2012).

Behavioral manifestations of abuse may be misinterpreted as symptoms of Autism, according to Edelson (2010). Therefore, a child exhibiting signs and symptoms of maltreatment may be overlooked. For example, children with ASD can be self-injurious. Signs that might otherwise be interpreted as abuse may be overlooked and attributed to the child’s self-injurious behaviors (Partnership for People with Disabilities, 2010).

According to Edelson (2010), children who are diagnosed on the autism spectrum may be unable to recognize a possible sexual offender due to deficiencies in ability to identify emotions and motivations of others. Therefore, children with ASD may not be able to readily identify sexually abusive behaviors.

Even if a child with ASD is able to identify abusive behaviors, that child may have no idea of how to report any concerns to others who will listen. They may have difficulties in language usage that makes it hard for others to understand what they are saying. Those who are aware and better able to speak may not want to have their parent or caretaker ‘in trouble’ and thus may remain silent about abuse (Tantam, 2012). Edelson (2010) relates that up to half of children with Autism are functionally nonverbal. These children may be perceived by offenders as a desirable target since their ability to report is quite limited.

According to data released in April, 2011 by the Interactive Autism Network through the Kennedy Krieger Institute (Law & Anderson, 2011), about half of children with Autism attempt to elope from a safe environment. This rate is nearly four times higher than their typically-developing siblings. For those ages 7 to 10, children with ASD are 8 times more likely to wander or elope than their typically-developing siblings. Two in three parents of elopers report that their child had a ‘close call’ with a traffic injury and one in three parents report a ‘close call’ with a possible drowning. More than a third of children with Autism who wander are never or rarely able to communicate their name, address, or phone number.

In 2012, the National Autism Association found that from 2009 to 2011, accidental drowning accounted for 91% of the total U. S. deaths reported in children with Autism subsequent to wandering. About a fourth of the wandering-related deaths occurred while the child was in the care of someone other than the parent.

Reduced pain sensitivity is widely reported to be a feature of children with Autism. At least one study (Nadar, Oberlander, Chambers, & Craig, 2004) casts doubt on this commonly-held assumption. However, if parents and others believe that children with ASD are insensitive to pain, they may be less careful or harsher, inadvertently subjecting the child to pain. Nadar et al. suggest that adults may have trouble decoding pain reactions in children with ASD. In addition, there are indications that ASD increases a child’s risk of abuse through the parent’s or caretaker’s lack of awareness of pain-related behaviors in the child (Kvavik & Gresham, 2011).

**Risk of Re-abuse**

Two 2008 studies suggest that once children with disabilities are maltreated, their risk for re-abuse is higher than previously abused children without disabilities. A multi-state analysis of repeated child victimization found that children with a disability were 1.5 times more likely to experience substantiated maltreatment 2 years after the first report (Fluke et al., 2008, cited in Child Welfare Information Gateway, 2012). An Illinois study found children with a behavioral health condition who were maltreated before age 3...
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tion to raising risk for maltreatment, difficulty decoding pain reactions could result in risk for substandard pain management in situations where children with ASD have physical injuries.

Children with ASD, as is true for children with other disabilities, may lack training in the identification of maltreatment. Training in personal safety and sexuality that is offered to typically developing children may not be taught to those with developmental disabilities, further limiting their knowledge of what is and is not appropriate and how to report concerns.

In addition, many researchers believe that societal attitudes towards children with disabilities and limited public knowledge about disabilities can be factors in heightening risk for maltreatment. The Child Welfare Information Gateway publication (2012), *The Risk and Prevention of Maltreatment of Children With Disabilities*, discusses a number of societal risk factors and cites supporting research. Separation of children with disabilities from the mainstream can make those children appear unworthy of the same protections as others. Some adults and peers may rationalize poor treatment of children with disabilities because they devalue those children. Some may believe that caregivers would never harm a vulnerable child and therefore don’t pay proper attention to warning signs. If children with disabilities are viewed as asexual, they may be deprived of education about sexuality and how to protect themselves from exploitation. Harmful therapies can be employed if people believe that children with disabilities do not feel pain. Children who have internalized poor attitudes about their self-worth may not report abuse. If professional staff lack training specific to identifying maltreatment in children with disabilities, then signs of abuse will be overlooked.

Maltreatment Risks for Parents and Caretakers

Parents are often overwhelmed by the challenges of a child with Autism Spectrum Disorder. Parents of children with disabilities are felt to be especially vulnerable to stress (Algood et al., 2011; Washington, 2009). Stress is thought to increase the likelihood of maltreatment. Research (cited in Wilkinson, 2010) has shown that parents of children with Autism exhibit a characteristic stress profile which includes anxiety related to the child’s uneven intellectual profiles, deficits in social relatedness, disruptive behaviors, and long-term care concerns. For example, mothers of children diagnosed with Autism reported higher levels of stress on 13 of 14 subscales of the Parenting Stress Index than mothers of typically-developing children (Hoffman et al., 2009). Aniol, Mullins, Page, Boyd, and Chaney (2004) found that poor family relationships and high parenting stress independently increased the risk of maltreatment for children with a disability. Little (2003) reports that mothers of children on the autism spectrum are more likely to be taking medication for depression and report being pessimistic about their child’s future.

Costs can be daunting for parents of children with ASD, according to Tantam (2012) and to Washington (2009). There are costs for parents due to lost days at work while attending to their child’s special needs. The medical costs themselves are considerable. In 2004, medical expenditure for children on the autism spectrum was 4.1 to 6.2 times higher ($4,110 to $6,200 higher) than comparative children who were developing typically.

Parents of children with Autism Spectrum Disorder can confront barriers to obtaining services, struggle to understand how to provide their child with adequate care, and have difficulty finding respite (Little, 2003). Barriers to accessing disability services can be many, according to the Partnership for People with Disabilities (2010). Lack of resources or denial of services can leave parents feeling alone and overwhelmed. Parents may lack time, money, or transportation needed to access services. Parents of children with disabilities may themselves have mental health, cognitive, or physical problems. There may be a lack of community or family support and family members can even be opposed to services. Family members other than the child with ASD may have pressing needs, meaning that parents have trouble attending to their child with disabilities. Observers who sense a problem may rationalize the maltreatment, saying that the parents are doing the best that they can.

According to studies cited by the Child Welfare Information Gateway (2012), in Algood et al. (2011) and in Hibbard et al. (2007), an unskilled parent can be at higher risk for abusive behaviors. If the child exhibits challenging behaviors, parents might exert unnecessary control or use excessive physical punishment. Parents may not have formed a positive bond with their child, or frequent hospitalizations might have weakened the parent-child bond, raising the risk for maltreatment. A family member who views the child with disabilities in a negative fashion or as an embarrassment might be overly harsh. A parent with limited skills or resources may not provide adequate care or supervision. Finally, parents may be unaware that their children with disabilities have a heightened risk for maltreatment and may not be alert to risky situations or abuse from caretakers.

There is some research that raises concerns about the discipline practices of mothers with children diagnosed with Asperger’s Disorder. Little (2002) surveyed 411 mothers of children ages 4 to 17 who were diagnosed with Asperger’s Disorder and nonverbal learning disorders. A total of 728 surveys were mailed with 508 returned (70%) and 411 of those were used for the study. The mothers ranged in age from 23 to 58 years, were mainly Caucasian (98%), married (89%), and worked outside the home (62%). The annual income for over half of the households fell between $60,000 and $79,000 and 60% of the mothers had a bachelor’s or master’s degree. For the study, corporal punishment was defined as physical force meant to cause pain but not injury (such as spanking, slapping, shaking or pinching). Psychological aggression was defined as communication intended to cause psychological pain such as shouting, screaming, yelling, cursing, calling names or making threats. The Conflict Tactics Scale-Parent Child Form (Straus et al., 1998) was used to measure the frequency and use within the past year of various disciplinary behaviors, including positive discipline techniques.

Little (2002) found that most parents used some positive techniques such as explaining why something was wrong (99%), taking away a privilege (87%), or redirecting the child (86%). Psychological aggression was also very common. For example, 94% shouted, yelled or screamed at the child; 42% threatened to hit or spank; 39% swore or cursed; 21% called the child ‘dumb’ or ‘lazy’; 20% threatened to send the child away or kick the child out of the home. Spanking was common (50% of 4 to 9 year-olds; 39% of children 10 to 13; and 13% of those 14 to 17 were spanked). Slapping was even more prevalent with 50% of 4 to 9 year-olds, 45% of 10 to 13 year-olds, and 30% of those 14 to 17 experiencing slapping within the past year. For all ages combined, 16% were shaken, 11% were hit on the bottom with an object, and 7% were pinched.

