At a time when we all are feeling vulnerable and a little less safe, we don't really like to talk about it; we don't really like to acknowledge it, but the evidence is mounting that children with disabilities are more likely to be abused than children without disabilities. Thus, this edition of Disability Aware brings you information about what child abuse is, why children with disabilities may be at higher risk, one man's experience, and how to report suspected abuse. As we researched this edition, many people told us that they don't quite know how to recognize the signs of abuse in a child with a disability, so we developed our own list, combining information from the Delaware Division of Family Services with the literature about abuse in the disability field. We are also writing about stress in family life, and why some families are better able than others to adjust to and cope with a family member with a disability. As a final note, sprinkled throughout this issue, you will also see photographs that are examples of positive parenting activities.

Disability Aware is sponsored by the University of Delaware's Division of Disabilities Studies and the Developmental Disabilities Council and funded by the Helen F. Graham Foundation. Comments may be made by calling (302) 831-6974 or TDD at (302) 831-4689, faxing (302) 831-4690, or writing to M. Theda M. Ellis, University of Delaware, Center for Disabilities Studies, 166 Grahm Hall, Newark DE 19716-3301.

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Detecting abuse: signs, risks & protective factors

At any situation, one can increase the risk of abuse. For example, children under six years of age are at greater risk, because they need constant care, and parents typically get less support from school or child-care options. Risk also increases if the parents have problems, such as substance abuse, that influence their ability to cope with a child who needs attention.

Parenting a child with disabilities brings additional challenges. One is increasing the risk for abuse and difficulties for its detection. Many people assume that the risk is higher for children with disabilities because of increased and overwhelming stress on parents to meet their needs. Another is that we don’t know exactly how much abuse exists among children [and persons of any age] with disabilities.

Richard Sobsey suggests that social factors and particular environments can set the stage for all forms of abuse. For example, children (and adults) more vulnerable, may give us at least some idea of who could be at risk.

Legally defining child abuse is not as easy as it looks. The state of Delaware’s current definition of child abuse (Child Abuse Prevention Act of 1997) states that abuse has happened when anyone who is caring for a child hurts that child by being too forceful. “Hurt” is defined as physical, sexual, emotional, or neglectful. If the definition were limited to children, all acts of abuse have already been abused, it would be unable to protect children from verbal or emotional abuse. However, if the definition were broader to include every possible kind of child abuse, it could include loopholes, Dick Sobsey, in his 1994 book, Violence & Abuse in the Lives of People With Disabilities, writes that broader definitions do not help victims but instead could keep the courts from being able to enforce the laws at all.

The definition of child abuse among children with disabilities varies because researchers define abuse depending on their specific research questions. This is appropriate for good research, but it confuses the “big picture” for others. Marta Kwan, in her 2000 article about research of sexual abuse of children, uses the word “abuse” to describe “hurt” definitions of abuse because they do not consider all acts of abuse defined as abuse. Researchers defined it as any act that成效 their ability to cope with a child who needs attention.

Carole Hillegas, Delaware Autism Program

A nother important aspect of monitoring is documenting behavior on a regular basis. The Chimes is an organization that provides a range of supports to adults with autism and mental retardation. Richele Lawson, Director of Health Services at Chimes/Philadelphia, describes policies that echo Hillegas’ emphasis on keeping records. The Chimes/ Philadelphia policy to note behavior that could result in physical injuries later. For example, Lawson mentioned that thrashing behavior is especially noted. "[A client] might have thrashed today but not shown bruises yet, so we document the thrash, and if injuries surfaced in a couple of days we already know where they are likely to have come from." Suspicion is warranted if a person’s behavior changes noticeably, especially if the new behavior looks like something the person used to do a long time ago. “We try to err on the side of caution,” continued Lawson.

Our most common reason for ordering evaluations is the occurrence of a behavior that we cannot find an explanation for. It’s important to call a physician in if there is any question—there could be a medical reason for the behavior, or it might be an old one resurfacing. Either way, the explanations are systematically considered.

