

Rule Out Abuse Campaign Part 2

Specific suggestions for addressing the reason for the Rule Out Campaign are grounded in the research on abuse of children and adults with intellectual and developmental disabilities. Part 2 includes citations to the research. Part 2 was designed to include a “quick look” at signs and symptoms for health practitioners, and provide a quick look at contributing factors such as trauma and the ACE Study.

This second part also allows for a brief comment responding to questions that have arisen regarding suspecting the parents of child abuse. While it is true that a large percentage of abusers are family members, it is also true that an apparently growing number of abuse cases occur without the knowledge of the parents while their children are attending school, supportive therapy sessions, on the school bus, or for older children or adults, attending state-supported day or work programs, or participating in Independent Living Skills programs or residences. The Rule Out Abuse Campaign began with a focus on these cases, where the parents are blindsided by the changes in their children, and are at a loss to discern the reason for the signs and symptoms listed herein. And, when consulting with their physicians, found that they were baffled as well, and none suggested abuse as a possible contributor.

1. Statistics On Abuse Of Children And Adults With Disabilities

a. Children with disabilities are abused more than generic kids.

Research shows that children with disabilities are more vulnerable to abuse than their generic counterparts by a factor of 1.7 (Westat, 1991) or 3.4 (Sullivan et al 2000). Here are the numbers when you “Do the math.”

All types of Child Abuse Girls 1 in 4	Boys 1 in 4
Sexual abuse Girls: 1 in 4 (sexual abuse) (25%)	Boys: 1 in 6 (17%)
x 1.7 = 43%	x 1.7 = 28%
x 3.4 = 85%	x 3.4 = 58%

Sources:

1. Finkelhor D, Turner HA, Ormond R, Hamby SL. Violence, crime, and abuse exposure in a national sample of children and youth: an update. JAMA Pediatr 2013; 167(7):614-621. doi:10.1001/jamapediatrics.2013.42
2. 1.7 DHHS/NCCAN (Westat Inc., 1991)
3. 3.4 Boystown Research Hospital (Sullivan & Knutson, 2000)

According to American Humane Associates:

One million children abused annually. 50.7% girls, 47.3% boys.

8% of these are children with disabilities, who are abused at twice the rate of generic children.

$2 \times 50.7 = 101.4\%$ $2 \times 47.3 = 94.6\%$

(<http://www.americanhumane.org/children/stop-child-abuse/fact-sheets/child-abuse-and-neglect-statistics.html>) downloaded 4/30/15.

b. Abuse of adults with disabilities:

- Annually abuse is reported among vulnerable adults, elders and children:
 - 5 million vulnerable adults
 - 2 million elders
 - 1 million children
- 2 million + 1 million = 3 million children/elders abused compared to 5 million adults with disabilities who are abused
- From this data, we can see that adults with disabilities are abused more than children and elders combined.

(Petersilia, 2000)

(NCPEA, 2013)

(NACC, n.d.)

2. Signs And Symptoms Of Abuse Among Children And Adults With I/DD

Signs vary among abuse victims. Here is a list of common signs. The essential sign is a change in the person.

Abuse that is not sexual in nature:

There has been a *change* in mood, conduct, and/or communication.

DEVELOPMENTAL

Regression from skills already mastered

New disabilities psychiatric, physical, sensory, communication or other.

BEHAVIOR

Eating, sleeping, dressing skills/preferences

Does not want to go to x location or with x person

Re-enacting/acting out what was done to him/her (replicating the assaultive act upon self or others)

Self-harm or mutilation

Self-injury

PHYSICAL

Clothes are changed, soiled or torn

Change in monthly menstruation

Diarrhea or constipation; enuresis or encopresis

Change in appetite, change in food preferences (food, texture)

Gain or loss of weight

Change in energy

New ailments: headaches, stomach ache, back ache, difficulty hearing, seeing, walking, etc. Include chest pain, heartburn, increased use of OTC's.

