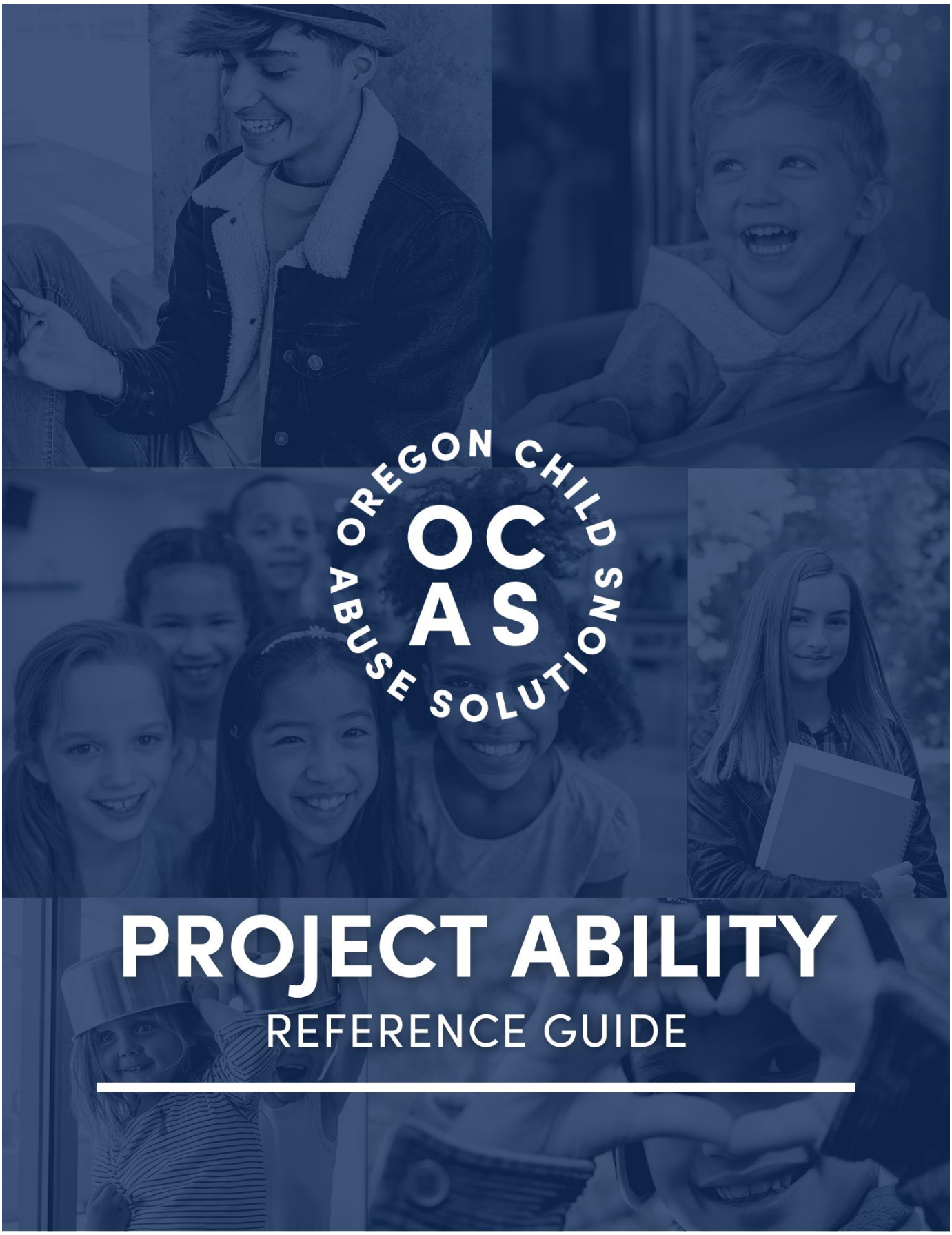
OREGON CHILD ABUSE SOLUTIONS
OCAS
PROJECT ABILITY
REFERENCE GUIDE

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INTRODUCTION

Project Ability: Demystifying Disability in Child Interviewing was developed in 2008 as an advanced forensic interviewing training curriculum for professionals throughout the State of Oregon who work with children with disabilities. The Oregon Children's Justice Act (CJA) Task Force commissioned the development of this work and specified a focus on strategies for interviewing children with disabilities about child abuse. In 2018, this curriculum was updated to incorporate best practices developed since Project Ability's inception. The current curriculum was updated in 2024 to include available research and publications.

Oregon Child Forensic Interviewing Guidelines and the Oregon Child Forensic Interview Training

The Oregon Child Forensic Interviewing Guidelines (*Fifth Edition 2024)* (OIG) were developed to promote consistency in the practices of child forensic interviewing in Oregon. The Oregon Child Forensic Interviewing Guidelines incorporate best-practice suggestions from a large body of research and literature in the field of forensic interviewing, as well as from several widely-used national models. In particular, the OIG recognizes the foundation for the document, which is drawn from the body of work by Dr. Michael Lamb and his colleagues at the National Institute of Child Health and Human Development (NICHD), Tom Lyon's body of research and forensic interviewing tools shared with professionals who work with children, and the American Professional Society on the Abuse of Children (APSAC)'s work developing guidelines in this field. The OIG provides forensically sound, research-based best practices in child interviewing. The guidelines provide a framework for conducting child forensic interviews in Oregon. This framework assists forensic interviewers in the process of talking with children about concerns of abuse while gathering information in a reliable, detailed, developmentally-appropriate, trauma-informed, and legally-defensible manner.