Other things may merit investigation after one occurrence, simply because they are so jarring. A Linda Shannon, I refuse to take an investigation program manager for the Delaware Division of Family Services (DDFS) pointed out—sometimes you can’t wait for a clear document pattern of behavior to appear. You might have a baby come in to daycare with a fracture that looks like their limb was twisted in a spiral, or there might be a child in school with a gash on his head who says he was hurt because his daddy got mad at him. Clearly, those kinds of things have to be reported and investigated right away. A nother important thing to consider when trying to explain noticeable changes in a child’s behavior is that people show different patterns across time. A s Lawson (Chimes/ Philadelphia) noted, “It’s easier for professionals who have known clients over time to explain changes in their behaviors, because the written records get purged periodically. It’s
behavioral cues are as subtle as overall, the essential thing self-abusive behavior. their repetitive ritualistic or comfort by an increase in might show anxiety or dis-

ple, DAP’s Hillegas notes DAP’s Hillegas notes

• The State of Delaware’s Department of Services for Children, Youth, and Their Families publication titled "A newspaper for people with disabilities, their families, and the professionals who support them"

BEHAVIORAL INDICATORS

PHYSICAL INDICATOR

• Reports physical, sexual, or emotional abuse at home, even if details are not accurate
• Acts afraid to go home or asks to stay at school instead
• Lies excessively or sits and stands, may spend most of time alone
• Wears extra layers of clothing or other concealment, extremity shy, avoids certain adults or places
• Delayed school performance
• Has nightmares or difficulty falling asleep, or may fall asleep at school
• Wets or soaks pants by school age
• Has repetitive habit disorders (biting, rocking, head banging, thumb sucking in an older child)
• Behaves as if he/she is a younger child
• Is depressed or attempts suicide
• Buys drugs or alcohol
• Behaves in extremes and on and off, overly demanding or withdrawn
• May not follow directions to gain some sense of personal control
• Vandals property
• Runs away from home
• Has professional responsibilities
• Has poor peer relationship

SEXUAL ABUSE

• Caregiver/family is isolated
• Caregivers may have impulsive behavior, and aggressive behavior, and

ENVIRONMENTAL FACTORS

• Social setting emphasizes vulnerability: child may have impaired physical defenses or lack critical information about what is appropriate to endure
• Caregiver/parent is isolated from society
• Stigmatized due to child: the more dehumanized they are, the easier it is to abuse them
• At least one type of abuse has occurred to the child in the past: increases risk in all other categories
• Other children are being abused in the caregiving setting: that an abuser will settle for one victim when others are available

What happens when you call the hotline? If yes—The supervisor will also note whether the report to the intake supervisor. If no—The supervisor notes why on the report and sends it back to the specialist who wrote the report. A Family Service specialist, like Donna Greve, will write a report concerning your fears for the child in question. The specialist will then forward the report to the intake supervisor. The intake supervisor screens the information in the report to determine if it's appropriate to investigate yes or no. What if you don't report your fears and concerns—and you were right? Call 1-800-292-9582. What if you call the hotline? A Family Service specialist, like Donna Greve, will write a report concerning your fears for the child in question. The specialist will then forward the report to the intake supervisor. The intake supervisor screens the information in the report to determine if it's appropriate to investigate yes or no. Risk feeling like a fool and ignore the people telling you to mind your own business. Let the professionals decide if your concern is real. What if you don't report your fears and concerns—and you were right? Call 1-800-292-9582. To make a report about child abuse or neglect in – Kent County, press 1. – New Castle County, press 2. – Sussex County, press 3. – New Castle County, press 4. One real person will answer your call and address your fears. For the last 14 years, Donna Greve has been one of the people answering the phones at the Child Abuse Report Hotline, which is run by the Division of Family Services (DFS). Currently a master Family Service specialist, Greve became a caseworker, so she is well-versed in the process for helping children who are being abused.

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Detecting Abuse

Attention to environmental needs is not easy. You have to keep a way to communicate; we function. People always have problems speaking clearly, we training leads to better investigation request. Mary Anderson, Quality Language, or failure to thrive, recognize things like delayed language, or delayed milestones, so they can recognize "the Division of Family Services. (Call 1-800-292-...)."

Linda Shannon of DDFS expressed concern that any one would feel their report was not taken seriously, saying, "The Division of Family Services has a policy of taking reports seriously—whether the person in question is able to express it verbally or not. Having a disability or an inability to speak for oneself should not EVER be a reason to reject a complaint or to refuse an investigation request."