Little found that the use of corporal punishment increased through age 10. Mothers of 10-year-olds used psychological aggression the most frequently, an average of 33 times during the prior year. The frequency declined gradually to a mean of 16 times for 17-year-old youth. Corporal punishment was most frequent for 4-year-olds with an average of 14 uses during the prior year. Corporal punishment declined gradually as children aged to a mean of three times a year for those 14, 15 or 16 years of age.

Although there was no control group of typically-developing children, Little (2002) felt the rates of corporal punishment and psychological aggression reported by the mothers of children with Asperger’s Disor-
der were high because children’s misbehaviors could have been caused by their impairments in social and communication abilities. She felt the rates raised concern about maternal distress. Little did mention that the rates of corporal punishment and psychological aggression were higher than what was found in a study by Straus et al. (1998) using parents of children without disabilities.

Molly Dellinger-Wray at the Partnership for People with Disabilities discussed with VCPN staff risks for some of the less usual possibilities for maltreatment. “Medication may be misused,” she explained. “Because it is expensive, doses may be withheld or a lower dose given. Medication may be withheld as a punishment. Sometimes we notice the opposite problem of children being deliberately overmedicated in order to try to control their behaviors.” Dellinger-Wray says that isolation can be used as a punishment. Taking away a communication device can be a punishment, because the child is no longer able to speak. More subtle can be threats, emotional abuse, and fostering dependence. “Caregivers, bus aides, and school staff can also use these tactics that result in maltreatment,” she added. “People should ask questions and keep in mind the wide range of maltreatment that is possible.”

Foster parents can also experience heightened risk for maltreatment of children with disabilities (Hibbard et al., 2007). They may not be informed in depth about the child’s medical and emotional needs. Foster parents may lack education about the child’s specific condition. Children in foster care may lack a permanent placement and lack a medical home (where providers are familiar with the child over a longer period of time). Indeed, research on out-of-home placement for young children with developmental disabilities and medical conditions has found that these children experience more removals from parental care, are placed in a higher number of settings, and are less likely to return to their parents at the end of foster care than peers without disabilities (Rosenberg & Robinson, 2004). The authors state that the higher number of placements that children with medical or developmental disabilities experience is evidence that these children can overtax foster families.

**Maltreatment Risks from Other Children**

As mentioned before, children on the autism spectrum have difficulty with social relationships. They lack emotional reciprocity, lack spontaneous interest in sharing with others, and may not want to interact with peers. They may interpret social cues poorly, if at all, and have trouble understanding the intentions of others. These children may be rigid and inflexible and show puzzling repetitive behavior patterns. They can range from socially withdrawn to socially intrusive.

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These characteristics can render a child on the autism spectrum vulnerable to bullying from peers and siblings (Little, 2002, 2003; Poon, 2009).

Tantam (2012) and others (Poon, 2009) discuss a number of social factors that affect the quality of life for children and youth who have Autism Spectrum Disorders (ASD). First is marginalization. Children with ASD are observers and passive bystanders, rather than participants. From about age 8 onward, those who are higher functioning realize they are different and can feel disconnected and lonely. Adolescents with ASD are less motivated to seek friendships and the quality of their friendships can be poor. Attempts to interact with others may be ineffective due to a rigid manner or the introduction of seemingly meaningless activities or rituals that are not understood by other children.

According to Tantam, children with ASD are especially vulnerable to bullying. In a large study of children in England and Wales, children with special needs and autism were 7.1 times more likely to be bullied than children without special needs (Naylor, Dawson, et al., in press, cited in Tantam, 2012). Sometimes, according to Tantam, youth with ASD may direct their frustration to bullying younger children or vulnerable targets. Bullying can cause aggression in those with ASD. Those who blame others for their inability to ‘fit in’ are likely to externalize, while those who blame themselves will internalize. Poon (2009) says that angry and aggressive outbursts are attempts by the adolescent with ASD to control the environment. Youth with co-morbid diagnoses of ADHD appear at greater risk of aggression (Tantam, 2012).

Bullying can cause the youth with ASD to avoid or drop out of school (and in later years, bullying at work can cause job loss). The child or youth with ASD can develop social phobias and refuse to attend school or functions or be in the work place (Tantam, 2012).

There are also more subtle risks for peer maltreatment. Some children with Autism Spectrum Disorder may be naïve and gullible. These children and adolescents may try to ‘purchase’ their way into social groups, either by buying goods and giving them to peers (in exchange for acceptance) or by ‘favors’ (such as sexual favors or helping with criminal activity) (Little, 2003; Poon, 2009; Tantam, 2012).

Some adolescents with ASD have become interested in a peer of the opposite sex and have followed that person ceaselessly or flooded the person with unending e-mails or text messages. Poon (2009) mentions that some teens with ASD will threaten to harm another student who is friendly towards the peer they are interested in. According to Tantam (2012), unreciprocated attachments are “not unusual” (p. 419) in youth with ASD. Stokes, Newton and Kaur (2007) found youth with ASD were more likely to engage in inappropriate courting behaviors (such as showing obsessional interest; following the person of interest; pursuing the desired person in a threatening manner; making threats against the person; making threats to harm himself). ASD youth in their study persisted in pursuing a relationship for significantly longer time periods than typical adolescents do after receiving a negative response.

Because the young person with ASD has limited ability to empathize with others, fantasies can progress to where the youth with ASD believes that he has a relationship that allows demands on the person desired and justifies jealous reactions if that person has a partner already or shows interest in others. If stalking accompanies the preoccupations, extreme rejection of the youth with ASD can result, or the person desired can become extremely afraid of the youth with ASD who is actively pursuing contact (Tantam, 2012).

It is important to remember that most children on the autism spectrum are similar to other children in their need to be part of a social group. Molly Dellinger-Wray of the Partnership for People with Disabilities explains, “Children on the spectrum have a sincere desire to fit in with their peers and belong to a community of people, but they have a hard time doing that. They long for meaningful relationships, and feelings of loneliness and rejection are often the root of other behavioral problems.”

One study of peer victimization was found. Little (2002) in a survey of 411 mothers, found that 94% reported that their child with Asperger’s Disorder or nonverbal learning disorder had been victimized in the last year. Bullying by peers or siblings was true for 75% with actual assaults experienced by 73%. Shunning (33%) or not being invited to peer events (35%) were both common, as was being picked last for teams (31%) and eating alone at lunch (11%). When these rates were compared to rates from two national samples, peer and sibling assault was eight times higher than for youth in an internet safety study (Finkelhor et al., 2000) and twice as high as what was reported by a large national sample in the National Youth Victimization Project (Finkelhor & Wolak, 1995). The rate of gang attacks for the sample of children with Asperger’s (10%) was five times higher than for the internet sample.
Reconciliation of roles of government and NGOs is needed. The document also mentions the importance of involving families in the decision-making process. It highlights the need for a comprehensive approach to address the root causes of crises, including poverty, lack of social services, and cultural factors. The report advocates for a multi-sectoral approach involving education, health, and social sectors. It calls for the provision of psychosocial support to affected communities and the strengthening of local governance structures. The document also touches upon the importance of international cooperation and funding for conflict-affected areas.

In conclusion, the report presents a detailed analysis of the impact of the conflict on the local community, emphasizing the need for a comprehensive, multi-sectoral approach to address the root causes of crises and minimize their impact on affected populations. The document highlights the importance of involving families in the decision-making process and calls for international cooperation and funding to support the recovery efforts.

**References**

- [World Bank Report on Conflict-affected Areas](https://www.worldbank.org) (Accessed: [Date])
- [International Alert on Humanitarian Crisis](https://www.international-alert.org) (Accessed: [Date])
- [UNICEF Report on Child Protection](https://www.unicef.org) (Accessed: [Date])

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**Note:** The above text is a fabricated example and does not reflect any real document or report. The information provided is for demonstration purposes only.
prior investigation where the child was interviewed, it may be helpful to check with that investigator. “In general, the investigator needs to understand the context and the ‘larger picture’ prior to meeting with the child,” comments Griffith.

Interviewers should determine the best time of day to conduct the interview. For example, the child may be more alert in the mornings. The investigator needs to fit his or her schedule into what will be most effective for the child. “Pick a place where the child will be comfortable but not distracted,” says Griffith. Danielsen notes that comfort items such as a favorite stuffed animal are allowed. If the child relates better through drawings, that medium can be used.

Griffith-Matko observes that language can be very important. “Watch your wording,” she says. “Use vocabulary that the child uses. Don’t talk ‘over’ or ‘under’ the child’s comprehension level.” Griffith-Matko suggests using short questions that require short answers. “Avoid asking a question with complex grammar,” she says. “Avoid talking to the child in paragraphs.” She also notes the importance of building trust, in part by showing patience to listen. “You need to assure the child that he or she can speak to you in their own words. Give the child time to formulate a response.”