Bruising, petechiae, swelling or lack of use of an extremity, welts, burns, marks of objects, bite marks

Sweating, anxiety, dizziness, sense of panic

PSYCHOLOGICAL

Onset of new fears such as social anxiety, generalized anxiety, specific phobias

Depression and sadness, tearful, crying, inconsolable

Irritability, anger, easily frustrated

Withdrawal

Trouble thinking, concentrating, remembering

Somatization

Change in normal behavior & personality

Sleep disturbances

Needing to sleep with parents

Change in interest in normal activities

Difficulty learning

Angry, irritable, easily frustrated

Wanting to stay home

New phobias, terror of leaving the house or going to usual location (school, day program, church, work, etc.)

Episodes of lack of control, tantrums longer and inability of parents to communicate during tantrum w/ child

COMMUNICATION

Change in communication including selective mutism (when a previously verbal child stops talking after a trauma.)

Sexual Abuse:

BEHAVIOR:

A change in modesty, ranging from becoming overly concerned about their body to engaging in inappropriate sexual behaviors; Onset of increased sexualized conduct; Self-molestation (replicating assaultive act upon oneself)

PHYSICAL:

Genital pain, itching, discharge and bleeding; stomachaches, headaches and other physical complaints; Indications of a sexually transmitted disease (STD) – itching, burning, pain with urination/defecation; Change in monthly menstruation

PSYCHOLOGICAL:

Sleep disturbances, bed-wetting, new fears, and refusal to go to certain places or be with certain people. School problems, difficulties with peers, excessive crying, depression, clinginess, aggression or secretiveness. Other psychological changes include running away, drug or alcohol use, excessive day dreaming, isolating themselves.

COMMUNICATION:

New questions related to sex, the body, pregnancy, touching the body, photos or pornography. New problems are emerging regarding texting, being asked to take and send photos.

NO CHANGE:

Some may not demonstrate any type of change. Some offenders are able to groom children for abuse in a manner that makes the child feel comfortable, close to and even protective of the offender, while remaining unable to report or evade the abuse.

3. Signs Of Post-Traumatic Stress Disorder (PTSD) In DSM-5

Health practitioners should be aware of the changes in DSM-5 developed by Michael Scheeringa, M.D.

A challenge for the Diagnostic and Statistical Manual (DSM) taxonomy has always been to consider developmental differences in the expressions of disorders in different age groups. Research has suggested that individuals of different ages may express features of the same criteria somewhat differently. The Fifth Edition of the DSM (DSM-5) includes a new developmental subtype of PTSD called Post-traumatic Stress Disorder in preschool children. Since an alternative diagnostic set of criteria was initially proposed by Michael Scheeringa and Charles Zeanah (2), the criteria have been refined empirically (3,4), and endorsed by a task force of experts on early childhood mental health (5). Because young children have emerging abstract cognitive and verbal expression capacities, research has shown that the criteria need to be more behaviorally anchored and developmentally sensitive to detect PTSD in preschool children (2,13). The criterion that the children's reactions at the time of the traumatic events showed extreme distress has been deleted. The change to the re-experiencing symptoms is a relatively minor change in wording to increase face validity and, thereby, lower the symptom detection threshold. The major change was to require only one symptom in either the avoidance symptoms or negative alterations in cognitions and mood. The symptoms of "sense of a foreshortened future" and "inability to recall an important aspect of the event" were deleted. The wording of two symptoms was modified to enhance face validity and symptom detection. Diminished interest in significant activities may manifest as constricted play. Feelings of detachment or estrangement may be manifest more behaviorally as social withdrawal. The symptoms "irritability or outbursts of anger" was modified to include "extreme temper tantrums" to enhance face validity.