Shannon went on to say that if anyone ever felt their complaints were not taken seriously, they wanted them to contact her so that she could address the problem personal...mation. The Division also has a video tape about the investigative process, available to anyone who would like to see a step-by-step explanation of the process. (Call 1-800-292-9582.) The DDFS investiga...tive staff is trained to use more than verbal interviews to gather information, particularly because the most vulnerable abuse population is children too young to speak for themselves. Shannon asserts, "Professionals are taught a variety of investigative tools and observational skills that should leave them able to determine abuse reasonably accurately even if the person cannot speak for him or herself. They are also trained in developmental markers, so they can recognize things like delayed language, or failure to thrive, and so on. We use a lot of detailed criteria to investigate abuse."

Any new child brings stress to a family. When a child needs even more time, attention, resources, physical care, or medical treatment than the typical child needs, parents can be overwhelmed. Still, most families of children with disabilities do not abuse their children. The question becomes—why can some families cope, and even thrive, while others struggle, and hurt their children?

What is stress? M McCubbin, Susman, and Patterson in their book, Social Stress and the Family, define stress as something other (i.e., as a result of a death or divorce), or family patterns and rituals change (i.e., work schedu...e changes; the family moves and leaves their extended family). What then is stress? The family must deal with it and respond to any hardships that come with it.

Family resources and capacity

At least in part, families respond to stress based on their resources and their capacity for coping with problems. (See page 6 the article "Keeping child abuse out of the family dynamics" addresses financial resources. However, family resources are more than just financial, and they vary from family to family. The most important resource is the family itself, the sense that the collective needs are more important than any one person's needs, the affection family members feel for one another, the sharing of common values, and the family's ability to adapt to new situations and unanticipated obstacles. The extended family is a critical family resource. Studies show that the more social support the family has, the greater its ability to adjust to crises and changes. Caplan, cited in Social Stress and the Family, found that social support allows people to adapt more easily, and it appears to protect us from the physical and emotional health consequences of stress. Thus, resources include income, medical benefits, extended family, family members, and personal identity, and the character and personalities of the various family members. The lack of any of these resources increases the effect of stress from change. For families with few resources, the impact is the greatest. (See their recent paper, A Longitudinal Study of Parental Risk Factors.)" Shade and Golding found that risk factors for parenting behavior who abuse their children are: less than 20 years old, lower educational achievement, an absent father (for women) or experiencing institutional care during childhood (for men)."

The lack of resources these young parents have, i.e., few family members, inadequate education, and modest income, are all significant obstacles to overcome. The addition of a family member with a disability in creases the magnitude of these obstacles considerably (C.H. Biddle & N. Jepson. 25:1377-1200, 2001)."

Family definition

Every family has its own view about a change, how serious it is, and how to react to it. Some families accept a disability as a challenge to be lived up to. In these families, parents often take on new roles in service and advocacy, working to increase the quality of their child's life. They understand that they can impact the lives of others as well. Delaware parent Gary Mears has been known to say, "My life didn't really begin until my daughter was born." Families like the Mears rely on their spiritual values to live their lives with new meaning and goals. Families who believe that a disability is a stigma seem less likely to approach coping as a challenge to their resourcefulness. They may feel that they no longer have control over their lives. This example of this attitude is the family that prides itself on academic success and is reluctant to expand their definition of "success" to include a child with intellectual delays. Ultimately, the meaning that a family finds in nurturing a child with a disability is a reflection of their values and experiences in dealing with...
life. The way they define the situation can either make it a worthy challenge to ensure that their child grows up successfully, or a reason for disapproval, or even shame. However, the meaning a family creates in their lives together is not solely a product of external conditions. Outside influences, like changing societal values and increasing acceptance of people with disabilities are lending support to families, not only to manage a different life course and accommodate the person with a disability, but also to experience it positively.

Pile-up

Disability, like life, is not a one-time event. Life doesn’t stop with this particular child or any one phase of life. Families may accept the disability, deal with it, and move on; but as children grow, change continues to occur and continues to bring new stresses associated with everyday life. Other children may exist, other life events happen, and soon the family can be dealing with a pile-up of stresses and strains. When pile-up occurs, a crisis may follow. There are five broad types of stresses that can move a pile-up into a crisis.