Danielsen notes that children with Autism Spectrum Disorder may be better able to address questions about “who” or “what” and less able to consider more abstract concepts. While a free narrative from the child is desired, it may be the case that ‘forced choice’ questions are used. Additional challenges can exist if the child speaks English as a second language and an interpreter is required. Part of maintaining integrity is to record all interviews so they can be scrutinized.

Short sessions are generally preferred over longer ones (Partnership for People with Disabilities, 2010). Danielsen notes that children’s attention spans vary and some do not need shorter sessions. “We need to ascertain what is realistic in terms of attention,” he states. Griffith encourages investigators to be prepared for the need for more than one interview. Prosecutors may prefer to have all the information gathered at once,” she says, “but that is not always realistic. Patience is necessary if children have trouble expressing their information. Investigators should plan on needing a second or third contact.”

Francis suggests that Child Protective Services workers need to know professionals within their own community who work with children who are on the autism spectrum. “The autism spectrum is very broad and each child is quite different from others with the diagnosis. It is good for workers to have a local contact who can consult with them about how to relate to specific children.” Griffith-Matko says that local law enforcement often has identified resource persons who can consult on cases. The State Police or even the FBI can be consulted for difficult situations. Griffith-Matko frequently consults to investigators in other jurisdictions.

The CAC in Richmond maintains a directory of educational advocates. Danielsen notes that the size of the Richmond area means that they have access to many specialists. Therefore, if they need help from an autism specialist, there are some who can be consulted. The forensic interviewer can wear a device in his or her ear that allows communication with the specialist who is watching and listening through a one-way mirror. For example, the child’s speech and language specialist can help the interviewer understand what the child is saying. The specialist can also suggest questions. Danielsen notes that only trained forensic interviewers conduct the interviews. “We encourage a high integrity process,” says Danielsen.

Prosecution

Prosecution of cases can be difficult. Children on the autism spectrum are less likely to have the capacity to give evidence in legal proceedings and are more susceptible (Tantam, 2012). Without corroborating evidence, prosecution may not be feasible.

If the child with ASD needs to appear in court, professionals can ‘demythify’ the process for the child. One helpful procedure is to offer the child a tour of the court room. The child’s questions about the setting can be addressed in advance and the child is likely to feel more comfortable after visiting the setting and perhaps meeting some of the people who work at the court (Partnership for People with Disabilities, 2012).

Griffith-Matko notes that the ‘closed circuit’ testimony can be a good choice for a child with disabilities. In this option (which requires a petition and a hearing to establish the need for its use), children can testify from a separate room and be seen on a closed circuit television. They can still be questioned by both attorneys. She says, “Children with disabilities may be especially sensitive to the many people who are in the courtroom. They may be frightened by the unknown persons and by the court room surroundings. The ‘closed circuit’ option can minimize the impact of these factors.” Griffith also notes that assistive devices such as language boards may require approval by the court prior to use.

Intervention

Lightfoot and LaLiberte (2006) report that there is no standard approach in the United States for Child Protective Services in serving children with disabilities. Further, few agencies have written guidance for workers on how to approach an investigation and intervention with a child with disabilities.

A preliminary study in Minnesota attempted to determine what policies and procedures were used in child protection when the victim was a child with disabilities (Lightfoot & LaLiberte, 2006). During 2002 and 2003, they conducted a telephone survey of all 84 county social services agencies in Minnesota with a response rate of 89%. Only five counties (6.7%) had written policies related to procedures for cases involving disabilities. More than half of the agencies cited dual case assignment with a case opened in both CPS and also in another unit. Most agencies (70.7%) collaborated or teamed informally with disability services providers. Collaborating appeared to be an area of strength for many agencies. Some agencies had CPS workers who were experienced with disability services (12%) and 6.7% had specialty CPS workers for cases involving disabilities.

A survey of all 50 states and the District of Columbia was undertaken by Shannon & Agorastou (2005). They had a response rate of 98% (50 of 51 surveys returned). They found that only 19 of the 50 states (38%) required documentation of pre-existing developmental disabilities of children who were victims of maltreatment. This was a decrease compared to data from 1982 when 26 states responded that they collected information about developmental disabilities. However, more states in the present study required documentation of specific disability (14 or 28% for the current study compared to 7 of 52 or 13% in a prior 1997 survey). Twenty of the respondents (40%) said workers were required to receive training in developmental disabilities. That figure compared to 13% in 1997. The authors concluded that although the link between maltreatment and disability is established, there can be only rough estimates of how many children with disabilities are being served by the nation’s CPS systems.

Disabilities do appear correlated with higher numbers of foster care placements, longer stays in foster care, as well as lower rates of return to biological parents (Rosenberg & Robinson, 2004). While short-term foster care does not appear to significantly impact abuse potential in parents of children with disabilities, interventions aimed at improving family relations and reducing parental stress may be beneficial (Aniol et al., 2004; Shannon & Agorastou, 2005).

School can be a source of comfort and support for a child who has been victimized.
Schools provide a constant and stable environment (Partnership for People with Disabilities, 2010). Unless the maltreatment occurred at the school, efforts should be made to allow the child to continue daily contact with this familiar environment.

There may be need for CPS agencies to develop or locate specific training resources for parents of children with disabilities. Support groups for parents of children with disabilities and positive working relationships with educational specialists can also reduce stress (Shannon & Agorastou, 2005).

Prevention

The Child Welfare Information Gateway (2012) suggests that prevention efforts should be coordinated and multifaceted. Prevention efforts can be aimed at the general population of parents or can be targeted specifically to families and caretakers of children with disabilities. Prevention efforts can also include education of children with disabilities about personal safety.

Efforts to Educate the General Public

According to the Child Welfare Information Gateway (2012), heightened awareness of the risk for maltreatment in children with disabilities can be helpful. Heightened awareness can lead to more funding for research and for better programming. One objective is to help the general public to perceive children with disabilities as valued and unique individuals. There is a need for increased awareness of the strengths of children with disabilities and the unique perspectives that the children and their families can offer the community. The promotion of inclusion can be helpful, as greater exposure can help the general public become more comfortable and confident when interacting with children with disabilities. Parents and relatives of children with disabilities can be powerful advocates for promoting safety for their children and all children in the community.

Efforts to mainstream children may need to be balanced against an increased risk of bullying and maltreatment from peers. For example, Briggs (2006) found that children in New Zealand with learning disabilities reported experiencing more violence in mainstreamed schools (47%) compared to separate single-sex special education centers (34%). Also, more youth reported bullying in mainstream settings (36%) than in special education settings (38%). Bullying behaviors were generally name-calling and teasing.

To prevent maltreatment of children in institutional settings, facilities must be adequately staffed and funded. Effective child/staff ratios are crucial. Strong policies about appropriate treatment are necessary. Supervision and support of staff is essential.

Assessment of Services for Virginians with Autism Spectrum Disorders
Report of the Joint Legislative Audit and Review Commission (JLARC)
To the Governor and the General Assembly of Virginia

In June, 2009, JLARC issued a report, “Assessment of Services for Virginians with Autism Spectrum Disorders.” The report made 21 recommendations to improve the manner in which Virginia serves individuals with ASD.

Virginia’s Department of Behavioral Health and Developmental Services (DBHDS) wrote a response to the JLARC report. DBHDS, though its work with other agencies and stakeholder groups, found that the current system, while moving in the right direction, is fragmented, uncoordinated, and lacks focus and clear goals. DBHDS made 31 recommendations to help Virginia move towards a more integrated system where policies and services can be better coordinated and families can have easier access to services.

Readers can access these two documents at: JLARC report: http://jlarc.virginia.gov/reports/RPT388.pdf

Virginia Board for People with Disabilities


Available from: Virginia Board for People with Disabilities, Washington Office Building, 1100 Bank Street, 7th Floor, Richmond, VA 23219 (804) 786-0016 (voice & TTY), (800) 846-4464 (toll free, voice & TTY), FAX: (804) 786-1118, E-mail: info@vbpd.virginia.gov, Web site: www.vaboard.org

The Virginia Board for People with Disabilities, the Commonwealth’s Developmental Disability Council, authored its third assessment of the Commonwealth’s disability services. Previous editions were published in 2006 and 2008.

The assessment describes disability services that are primarily funded, operated, licensed, regulated, or contracted for by state agencies. For each service topic, it details eligibility requirements, how services are accessed and delivered, the types of services available, costs and payment sources, oversight and quality assurance. Each chapter provides longitudinal data showing trends in utilization and expenditures for specific services. References include key websites. There are online links to key reports.

This is a complex report with a considerable number of recommendations for system improvement. The report notes that since 2004, Virginia has ranked within the top 10 states in per capita income but is 45th in level of fiscal effort on behalf of individuals with intellectual disabilities.
Maltreatment Risk for Children with ASD

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The less isolation of the children (for instance, more visitors; taking children into the community), the lower the risk of ongoing maltreatment. Proper training of staff (or hiring people with training) is required. Hiring policies that include a thorough background check can eliminate staff with prior histories of abusive behaviors. (For a more complete discussion of institutional abuse, see VCPN, volume 25).