(Taken from: PTSD for Children 6 Years and Younger by Michael Scheeringa, M.D. Dr. Michael Scheeringa is the Remigio Gonzalez, MD Professor of Child Psychiatry, Tulane University School of Medicine, New Orleans, LA. (References: 2. Scheeringa, M. S., Zeanah, C. H., Drell, M. J., & Larrieu, J. A. (1995). Two approaches to the diagnosis of posttraumatic stress disorder in infancy and early childhood. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34 (2), 191-200. doi: 10.1097/00004583-199502000-00014; 3. Scheeringa, M. S., Myers, L., Putnam, F. W., & Zeanah, C. H. (2012). Diagnosing PTSD in early childhood: an empirical assessment of four approaches. *Journal of Traumatic Stress*, 25 (4), 359-367; 4. Scheeringa, M. S., Zeanah, C. H., Myers, L., & Putnam, F. W. (2003). New findings on alternative criteria for PTSD in preschool children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42 (5), 561-570. doi: 10.1097/01.CHI.0000046822.95464.14; 5. Task Force on Research Diagnostic Criteria: Infancy and Preschool. (2003). Research diagnostic criteria for infants and preschool children: The process and empirical support. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42, 1504-1512.)

4. Trauma-Informed Medicine

According to Substance Abuse and Mental Health Services Administration (SAMHSA), *individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

“In the U.S., 61% of men and 51% of women report exposure to at least one lifetime traumatic event, and in public behavioral health settings, 90% of clients have experienced trauma. Data suggests that ... ignoring trauma can hinder recovery. All care — in all health settings — must address trauma in a safe and sensitive way in order to ensure the best possible health outcomes.”

Providing care in a trauma informed manner will promote positive health outcomes. A trauma informed approach is defined by SAMHSA as “*a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.*” Reference: <http://www.integration.samhsa.gov/clinical-practice/trauma>

5. ACE: Adverse Childhood Experiences Study

Adverse Childhood Experiences Study, completed in 1999, demonstrated that such events contribute to later significant physical maladies. Thus it is essential when identifying childhood abuse to be vigilant to prevention efforts. The ACE study information can be found online at:

<http://www.cdc.gov/violenceprevention/acestudy>.

The ACE Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. The study is a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego.

More than 17,000 Health Maintenance Organization (HMO) members undergoing a comprehensive physical examination chose to provide detailed information about their childhood experience of abuse, neglect, and family dysfunction. To date, more than 50 scientific articles have been published and more than 100 conference and workshop presentations have been made.

The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. It is critical to understand how some of the worst health and social problems in our nation can arise as a consequence of adverse childhood experiences. Realizing these connections is likely to improve efforts towards prevention and recovery. It is essential to include children with disabilities into an awareness of the impact of adverse child experiences on them.

6. References To Articles On Abuse Of Children And Adults With I/DD

1. Lancet. 2012 Sep 8;380(9845):899-907. doi: 10.1016/S0140-6736(12)60692-8. Epub 2012 Jul 12. Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. Jones L1, Bellis MA, Wood S, Hughes K, McCoy E, Eckley L, Bates G, Mikton C, Shakespeare T, Officer A. <http://www.ncbi.nlm.nih.gov/pubmed/22795511>
2. Child Abuse & Neglect, Vol. 24, No. 10, pp. 1257–1273, 2000 Copyright © 2000 Elsevier Science Ltd. Printed in the USA. All rights reserved 0145-2134/00/\$—see front matter; PII S0145-2134(00)00190-3, Maltreatment and Disabilities: A Population- Based Epidemiological Study; Patricia M. Sullivan Boys Town National Research Hospital, Omaha, NE, USA; John F. Knudson
3. Summaries from four reports Save the Children, Sexual abuse of children with disabilities. Docs-_22867-v1-sexual_abuse_of_disabled_children summaries_from_three_reports1_0.pdf
4. 2012 National Survey on Abuse of People with Disabilities, Disability and Abuse Project, Coleman, T. and Baladerian, N.J. <http://disabilityandabuse.org/survey/index.htm>

For additional information on abuse and those with intellectual and developmental disabilities, visit disabilityandabuse.org

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