The initial stressor and its hardships

This category includes the disability itself and the additional needs related to it. Normal growth and change in a family over time. A family changes over time. Babies are born, moms return to work, grandparents die, and children grow up. But the pile-up gets deeper when we combine the stresses of normal change with the additional changes that families who have members with disabilities experience, i.e., finding services for children, moving from one service system to another, and aging out of school into adult systems. At each stage, parents must again seek services, learn about new rules, and assist their child and the entire family to make the transition. Prior strains

Most families have strains left from previous events that are typically unrelated, unresolved, and, often, unknown. When the family is faced with a new stressor, these old strains and stresses can resurface. For families with members with disabilities, there may be issues or expectations that cannot be addressed completely because of the nature of the disability itself. The child may never walk, speak, or become totally independent. These issues accumulate with other typical family strains. Things like relationships with in-laws, resentment about one parent leaving the workplace to take care of the child, or the second parent taking on an extra job to support the family, tend to emerge when the family faces a new transition or stress event.

How families cope

Coping skills themselves can be a source of stress. For instance, behaviors that work well in the beginning, like having a drink before dinner to remove the “edge,” can take on a life of their own and add to the pile-up. Coping can also take the form of denial or distancing oneself from dealing with the issue. Some people jump into the community, making themselves very busy with family issues but less available to the family members themselves. Others retreat from social interaction outside the family and become isolated. When coping is tangled up with denial, the coping process itself begins to drain energy. Uncertainty in the family itself

There are social expectations about who families are, what they should be, and how they should react. A family member with a disability does not always fit easily into that picture of the family. Families need to recognize who participates as a member and who does not. This is true psychologically as well as physically. A spouse or grandparent, who copes outside activity or denial and leaves important decision-making and support activities to others, may be physically present but emotionally distant. A matter of those in the disability community don’t like to talk about is that families with children who have a disability may be more likely to divorce. This can add to the complexity of deciding who is a family member and who is not. Furthermore, a neighbor or friend may give support and assistance with decisions-making and become a family member, further expanding the definition of the family.

In the end, the family is essentially made up of the people you can count on; it may not matter whether they are related or even physically present.

By now, you may be asking, “How does a family process all of this information?” Looking at recent developments in social science research may give us a clue.

In the 1990s, the area of family stress and abuse began to be investigated more carefully. For example, research by Burt, Thompson, and Sexton (1994) found a clear connection between the lack of family resources and the potential for abuse. Therefore, if lack of resources is a factor contributing to abuse in any family, the issue of resources becomes even more critical for families with members with disabilities. The additional stress of dealing with a disability, and the pile-up that comes with it, may be the reason that abuse is more common in families of children with disabilities. Family support appears to be a critical component in keeping families intact and ensuring that children and adults with disabilities are safe within their families. By providing necessary resources during the times that families need them, we can reduce the potential for abuse.

The Helen F. Graham Grants Program provides Valuable Support

Looking for a way to fund that creative idea? The Helen F. Graham Grants Program may be your answer.

Readers of Delaware can see from our masthead that the M.B.A. Helen F. Graham Grants Program has funded the three issues published this year. We, at the Center for Disabilities Studies, have benefited twice from the generosity of this program of the M.B.A. Foundation: first, for Delaware, and more recently, for a distance learning project we are developing for foster families of adults with cognitive disabilities.

Fortunately, for those of us involved in disabilities supports and services in Delaware, the Helen F. Graham Grants Program funds initiatives that create opportunities for individuals with cognitive disabilities. The purpose is to promote and support programs that assist people with disabilities to become independent, self-sustaining individuals who live and work in our communities. The grants program supplements funds currently available to schools and community agencies, either for new initiatives or for expanding or enhancing current initiatives. It is particularly interested in, but not limited to these kinds of initiatives:

• Focused experiences that enhance and reinforce the achievement of specific educational objectives
• Joint projects among teachers, schools, or community organizations for improvements in education for people with disabilities
• Extended weekend, weekday, or summer educational programs
• Professional development opportunities that strengthen teachers’ effectiveness and directly benefit students
• Programs that teach job skills, improve participants’ employment prospects, or help in the transition from school to work
• Programs to improve participants’ ability to function independently in the community