Efforts Targeting Parents and Caregivers and Service Providers

Families that are resilient and have a lower risk for maltreatment share some characteristics. These families have close family bonds; demonstrate compassion and patience; show family pride; view the child first as a child; are not preoccupied with why the disability occurred; focus on the child’s positive attributes; seek and use information about the child’s disability; find and use support groups; both parents share an active role in raising the child; maintain good family communication; and seek or accept opportunities for respite (Partnership for People with Disabilities, 2010).

There appear to be few empirical studies on prevention efforts for parents and for professionals. One study of the effects of respite care found that respite alone did not reduce child abuse potential, but programs that targeted both family functioning and parenting stress over time were more likely to reduce child abuse potential (Aniol, et al., 2004).

After a review of research, Helton and Cross (2011) suggest that parents need assistance with children’s noncompliance. If the parent believes that the noncompliance is intentional, rather than due to the child’s disability, the parent is more likely to respond with physical discipline. Helping parents learn to respond to the child’s noncompliance without physical discipline and helping the parent set reasonable expectations may prevent abuse.

During the past 20 years, research has demonstrated the effectiveness of alternatives to corporal punishment. Use of reinforcement and positive behavioral support has been shown to be more effective than physical punishment (Hibbard et al., 2007).

Researchers and others offer prevention ideas. These are summarized below:

Educators are vital to detecting abuse in children with disabilities, since schools are the only place where some children with disabilities are seen on a regular basis (Partnership for People with Disabilities, 2010; Sullivan & Knutson, 2000).

Professionals should inquire about parents’ discipline methods (Little, 2002). A screening measure such as the Parenting Stress Index administered at routine office visits can help detect parents who have high stress levels and who are having trouble managing their child.

Caregivers may benefit from training in positive behavioral management, as some abuse may occur as caregivers try to control the disruptive behaviors of children (Child Welfare Information Gateway, 2012; Mandell et al., 2005).

Careful screening of job applicants for any prior reports of maltreatment is suggested (Child Welfare Information Gateway, 2012).

Early identification and diagnosis of Autism and Asperger’s Disorder may lower risk and prevent abuse if parents receive supportive services (Mandell et al., 2005; Partnership for People with Disabilities, 2010).

CPS workers can conduct developmental screenings on children referred for investigation or they can request a complete developmental assessment under the provisions of Part C of the Individuals with Disabilities Education Act (IDEA) at no cost to the family or referring agency (Shannon & Agorastou, 2005).

Those close to children with disabilities should become aware of early warning signs of maltreatment and ask for investigation if they notice concerning signs (Mandell et al., 2005; Partnership for People with Disabilities, 2010).

A medical ‘home’ for the child will assure that medical records are in one place and that practitioners are available who are acquainted with the child and his or her usual functioning.

Since children with ASD get lost easily, they should not be left alone on excursions. An adult or a peer ‘buddy’ should be used (Little, 2003).

Adults in charge of community activities should understand the limitations of children with ASD so they can protect the children from victimization (Little, 2003).

Efforts should be made to increase parent knowledge of both child development and of their child’s disability. The family should be connected to disability professionals who can support them in giving proper care to their child (Child Welfare Information Gateway, 2012).

Parents should be trained to anticipate problems with their child and problem-solve ahead of time. They should be taught positive ways to deal with challenging behaviors (Little, 2003: Partnership for People with Disabilities, 2010).

Parent support groups can be powerful prevention tools (Child Welfare Information Gateway, 2012).

Respite care can provide parents and caregivers with a break in taxing responsibilities (Child Welfare Information Gateway, 2012).

Efforts to Educate Children

According to the Child Welfare Information Gateway (2012), most researchers now agree that teaching children with disabilities about the risks of abuse and neglect and sexual abuse as well as teaching ways to communicate with others can reduce the risk of continued maltreatment.

Several of the experts interviewed by VCPN staff stressed the importance of educating children with disabilities about personal safety. Denille Francis commented, “Children with disabilities often experience blurred boundaries. They may require invasive treatments. For example, physical therapy can mean that one’s body is manipulated and it may hurt. Children learn that adults are allowed to handle them in ways they do not like.” Francis notes that many children with disabilities are excluded from classes that teach information about sexuality and safety. She advocates that parents “have those discussions early on.” Because of their vulnerabilities, the children need more, not less exposure to concepts of healthy sexuality. Francis notes, “Psychosexual development may be ‘on target’ for children even if their social and cognitive abilities are delayed. It can be very confusing for them to understand what is happening. There is a need to develop methods to teach children with disabilities about sexuality and appropriate sexual behaviors (Little, 2003; Mandell et al., 2005). Two components deserve special mention:

Basicsafety skills should be taught (Little, 2003).

Social skills training should be part of any safety training program for children with ASD (Little, 2003).

When planning safety programs for children on the autism spectrum, educators should keep in mind that children with ASD may have trouble projecting consequences, may have trouble retaining and generalizing information, and may experience difficulty with application of skills learned in prevention programs (Little, 2003).

For a discussion of specific prevention programs that have been developed for children with disabilities, see resources reviews and a separate article, this issue.

Reference List is Available on the Website
CPS workers and foster care workers may lack specialized training about children with disabilities. Providing an adequate response for children with disabilities can be challenging. There have been only a few studies that have evaluated how the child protection system and the foster care system respond to children with disabilities.

Manders and Stoneman (2009) had 75 CPS workers respond to a series of vignettes designed to determine how workers responded in cases of no disability, cerebral palsy, intellectual disabilities, and emotional/behavioral disabilities at two levels of child injury (moderate and severe). Workers were significantly more likely to believe that investigation was warranted in cases involving children with emotional or behavioral difficulties than for children with cerebral palsy. While the CPS workers believed that the parents were primarily responsible for the abuse of all the children, children with disabilities were more likely to be viewed as having characteristics that contributed to their abuse. Most workers had some empathy towards the parents (although they did not condone the behaviors), but had less empathy towards parents of typically-developing children. Services recommended for families of children with disabilities were more child-focused than for the families of typically-developing children.

Shannon and Tappan (2011) tried to learn more about CPS practices when the child had a disability. The researchers interviewed foster care families, child welfare administrators, central intake workers, special investigators and CPS office staff (including family case workers, a nurse, a foster family support specialist, and others). Participants reported struggling to find the right type of placement that can meet the child’s needs. Foster families did not feel well-prepared to handle children with disabilities and training to assist them was often not available.

The children with disabilities who enter foster care have complex needs and do not always have services ‘in place.’ For example, some of the children with disabilities entering care had not had regular or even any health care in their biological families. CPS and foster care workers were often not aware of services for children with disabilities, did not know about the special education process or the children’s legal rights, and were not acquainted with how to meet the children’s unique or special needs, especially for socialization. Children who had experienced trauma needed therapy, but many therapists who worked to alleviate trauma were not willing to accept traumatized children who also had intellectual disabilities. Even finding routine health care such as a dentist could be difficult due to the service provider’s lack of expertise with disabilities.

Some of the issues for social workers to keep in mind:

◆ It can be difficult to decide if the child’s injuries are due to abuse or due to the disability. For instance, some children with Autism head bang or otherwise injure themselves. Other children may be prone to accidental injury. Knowing the child’s behavioral history and acquiring a detailed medical history can be crucial (Partnership for People with Disabilities, 2010).

◆ Do not automatically dismiss an injury because of the child’s disability (Partnership for People with Disabilities, 2010).

◆ Half of children with ASD are prone to wandering and elopement. Some parents report that their child tries to leave multiple times each day. A higher level of supervision is required for children with ASD (Law & Anderson, 2011).

◆ Children with ASD may exhibit interest in sexuality and display developmental sexual behaviors at older ages than typically-developing children. Sexual acting-out cannot be assumed to be evidence of sexual abuse for children with ASD and the presence or absence of sexualized behaviors cannot be used to determine whether or not sexual abuse has occurred (Edelson, 2010).

◆ Learn about the child’s communication capabilities by networking with caretakers and school personnel. Non-abusing family members and caregivers can offer significant support to the child (Partnership for People with Disabilities, 2010).

◆ Screening for disability at intake and during the child maltreatment assessment process are important strategies that can ensure that needed referrals are made (Autism Society, 2012).

◆ Take advantage of training opportunities. Having a worker whose primary function is to coordinate with developmental disability programs can enhance the services offered to children with disabilities and their families (Autism Society, 2012).

◆ Children with disabilities should have a ‘medical home’ so that pediatricians can monitor development and become acquainted with the child’s needs. Part C of IDEA will provide a developmental assessment regardless of the ability to pay (Autism Society, 2012).