To be eligible for funding, organizations must be

• A public or tax-exempt 501(c)(3) private or parochial school in Delaware (teachers with classrooms in which fewer than 50% of the children have cognitive disabilities should apply to the Delaware Excellence in Education Grants Program) or
• A nonprofit 501(c)(3) community organization in Delaware

With federal and state funding sources becoming more difficult to secure, we are lucky that this grants program has opened. If you are interested in learning more about the program or in submitting a grant application, you will find all criteria and forms at www.mdhsfundation.org/ffgwg/ffwg.shtml or you may call the Helen F. Graham Grants Program at (302) 432-5220.
Keeping child abuse out of the family dynamic

Children can both inspire and challenge a family. “If you offer an opportunity to have a positive experience of family life,” writes Ellen Bass and Laura Davis in The Courage to Heal, “But children also bring up unresolved feelings. They can reanimate memories, put you face-to-face with the ways you’re like your parents, or remind you of your own vulnerability” (New York: Harper & Row, 1988: 270). These unresolved feelings are the parents’ responsibility. To resolve them, parents need to address their own issues and the stressors in their lives while simultaneously working to meet each family member’s needs, including their own. It’s a difficult balancing act, especially if you’re endeavoring to put the past and redoing the present; the reward is a healthy family dynamic.

Parenting is one of the most complex and demanding jobs anyone can undertake. It’s a complex and demanding job, requiring a variety of skills and abilities. A healthy family dynamic includes interactions that meet the needs of all family members. In contrast, an unhealthy family dynamic is one-sided, unbalanced; all the power is held by one person. According to Sarah Neale and Ellen Gay, the less functional the family dynamic is, the greater the chance for child abuse. And the more helpless a child feels, the more frustrating the child’s behavior will appear to the parents. “I believe,” says Neale, “the cause and effect of maltreatment and developmental delays or disabilities in some children are intertwined. Children with developmental delays or disabilities are particularly vulnerable to child abuse or neglect may result in a developmental delay or disability. For example, if a small child is propelled up in a highchair in front of the TV all day with absolutely no stimulation physically or cognitively, it is possible that the child may present a motor or cognitive delay. “The families I’ve worked with demonstrate key stressors, such as [a lack of] finances, substance abuse, and domestic violence,” adds Neale. “Children in families who are at a much greater risk for abuse or neglect. A parent may not understand that [the child] is different [from] other children. The parent doesn’t understand or know what is wrong, what to do about it, or who to call.” Even in the best circumstances, when the parents can meet the needs of a child with disabilities, the chance for abuse still exists. It all depends on the family’s strengths, support networks, and distribution of power. “With no extended family or means to draw on other resources,” explains Gay, “tensions will rise. Working parents especially, who accept and love a child with disabilities, [can] lose it without adequate support.”


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Denial—Loss of the idealized child—An unacknowledged experience (New York: Bantam, 1993). It is very difficult to be objective about your relationship with your children,” writes Bass and Davis, “you may feel defensive (‘I’m doing the best I can’), or you may feel that any criticism of your children reflects badly on you...” (The Courage to Heal, p. 273). Emotionally problems—Denial makes a lie of your while creating another set of very real problems. When a parent can’t see the needs of a child with a disability, emotionally problems arise. When the problem becomes too unmanageable, a frustrated child may become unmanageable, too.


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appropriate boundaries with your children now, or you may be confused about what is appropriate.... Clear emo-
tional boundaries enable you to express yourself as sep-
parate from your children. You realize that you don’t think and
feel as you do, nor should they. Their interests and needs are different from yours and don’t necessarily reflect
on you. Assuming your own individuality and allowing your
children theirs is respectful and healthy, though not always easy” (The Courage to Heal, p. 276).

Lack of control—Parents or caregivers may have emo-
tional boundaries otherwise; they will react badly in stress-
ful situations. Neil and Gay agree that these parents will
be unable to control their frustration level or to listen with an open mind. The ten-
dency, again, is to rage. Some issues of control place
children with special needs at higher risk. For
example, a child with Down syndrome, asking openly for affection, can be vulnerable to a sexually abusive parent or caretaker.

"Usually," explains Gay, "children with Down syn-
drome are pretty willing and compliant, so they need to
be protected from such abuse. This is where the family dynamic comes into play. The key is accep-
tance.” In other words, peo-
ple need to accept a child’s disability so they know not only how to meet the child’s needs but also how the child is vulnerable.”

"Caretaking,” writes Bas and Davis, “especially of small
children, is very physical, and it’s not unusual for [people] to feel an occasional sexual response. If these feelings are
neither consistent nor compelling, they are probably within a normal range. It, however, sexual desire and
affection for your children is strong or per-
cipient, get help for yourself immediately.

"Be aware,” advises Bas and Davis, "that children often

A healthy family dynamic includes interactions that meet the needs of all family members.

• • •

test limits, sexually as well as in other areas. They experi-
ment with boundaries regarding intimacy, closeness, and
physical affection. They might try to touch you in sexual areas or try to get you to touch them. If your child is testing in these ways, set limits firmly while staying affectionate” (The Courage to Heal, p. 277).

Lack of resources—A major
dresser in any family is a lack of financial resources. The lack overwhelms a family that can’t afford to meet the needs of a child with a dis-
ability, especially when the
family has inadequate med-
ical insurance or hasn’t applied for Medicaid on the
child’s behalf.

"Most abuse takes place,”
notes Gay, "when people
are frustrated. The biggest stres-
sors are limited emotional
and financial resources.”

"A family that wants serv-
es,” says Neale, "may not
know about or have access to
the resources that can help
get them, like the cost of transportation or a phone. Delaware offers excellent resources and programs for children with developmental delays and disabilities. Without knowledge or access to these services, the bene-
fits [that families are entitled to receive are very limited."

Therefore, try to educate families and help them become proactive (instead of reactive).

Helpful resources need to include books and programs for the child with disabilities that are appropriate for the child’s individual skill level. Aiding Bas and Davis, "Teaching children personal safety skills so they can pro-
tect themselves will replace their fear with self-confi-
dence. Children need to
know that there are certain
ways and that they can say no, and that they are capable of pro-
tecting themselves in a vari-
esty of ways” (The Courage to Heal, p. 283).

"We have a lot of built-in supports in Delaware,”
emphasizes Gay. “Use them!

O f f i c e o f P r e v e n t i o n a n d E a r l y I n t e r v e n t i o n , C h i l d r e n ’ s T r u s t F u n d & P r e v e n t C h i l d A b u s e D e w a r e
Preventing abuse of Delaware’s children

Child abuse was obviously an issue that
needed to be addressed when Frank
Boxwill and his colleagues formed a small unit of con-
sultants within the Delaware Division of Child Mental
Health Services. Immediately, the unit received a surprisingly high
number of referrals from Head Start and other preschool programs.

"When the unit was formed in 1989," says Boxwill, "[two staff members] provided training and consultation to the early childhood educa-
tion programs. At that time, the focus was on 3- to 5-year-
old children who exhibited challenging behaviors in the
classroom. On-site consulta-
tions for parents and teachers were provided as a way to
assist those caring for the children in addressing the children’s needs.”

In July 2001, Boxwill’s unit was
annexed by the Department of
Services for Children, Youth, and Their Families, Office of Preven-
tion and Early Intervention. The
move added mental health to the
Office of Prevention agenda and four more staff members with varied back-
grounds in training, consulta-
tion, psychotherapy, family
counseling, and education.

Today, the Delaware Community Consultation for Early Childhood Educations programs, the array of ser-
dices continues to look at the
behavior exhibited by a child. The reason: a child
reflects what is experienced and learned in the home and
school.

"We provide parents and
teachers with knowledge and
an understanding of why
children exhibit specific behaviors,” explains Boxwill. "When we consult with a family and preschool staff, our
first task is to help those [people who are close to]
the child give information about the
child [and write] the child’s story,” which
encompasses a brief history of the
child’s development from birth to the present. Because
the parents and caregivers spend a great deal of time with the child and have a
firm grasp on what the child’s
behavior looks like in the
home and in the classroom, we rely very heavily on what
they have to share about the child.”

To prevent abuse of Delaware’s children, the entire preschool population qualifies for the services offered by the programs.