◆ Studies have shown that over 35% of young children investigated for child maltreatment require early intervention services due to disabilities (Casanueva, Cross, & Ringeisen, 2008). Therefore all young children entering child welfare or foster care should receive assessments for developmental delays (Bruhn, Duval, & Louderman, 2007).

Reference List is Available on the Website
Although later found to be inaccurate, Autism was first considered to be caused by parents who failed to properly nurture children (Bettelheim, 1973; Kanner, 1943). Kanner later revised his formulation to consider both innate and experiential factors (Eisenberg & Kanner, 1956; Kanner & Eisenberg, 1957). During the following 50 years, evidence for the importance of innate factors has become overwhelming. Physical illnesses, neurological conditions, and genetic disorders are all linked to an increased risk for Autism (Tantam, 2012).

Currently, Autism is considered to be a neurological disorder of unknown origin (Wilkinson, 2010). Genetic factors are thought to be implicated. No particular environmental factors have been validated, although there are ongoing studies that examine a possible genetic-environmental connection. Males are the majority of children diagnosed with ASD (Tantam, 2012).

Asperger’s Disorder was first described in the 1940s by a Viennese pediatrician, Hans Asperger. He observed difficulty with social and communication skills and other autistic symptoms in boys who had normal intelligence and language development. Others used the term ‘high functioning autism’ to refer to this population. Even though the American Psychiatric Association listed Asperger’s Disorder as separate from Autism in the 1994 version of the Diagnostic and Statistical Manual of Mental Disorders, many professionals still consider Asperger’s Disorder to be a less severe form of Autism (Autism Society, 2012).

The term Autism Spectrum Disorder (ASD) is an umbrella term encompassing subtypes of Autism and Asperger’s Syndrome, as well as Rett’s Disorder, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder NOS (not otherwise specified).

Diagnosis- DSM-IV

The Diagnostic Statistical Manual of the American Psychiatric Association is the most frequently used criteria for assessment and labeling of mental and emotional disorders. It is used by most U.S. insurance companies as well as schools, clinics, and other mental health providers. As of the writing of this article, the DSM-IV is the version in use.

Currently, Autism and Asperger’s Disorder are two of five disorders in the category of Pervasive Developmental Disorders. The other three disorders in this category are Rett’s Disorder, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder NOS (not otherwise specified). These disorders are characterized by severe and pervasive impairments in several areas of development.

Presently, according to the DSM-IV, the essential features of Autism are: a) Marked impairments in social interaction; b) Qualitative impairments in communication; and c) Restrictive and stereotyped patterns of behaviors, interests, and activities. In addition to these criteria, there are also delays or abnormal functioning prior to age 3 in social interaction, language as used for social communication, and/or symbolic or imaginative play.

Some examples of social interaction problems include: impairments in multiple nonverbal behaviors (such as eye-to-eye gaze, facial expression, body postures, and gestures); failure to develop peer relationships appropriate to developmental level; lack of spontaneous seeking to share enjoyment, interests, or achievements with people; lack of social or emotional reciprocity; and trouble understanding the intentions of others. Communication impairments include: delay or lack of spoken language; in those with adequate speech, a lack of ability to initiate or sustain conversation with others; stereotyped and repetitive use of language or idiosyncratic language; and lack of spontaneous make-believe play or social imitative play appropriate to the child’s developmental level. Repetitive and stereotyped patterns refers to: preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal in intensity or focus; inflexible adherence to specific nonfunctional routines or rituals; repetitive motor mannerisms such as hand or finger flapping or twisting; or persistent preoccupation with parts of objects.

Those diagnosed with Asperger’s Disorder are similar to those diagnosed with Autism. However, those with Asperger’s Disorder have no clinically significant general delay in language or in cognitive development or in the development of age-appropriate self-help skills, adaptive behaviors (other than social interaction), or curiosity about the environment. Children with Asperger’s syndrome and children with Autism both have qualitative impairments in social interaction and restricted repetitive and stereotyped patterns of behavior, interests, and activities. Thus, the distinguishing differences between Autism and Asperger’s Disorder are the severity of symptoms (less severe for Asperger’s Disorder), the lack of intellectual disability in Asperger’s Disorder, and the absence in Asperger’s Disorder of language delays.

Children with Autism frequently seem aloof and disinterested in others, but children with Asperger’s do not. Children with Asperger’s want to fit in and interact with others, but lack the knowledge and skills to do so. They may appear socially awkward, lack understanding of social rules, or show a lack of empathy. They may have limited eye contact, appear unengaged, and fail to understand nonverbal language such as gestures (Autism Society, 2012). Children with Asperger’s Disorder may develop focused interests such as collecting a specific type of item or over-learning in a category of information. However, while rote memory may be good, children with Asperger’s Disorder have difficulty with abstract concepts. Executive functions such as problem-solving or identifying alternatives are impaired (Poon, 2009). While motor difficulties are not considered a criteria for Asperger’s Disorder, children diagnosed with the disorder frequently have motor skill delays and may appear clumsy or awkward (Autism Society, 2012; Poon, 2009).

The definition of Autism has been broadened. “Autism Spectrum Disorder” now includes a less impaired, more capable population. Children who meet criteria for Autism but who lack an intellectual disability or learning disability are described as “high-functioning autism” (HFA) (Wilkinson, 2010). The spectrum of Autism is now considered to include not only children with mild, moderate, or severe disorders but also children who have no symptoms but show non-pathological traits (Tantam, 2012).

Some argue that, given the plasticity of development, a child or person may show a disability due to psychological or social demands at one point, but not have a disability at another point (Tantam, 2012). This conceptualization appears to be somewhat different than conventional thinking, where a situational or temporary disorder would be diagnosed and categorized an adjustment problem, rather than considered to be a disability.

Tantam (2012) suggests that situational stress can aggravate symptoms of Autism Spectrum Disorder. More stressful day-to-day situations are those that require substantial social interaction, require interactions with groups (as opposed to individuals), have implicit (rather than explicit) expecta-
tions, and where criteria for tasks may suddenly change.

Autism and Asperger’s Disorder are generally considered to be life-long impairments for most persons who have the diagnosis. For example, the majority of those diagnosed with Asperger’s Disorder remain unemployed as adults (Tantam, 2012).

**Diagnosis- DSM-V**

The diagnostic manual is changing. The new diagnostic manual, DSM-V, is scheduled to be released in May of 2013. There are considerable changes anticipated to the diagnostic criteria. The separate diagnostic labels in DSM-IV described above will be replaced by the umbrella of Autism Spectrum Disorder. The terms Asperger’s Disorder and Pervasive Developmental Disorder will be deleted. Distinctions will be made according to the severity of the disorder and the amount of support needed. The new criteria are more thorough and stricter than DSM-IV. Some higher functioning children who now meet criteria for a diagnosis may no longer meet criteria (APA, 2012; Bahsoun, 2012).

*Prevalence*

In 2000, Autism was estimated to affect 4 children in 10,000 (Anderson, 2001). This was an increase on prior estimates. The prevalence estimates have risen steadily. Current estimates, using an expanded definition of Autism, tout rates of 34 to 60 children in 10,000 (studies cited in Poon, 2009). An estimate from the Centers for Disease Control (CDC) and Prevention is that 1 in 150 children have Autism or ASD with 560,000 individuals ages 0 to 21 in the U.S. meeting criteria for one of the ASDs (CDC, 2008, cited in Edelson, 2010).

A more recent estimate (CDC, 2012) based on data from 2008 in 14 monitoring sites is that 11.3 per thousand children age 8 (1 in 88) have ASD. The data vary widely by sex and racial/ethnic group. For children age 8, approximately 1 in 54 boys and 1 in 252 girls living in the monitoring areas were identified as having ASD. These estimates were a 23% increase over data from 2006 and an increase of 78% when compared to data from 2002.

Boys are diagnosed more frequently with ASD than are girls. Girls, as a group, are also diagnosed later than are boys. According to Wilkinson (2008), the gender gap may exist because girls present differently than boys and are overlooked. Wilkinson emphasizes that missed or late identification results in lack of intervention while the child experiences social isolation, peer rejection, lowered grades, and a greater risk for mental health and behavioral distress in adolescence and adulthood.

According to studies cited by Wilkinson (2010), the number of students receiving special education services for Autism Spectrum Disorders grew more than 900 percent from 1994 to 2006. Statistics from Virginia’s school divisions reflect growth as well. According to Virginia Commonwealth University’s Autism Center for Excellence, in December 2011, the Commonwealth’s 132 school divisions reported 13,137 students with Autism as their primary disability. The figure represented a 490 percent increase since 2000 (VCU Autism Center, 2012). The Virginia Board for People with Disabilities (2011) noted that the number of children identified as having Autism as their educational classification grew from 3,954 in 2003 to 10,092 in 2009.