"I tell the goal,” states
Boxwill, the current mental
health program administrator at the Terry Children’s Psychiatric
Center, “is to help preschool staff under-
stand that, through changing certain aspects of the child’s environ-
ment, most challenging behaviors can be reduced.”

To that end, four training programs are available within Community Consultation:

• I Can Problem Solve is a prevention program that preschool teaching staff can use to teach children about how to become their own problem solvers.

• Positive Behavior Support introduces a process for achieving positive behav-
ial change by engaging those people who are involved with children in building on his or her strengths, gifts, and talents.

• Training of the Trainer pro-
vides the skills, knowledge, and techniques that make an effective trainee.

• Promoting the Development of Infant/ Toddler Mental Health (Continued on next page)
Preventing Abuse... From previous page

offers teaches the skills and knowledge needed for positive approaches that enhance the social and emotional development of children up to the age of 3.

For more information, call (302) 577-4270, extension 3079.

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Weaving prevention into the fabric of experience

Children’s Trust Fund promotes and produces primary programs aimed specifically at preventing child abuse. A addressing such issues as violence, sexual abuse, and safety on the streets, these programs are accessible to all backgrounds and available in any community, whether rural or inner-city, at times when people will attend. Two examples of facilities that house these programs are the Boys & Girls Clubs of Delaware (where the Trust Fund’s offices are located) and the Latin American Community Center in Wilmington.

There’s a Children’s Trust Fund in every state and district of Columbia. “We look for the people who are the best at delivering programs and who are the best at delivering them,” adds Donges. “We also look for the people who are the best at delivering programs and who are the best at delivering them, and we’re not limited to who we work with. We’re autonomous, because we’re autonomous, we’re not limited to who we can fund,” says Richard Donges. “We look for the best programs as well as individuals and church groups who work with children in their neighborhood and in the community. It also like that the Trust Fund is a state-linked ongoing program with the Boys & Girls Clubs,” adds Donges, “because the message is reinforced over time. It’s not a one-shot deal. It’s all woven into the fabric of the experience here. A not the message is being relayed by qualified professionals. People with master’s degrees in Social Work volunteer their time on subjects like healthy lifestyle, how to avoid danger, conflict resolution, and sex abuse prevention.”

One of the Fund’s many prevention programs involves respite. The short-term goal is to stabilize a family in crisis. The long-term goal is to keep the family together. The statistics prove that children with families receiving prevention-respite care are less likely to experience abuse,” explains Donges. “Our goal is to develop a network of respite services that are accessible and available in both the short and long term. That’s why we’re always looking for good programs that address the needs of children with disabilities and their families. For example, a few years ago, a portion of the respite program was funded with United Cerebral Palsy. Set up for children with gastrointestinal tubes and extreme physical needs, this program offered a quality day camp for the entire summer. A appropriate transportation made sure the children arrived safely each day. In turn, responsibility for the children’s care was taken out of their parents’ hands for the day. Donges hopes this program will be available again this summer. The Children’s Trust Fund also addresses some secondary prevention programs, which work with parents who have had abuse problems in the past and want to stop the pattern. “Ideally,” says Donges, “we want to stop the abuse from ever happening—but we also want to stop it from happening again.”

For more information, call (302) 836-8550 or go online at www.ChildrensTrustFund.org.

Community prevention efforts What can each of us do to help? A mother key player in Delaware’s efforts to prevent child abuse is Prevent Child Abuse Delaware. The local branch, which arrived in Delaware in 1977, serves more than 20,000 children and families every year. Its varied services for consumers and professionals dedicated to the primary prevention of child abuse are all influenced by the idea that people need to have a better sense of what strategies are most effective. Karen DeRamos, Director, explains, “If people know child abuse is a problem, but aren’t quite sure what to do about it. A buse is preventable in most cases, if the most appropriate approach is used.” For example, when addressing the needs of families who have a member with disabilities, the agency is aware that any interventions need to be particularly sensitive about addressing family stressors. “No matter what age the family member who has disabilities is,” says DeRamos, “we try to help all family members cope with their stresses and support them all as much as possible.” Further asserting the belief that more prevention could occur if people just knew more about how to help at the community level, Prevent Child Abuse, Delaware’s website includes a summary of ways to actively prevent child abuse before it starts. Suggestions include making sure children (and people with disabilities of any age) feel valued and encour-