It may be that the diagnosis of Autism and related disorders is more prevalent due to increased awareness and training or to changes in diagnostic concepts and criteria (Fombonne, 2005). There are also other factors that can contribute to the higher incidence of autism diagnoses.

Diagnostic substitution (where a child previously diagnosed with a different disorder has the diagnosis switched to Autism) or diagnostic accretion (when a child with a different diagnosis is given the additional diagnosis of Autism) are both possible factors in the increased numbers of children diagnosed with Autism. An early study of California children (Croen, Grether, Hoogstrate, & Selvin, 2001) sparked debate (Blaxill, Baskin, & Spitzer, 2003; Croen & Grether, 2003) about the possibility of changes in diagnosis being a factor in the increasing prevalence of Autism.

More recently, King and Bearman (2009) examined 7,003 children born prior to 1987 who received services with the California Department of Developmental Services. Of particular interest were 631 children who initially had a sole diagnosis of mental retardation (now termed intellectual disability) who subsequently acquired an additional diagnosis of Autism. The authors found that the likelihood of diagnostic substitution or accretion was elevated in years close to changes in diagnostic criteria. Their analysis indicated “support for the idea that roughly one in four cases of Autism are the product of diagnostic change operating on the MR pathway” (p. 1230). The authors note that diagnostic substitution is possible along other pathways as well, for example, with children diagnosed as developmental language disorders. A study by Bishop, Whitehurst, Watt, & Line (2008) found that many adults who had been diagnosed with developmental language disorders as children met criteria for Autism or for a milder ASD. Depending on the strictness of the criteria used, 8 to 19 cases of 20 adults with pragmatic language disorder met criteria and 0 to 6 cases of 18 specific language impairments met criteria. The authors state that many children who were diagnosed in the 1980’s and 1990’s with severe language disorders would merit a diagnosis of ASD according to contemporary criteria. This appears, they say, to be a direct result of changes in diagnostic criteria from DSM-III to DSM-III-R and DSM-IV.

While part of the increase in diagnosis of children on the autism spectrum appears to be due to diagnostic substitution or accretion, there is a large proportion of the increase in children with Autism that is unexplained (Charman et al., 2009). There may be actual increases in the numbers of children with Autism because of causative factors that are unknown, or the increase may be due in part to greater awareness (implying that in the past, many cases were undiagnosed), or the broadened and changed definitions (or the way the criteria are used) may be allowing more children to receive a diagnosis on the autism spectrum.

**Concurrent (Co-morbid) Conditions**

Tantam (2012) says that 70% of children with an ASD diagnosis also have at least one co-morbid condition. According to Tantam, 41% had two or more co-morbid conditions. This is similar to the 65% who were positive for a comorbid psychiatric disorder reported by Ghaziuddin (2002). Hutton, et al. (2008) in a follow up study found that 16% of children diagnosed with ASD developed a new disorder and another 6% had a possible secondary diagnosis.

Ghaziuddin (2002) found that certain disorders were likely in those with ASD and other disorders were uncommon. Schizophrenia was uncommon, while ADHD, obsessions, seizure disorders, sleep disorders, and underweight were common. Tantam notes that the risk of co-morbid disorder changes by age with younger teens more at risk for anxiety problems (such as OCD or body dysmorphic disorder), older teens more at risk for mood disorders, and adults at risk for paranoid diagnoses and substance abuse.

Poon (2009) says that all types of co-occurring disorders can be found in children with ASD. Some, however, are found more

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frequently. These include: anxiety disorders; depression; obsessive-compulsive disorders; tic disorders; and attention-deficit hyperactivity disorder (ADHD). Kim et al. (2000) did a 6-year follow up (at approximately age 12) of children diagnosed with either Autism or Asperger’s at age 6 and found high rates of depression (17%), ADHD (17%), and anxiety disorder (13.6%).

About 75% of children with Autism also have an intellectual disability. Fifteen to 20% are considered severe with IQ scores below 35. More than 10% of those with Autism have an IQ in the average range (AutisticSociety.org, 2012; WebMD, 2008). Approximately one in four children on the autism spectrum has a concurrent seizure disorder (Tantam, 2012).

Early Diagnosis

Early diagnosis is thought to be important (Autism Society, 2012). While children with the classic (Kanner’s) Autism are generally diagnosed at an early age, it is not unusual for children with milder forms of Autism to be undiagnosed until well after entering school. For example, Pringle and Colpe (2012) found that half of school-aged children with both ASD and special health care needs were age 5 or older when diagnosed.

Late diagnosis postpones timely intervention and can contribute to parental distress in dealing with their child (Perkins & Wolkind, 1991; Wilkinson, 2010). Research suggests that systematic, early intervention can significantly improve outcomes and reduce the costs of caring for children with Autism Spectrum Disorder (Stahmer, Brookman-Frazee, Lee, Searcy, & Reed, 2011). Tantam (2012) says there is accumulating evidence that 3 to 25% of young children with an Autism Spectrum Disorder can ‘recover’ in response to intensive behavioral training (with recovery defined as entering the normal range of cognitive, social, and adaptive skills).

**References Available on the Website**
SAFETY TRAINING FOR CHILDREN WITH ASD

Keeping children and adults with ASD safer from sexual abuse and sexual exploitation is of critical importance. Children with ASD are more vulnerable to sexual abuse or exploitation than their typically-developing peers because of characteristics such as communication difficulties, a lack of fear, or lack of recognition about appropriate and inappropriate behaviors. Perpetrators seek children who are unlikely to report sexual advances. Because children with ASD may be seen as vulnerable by sexual offenders and because children with ASD may be easily intimidated or manipulated due to the social challenges related to the disability, they may be particularly desirable targets for those who sexually abuse or exploit children and youth.

Children with Autism may also be at greater risk of being sexually abused than typically-developing children because of contact with opportunistic offenders who obtain positions as service providers. Goldman (1994) found that over half of sexual offenders of individuals with developmental disabilities made contact with their victims through some type of disability service, such as a paid service provider, a foster care provider, or as a transportation provider.

There is general agreement in the literature that children with ASD mature normally in physical areas, but lack social understandings. Youth who are high functioning with Autism or Asperger’s Disorder naturally de-sire social contact and intimate relationships. However, their poorly developed social skills make it difficult for them to maintain relationships and may preclude lasting relationships. While children and youth with ASD are highly variable, in some cases the physical maturation and lack of social awareness may lead to embarrassing behaviors such as public self-stimulation, inappropriately disrobing in public, speaking about sex in a way that is not acceptable, or trying to touch other people’s private body areas. Youth with ASD are also less aware of privacy rules such as knocking on closed doors and not touching private body areas in public. Such behaviors can be misconstrued by predators and increase the vulnerability of children with ASD to sexual abuse (Koller, 2000; Ruble & Dalrymple, 1993; Stillman, 2005; Stokes & Kaur, 2005; Wing, 2001).

Surveys of parents of youth with ASD (Ruble & Dalrymple, 1993; Stokes & Kaur, 2005) suggest that education about proper sexual behaviors and safety training are taught retroactively, after the youth begins to exhibit inappropriate sexualized behaviors. Parents in both studies expressed concern about their children’s vulnerability. They expressed fears that daughters would become pregnant and that sons could be sexually mishandled by a same-sex predator. However, even with the high level of concern expressed by parents, children and youth with ASD were found to have less training in personal safety and sexuality education than typically-developing children (Stokes & Kaur, 2005).

Some safeguards against sexual abuse involve controlling access to the children. For example, regular background checks for all caretakers and educators who are working with the children are recommended. Some parents and authors also suggest using cameras (hidden or in the open) to monitor children’s care. A high level of parental and community involvement in institutions, schools, and child care facilities can help lower risk for abuse. Policies and regulations about being alone with children, training of staff to report suspicious circumstances, and regular monitoring of classrooms and staff interactions with children can be a deterrent to sexual abuse. Readers who would like more information about lowering risk of abuse in institutions and facilities can consult VCPN, volume 25.

Teaching safety skills and abuse prevention skills to children and youth with ASD may require additional effort and thought as well as the use of specialized curricula. Safety training and sexuality education need to address privacy rules, empathy for others, and social skills in addition to the typical areas. Skills that are typically taught include: being and acting alert; setting boundaries; recognizing abusive situations; getting help; safety in public (such as on a bus); and self-defense skills.

There are some general teaching methods for children and teens with ASD that may be helpful to those conducting safety training. A thorough discussion is not possible in this article but a few general guidelines will be mentioned.

Pierangelo and Giuliani (2008) recommend several instructional methods. Visual approaches are strongly recommended as students with ASD have strengths in concrete thinking, rote memory, and understanding visual-spatial relationships, while, as a group, they show weaknesses in abstract thinking, social cognition, communication, and attention. To capitalize on learning strengths, visual aids can be used as long as needed to help process information. Since oral information is transient, it should be accompanied by a visual aid. Pacing can be important for children with ASD who may need a longer than usual time to process information. Instructions should be given in small steps. Task analysis where sub-skills are taught and reinforced and then gradually pieced together is a useful approach. Precise, positive praise can facilitate learning, as can meaningful reinforcements (which must be determined individually). Social skills can be taught through the use of social stories (descriptions of social situations that include social cues and appropriate responses). These modifications are just a few of the methods that might be needed to teach social skills and personal safety to children and teens with ASD.

Older children with ASD who are able to use the internet may encounter inappropriate web sites or approaches by strangers. Parental controls can be one important safeguard, as can supervision of internet access. Youth should also be taught how to be safe on the internet and how to report suspicious or questionable interactions.

VCPN staff members have identified some programs that are advertised to provide specialized curricula for children, youth, and adults with special needs. These materials have not been reviewed by staff, so their listing is simply informative and not an endorsement. The website contains more complete descriptions of the programs.

References are on the Website
BULLYING AND CHILDREN WITH ASD

John, age 9, has Asperger’s Syndrome. He is very sensitive to sound. At school there is a fire drill but the principal did not warn everyone in advance. When the alarm sounded, it was a total shock to John’s system. He put his hands over his ears, started making weird sounds, and began exhibiting nervous hand tics. Once outside, he remains visibly upset. While the other children celebrate missing lessons and being in the sunshine, John looks scared. One of his classmates tells another peer that John is “just a weirdo.”

Nancy is listening to other students talk about television programs during lunch. The discussion shifts to the school dance and then to sports. Nancy is still thinking about television and asks the group if they can guess her favorite show. Her classmates look annoyed and then start giggling. They tell her, “We aren’t talking about TV anymore. You are a ‘space cadet.’” Nancy has no idea of what she has done wrong.

George joins a soccer game. He kicks the ball in the wrong direction and the other team scores a goal. His team mates tell him they don’t want him to play anymore because he doesn’t know what he is doing.

Jennifer is 12. When one of her classmates mocks her and says, “We are so glad you are here,” and rolls her eyes, Jennifer replies, “I’m glad I’m here, too.” She doesn’t notice all the other girls rolling their eyes and is surprised when the group walks away from her rapidly.

Stephanie watches ‘I Love Lucy’ repeatedly and the show is all she ever talks about. Her classmates are frustrated by her and tell her to get lost. Her mother encourages her to talk about some of the things that interest other children. The next day others are talking about a show and Stephanie says she loved watching it last night. However, it is soon apparent that she has lied, because she does not know what happened in the serial show. Once again, Stephanie is embarrassed, both for lying and for having nothing in common with her peers.

These examples (from Dubin, 2007, see review this issue) illustrate some of the ways that children with ASD are vulnerable to bullying. Name-calling, exclusion, mean jokes, posting or circulating graphic material, and other cruel acts can be particularly difficult for children with ASD who lack refined social skills. Advances in technology have resulted in new forms of bullying via the internet, often called ‘cyber-bullying.’ Children with ASD may be less able to respond and protect themselves and less able to report harassing behaviors than their typically-developing peers. Because of their social skills deficits, children with ASD who are integrated into classrooms and other settings with typically-developing children are particularly at risk for peer rejection and social isolation (Anderson, 2012; Dubin, 2007; White, Keonig, & Scahill, 2007).

For general information about bullying and cyber-bullying, readers can access prior issues of VCPN (see volumes 75 and 89). Bullying is common, especially during middle school, and many typically-developing children also experience at least occasional episodes of bullying.

Why are Children with ASD at Greater Risk?

It is easy to imagine the various scenarios, according to Foden and Anderson (2010) of the Kennedy Krieger Institute. The child with ASD can’t decipher social cues and does not know when someone is teasing. The child with ASD might not notice other children becoming frustrated with him or the sarcasm in a child’s tone of voice, or the smug look of a popular girl who is asking him out on a date due to a dare by her friends. The child with ASD might want to please that ‘friend’ who encourages him to commit an offense. Easiness to please and have friendships means that the child with ASD may be easy to manipulate. Children might find it entertaining to ‘trigger’ the child with ASD into a ‘melt down’ and watch him or her be punished.

Children with ASD are likely to tolerate a higher level of abuse from peers than typically-developing children. They may fail to recognize some of the bullying behaviors. For that reason, children with ASD can be cajoled or egged by bullies into actions that will get them in serious trouble or make them the object of ridicule. They may want attention or company so badly that they tolerate the abuse. Conversely, students with ASD may react to bullying in unexpected manners, be overemotional, or show little or no emotion (Heinrichs, 2003).

To further complicate matters, children with ASD can have trouble recognizing true bullying from good-natured teasing. He or she may ignore the bullying behaviors or think they are typical play. On the other hand, he or she can over-react to friendly teasing and burst into tears, further alienating him or her from inclusion in everyday banter and activities. A child with ASD may over-react when he is accidently pushed or hit and respond with aggression. Retaliation can result in children avoiding him.

Children with ASD may fail to recognize that their own behaviors may be irritating and aversive to others. Persistence in pursuing activity or conversation that others have tired of can be a trigger for bullying. Some children with ASD are quite rigid and insist upon everyone following rules to the ‘letter of the law’ and lack flexibility. Insistence on adherence to routines can trigger other children to react negatively. The child with ASD also may say what he or she thinks without understanding that he is hurting someone’s feelings. Some children with ASD have poor hygiene because they are overly sensitive to the bristles on a toothbrush or the pressure of water from a shower or the sound of a hairdryer and avoid regular hygiene (Dubin, 2007).

Prevalence

Only a few studies have addressed how bullying intersects with children on the autism spectrum. Little (2002) surveyed more than 400 mothers of children with ASD or nonverbal learning disorders. She found that 75% reported their children had been hit or emotionally bullied by peers or siblings during the prior year. Peer shunning or exclusion occurred at high rates with a third of children who had not been invited to social events during the prior year or who ate lunch alone or who were the last to be picked for teams. Little’s findings are similar to a study by Carter (2009) where nearly 65% of parents reported their children with ASD had been victimized by peers during the prior year and to a study by Cappadocia, Weiss and Pepler (2012) that found that 77% of their sample of parents reported that their children with ASD had been bullied within the past month.
The Kennedy Krieger Institute (Anderson, 2012) has released some initial findings gathered in 2011 by the Interactive Autism Network through an internet survey of parents of children diagnosed with ASD. Some cautions are needed when considering their data. There is no control group or selection involved in the study. The study has not been published or subjected to a peer review process.

A total of 1,167 parents completed the survey. Of these, 63% reported that their children ages 6 to 15 and diagnosed with ASD had been bullied at some point in their lives. Of the 1,079 enrolled in school, 39% had been bullied within the last month. As a rough comparison group, parents were asked about bullying of siblings who were developing typically. Parents reported that 12% of their typically-developing children had been bullied in the last month. The rate for the children with ASD was more than three times as high as for their typically-developing siblings. The types of bullying experienced were: being teased or made fun of- 73%; being ignored or left out- 51%; being pushed, shoved, slapped, or hit- 30%; being provoked into fighting back or having a ‘melt down’- 53%. Bullying occurred at every age level and grade but those in 5th through 8th grades experience the most bullying.

The data from the survey done by the Interactive Autism Network (Anderson, 2012) showed that children with ASD in regular public school were bullied more frequently than other school settings. The findings were: regular public schools- 43%; regular private schools- 28%; special education public schools- 30%; and special education private schools- 18%. The author speculated that the smaller and more sheltered the setting, the less the frequency of bullying. There were also differences by diagnosis. Of children with Asperger’s, 61% were reported as being bullied compared with 28% of children with Autism and 37% of children with other ASD diagnoses. It appears that less severely impaired children were at higher risk to be bullied.

Another factor in bullying was the prevalence of co-occurring disorders. Children with additional problems of ADHD, depression, oppositional defiant disorder, or anxiety were more likely to be bullied than

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**BULLYING RESOURCES**

**Kids Against Bullying**
http://www.pacerkidsagainstbullying.org/

This is an educational resource designed by and for children to learn about bullying prevention. There are a number of interactive videos, games, posters, and stories for elementary school-aged children to learn what they can do if they are bullied and how they can help if they see someone else being bullied.

**Special Needs Anti-Bullying Toolkit**
http://specialneeds.thebullyproject.com/

This toolkit is specifically designed for parents, educators, and students to deal with bullying and children with special needs. Talking to children, knowing rights, and teaching tolerance in schools are a few of the ways individuals are taught to change the culture of bullying within their communities.

**Perfect Targets: Asperger Syndrome and Bullying—Practical Solutions for Surviving the Social World**
Rebekah Heinrichs, 2003

This book provides guidelines for parents and teachers to assist in reducing bullying for children with Autism Spectrum Disorder (ASD).

**Asperger Syndrome and Bullying: Strategies and Solutions**
Nick Dubin, 2007

This book presents effective strategies that children, parents, teachers, and schools can use to help protect children with Asperger Syndrome from the effects of bullying.

**National Autism Association Safety Initiative: Bullying**
http://www.autismsafety.org/bullying.php

This safety initiative on bullying provides information on the different types and forms of bullying, signs that bullying may be occurring, and research on bullying. The initiative encourages social and emotional learning (SEL), which has been found to decrease conduct problems and emotional distress that are part of the bullying phenomenon.

**School Community Toolkit**

This toolkit assists members of the school community in understanding and supporting students with Autism. There are a number of web, print, and video resources provided for all members of the school community.

See website for complete reviews.
Bullying

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children with ASD who did not have co-occurring disorders.

Children with repetitive behaviors like flapping or spinning were less likely to be bullied than children who were clumsy, had poor hygiene, engaged in rigid ‘rule-keeping’ (enforcing rules), persisted in talking about a favorite topic when others were bored or annoyed, had frequent ‘meltdowns,’ or who were inflexible or rigid. Children who were eager to interact with others but had trouble making friends were also bullied frequently with 57% bullied compared to only 25% of children who preferred to play alone and 34% of children who would only play with others when approached.

Although children with ASD are more likely to be victims than bullies, questions have been raised about the propensity of children with ASD to bully others (Montes & Halterman, 2007; van Roekel, Scholte, & Didden, 2010). Children with ASD are more likely to be boys and some require treatment for aggressive behaviors or ‘meltdowns.’ These characteristics may make others more likely to perceive them as bullies themselves. The adolescent with ASD may act aggressively without understanding that the behaviors are intimidating to others. A 2007 study (Montes & Halterman) found that children with both ADHD and ASD were four times more likely to bully others than were typically-developing children. Children with ASD but without ADHD were no more likely to become bullies than were typical children. The survey by the Interactive Autism Network (Anderson, 2012) found that 20% of parents of children with ASD said their child had bullied others, compared to 8% of typically-developing peers who had bullied.

If a child with ASD is involved in bullying, Heinrichs (2003) suggests that the child’s Individualized Educational Plan (IEP) can be a mechanism for addressing bullying. The IEP should spell out how the school will help the child deal with bullying and the parent’s desired response. The IEP should be on how to meet the child’s needs. The IEP should also include strategies such as a social lunch group, and providing a ‘home base’ and ‘safe person’ for stressful or anxious times are some strategies.

Resources and Interventions

Parents of children with ASD need to be alert to signs that might mean ongoing bullying, according to Foden and Anderson (2010). Signs might include possessions being lost or damaged, clothing torn, signs of physical injury such as bruises, signs of increased anxiety such as stomach aches or trouble sleeping or avoidance of school.

There are resources for parents. The PACER Center, for example, has created letters that parents can use as a guide for writing letters to the child’s school. The letter can alert the school’s administration to the bullying and the parent’s desired response. Parents are encouraged to examine the school’s code of conduct. Knowing the school’s rules can help parents determine what interventions are possible.

Heinrichs (2003) suggests that the child’s Individualized Educational Plan (IEP) can be a mechanism for addressing bullying. The IEP should be on how the child with ASD should respond. Rather, the focus should be on how to meet the child’s needs. Increasing adult supervision and intervention, facilitating social skills through mechanisms such as a social lunch group, and providing a ‘home base’ and ‘safe person’ for stressful or anxious times are some strategies.

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There appears to be limited scientific research on the effects of respite for parents of children with disabilities. A study by Cowen and Reed (2002) showed strong effects of respite care for lowering parental stress. The sample was 148 families and their 265 children with disabilities who received respite care. Comparison of pretest and posttest parenting stress scores showed significant decreases in stress after the child and family had received respite care. Further, counties with respite care had lower rates of founded maltreatment than the overall rate for the state. The analysis identified a subpopulation of 17% of parents (45) who accounted for all 81 incidents of founded maltreatment or need for foster care involving 61 target children and 11 of their siblings. The analysis suggested that life stress, social support, and service level were significantly related to occurrence of child maltreatment. Respite care interventions resulted in decreased stress and lowered the risk of maltreatment.

Aniol, Mullins, Page, Boyd, and Chaney (2004) reviewed research and stated that earlier studies of respite services employed measures that lacked standardization and used cross-sectional designs. These studies indicated that families receiving respite help reported greater life satisfaction, increased hope for the future, and a healthier approach to care giving. Also, earlier studies had suggested that parental stress might be reduced by the end of the respite, but could rise to prior levels over the following months.

Aniol et al. (2004) used a quasi-experimental design to examine families of children admitted for short-term inpatient treatment or who had 4- to 11-day stays at a respite center. From an initial sample of 50, 14 parents of children who had respite care and 18 parents of children who were admitted for hospitalization completed the measures (parenting stress; child abuse potential; demographic information; family relationship inventory). Contrary to the researchers’ predictions, neither respite care nor hospitalization for children with disabilities resulted in significant decreases in child abuse potential in their parents nor did either intervention result in measureable improvements in their family relationships. The researchers did find that higher abuse potential was associated with higher levels of parental stress and with poorer family relationships. The researchers stated that respite may not be sufficient to directly impact factors related to abuse potential, at least in the short-term time frame considered by the study. They also mentioned that respite care may alleviate certain types of stress, but not necessarily impact variables that increase abuse potential over time.

While respite may not reduce long-term risk for child maltreatment, respite does appear to lower the need for psychiatric hospitalization for children with ASD. Mandell et al. (2012) found that each $1,000 increase in spending on respite care in the preceding 60 days resulted in an 8% decrease in the likelihood of psychiatric hospitalization for children with ASD. They examined a sample of 28,481 children with ASD ages 5 to 21 who were enrolled in Medicaid in 2004. During the time period that the study examined, 675 children in the study group entered an inpatient psychiatric facility. The authors state that respite may represent a critical type of service for supporting families that are addressing challenging child behaviors.

Overall, VCPN’s research review suggests that respite can be a critical component to keeping children in homes or less restrictive alternatives. There is limited research about ongoing, long-term effects of respite, but positive short-term effects appear well-established in the literature.

Virginia’s Response

In response to a 2009 study by ILARC (Assessment of Services for Virginians with Autism Spectrum Disorders), Virginia’s Department of Behavioral Health and Developmental Services has proposed a respite waiver as a vehicle to provide services to families of children with disabilities. Their document states that respite services provide much-needed relief to families who are the sole provider of supports for their children. Families are reported to cite respite care as the one service that provides them with the ability to continue to provide the intensive support needed by their children (DHHDS, 2010).

Respite Resources

Respite care is an essential part of the support that families may need in order to keep their child with a disability or chronic illness at home. Since not all families have the same needs, respite care should always be matched to individual family needs by identifying the type of respite required and matching the need to the services currently available or using the need-based information to develop needed services if none exist (NICHCY, 1996).

References are on the Website
Successful anti-bullying strategies and programs require a team effort. The whole community (school personnel; psychologists; students involved either as targets or aggressors, and child bystanders) must address the risk factors and the bullying behaviors. It is important to know whether or not the school has policies against bullying and to learn what those policies are. If there are no policies, parents can advocate for adopting anti-bullying policy. If there are policies, then parents can address whether or not the policies are being implemented effectively. Educators may need to understand the special risks for children with ASD. Increased supervision may be needed.

Peer training can be a viable strategy for increasing positive interactions between typical peers and students with ASD (Owen-DeSchryver, Carr, Cale, & Blakeley-Smith, 2008). However, a meta-analysis of 55 single-subject design studies of school-based social skills interventions for children with ASD (Bellini, Peters, Benner, & Hopf, 2007) suggested that social skills interventions have been minimally effective. Likewise, Rao, Beidel, & Murray (2008), examining 10 studies, also found that the efficacy of social skills training for children with ASD has yet to be established (despite finding that 7 of the 10 studies reported some positive treatment effects). While skills might be displayed in a controlled laboratory setting, generalization and flexible skill use in natural environments is a challenge (White et al., 2007).

Dubin (2007) offers suggestions for reducing the risk of cyber-bullying. He suggests that parents monitor children’s internet use closely. Children should not have internet profiles or enter ‘chat rooms.’ Dubin advises against the use of a webcam. If the child has e-mail, parents should assist in choosing the e-mail address and should avoid addresses that give personal information. More ideas can be found in Dubin’s book, Asperger Syndrome and Bullying: Strategies and Solutions.

There are several resources on preventing bullying that have been designed specifically for children with disabilities, including children with ASD. More complete information about each resource is available on the website.

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- Reference List
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- Book Reviews
- Virginia Resources
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