The Oregon Child Forensic Interview Training (OCFIT) was developed in 2012 and is reviewed and updated annually to provide consistent, standardized training for professionals across the State of Oregon on the OIGs. The OCFIT addresses a wealth of information regarding evidence-based practice supported by current research on forensic interviewing techniques that meet the needs of the Multidisciplinary Team (MDT) professionals in the state.

Research shows that children with disabilities are at a greater risk of child maltreatment than typically-developing children. The OIG and OCFIT include fundamental information on interviewing children with disabilities. However, this topic is large, complicated, and often can be overwhelming to professionals. Many professionals who conduct forensic child interviews are not "experts" on disabilities, which can lead to fear and/or apprehension about conducting interviews with this vulnerable population. Therefore, the Project Ability curriculum was developed to build upon the OIG and OCFIT curriculums to include more detailed information and advanced techniques that help professionals interviewing children with disabilities have the best outcomes.

COURSE OBJECTIVES AND COMPETENCIES

At the end of this training, participants will be able to:

1. Define the term “disability” for Oregon.
2. Formulate 5 strategic questions when preparing for interviews with children with disabilities.
3. Discuss characteristics and accommodations for interviewing a child who has difficulties or delays in one or more of the following areas:
    a. Communication
    b. Intelligence Cognition or Cognitive Skills
    c. Behavior
    d. Physical Functioning

CHAPTER 1

DISABILITY DEFINITIONS, STATISTICS, AND VULNERABILITIES

Nationally, approximately 14 percent of children and youth ages 3 to 21 qualified for special education services during the 2019-2020 school year. (1) This statistic does not capture children with undiagnosed and/or unidentified disabilities.

As a person who interviews children, you will work with children with disabilities. A child with disabilities has more similarities than differences with a typically-developing child regardless of any condition, difficulty, or limitation they may experience. As an interviewer, it is crucial to focus and build upon the child's strengths and abilities. This shows respect for the child and will ultimately allow for the best possible outcome: an interview where the child has the best opportunity to share their experience and provide information that helps professionals provide safety.

DEVELOPMENTAL DISABILITIES AND THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT

It is important to review some basic information about developmental disabilities and the current classifications of disabilities children may experience.

Developmental disabilities

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

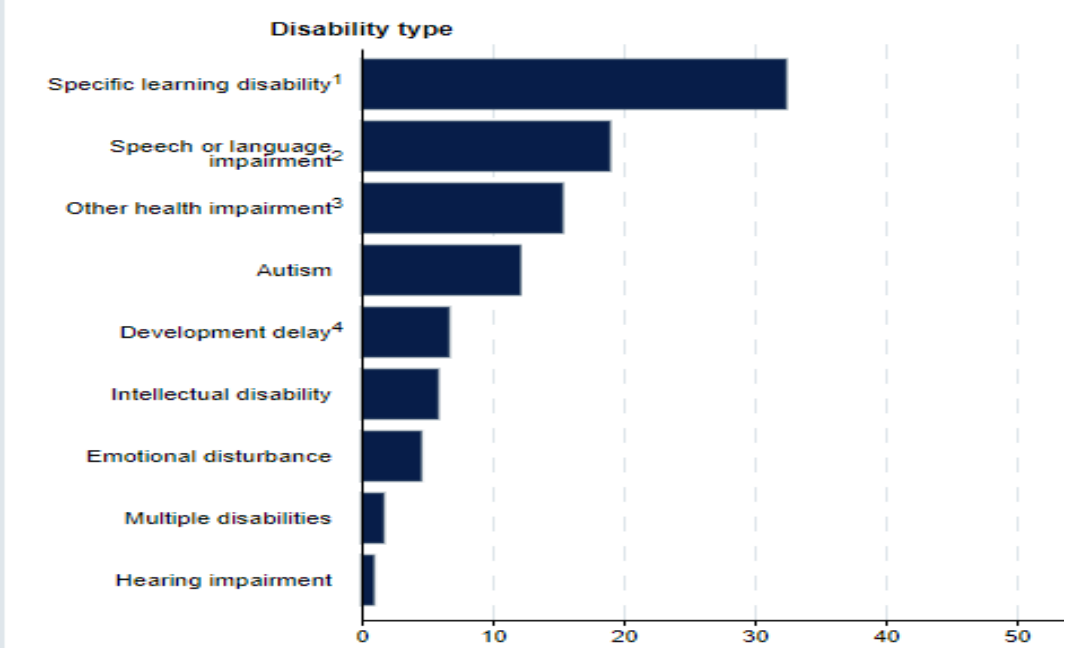
The Centers for Disease Control defines developmental disabilities as follows: (2) A group of conditions that are due to physical, learning, language, behavioral, or mental impairments that:

- Become apparent as a child grows,
- Are usually detected when a child falls away from the trajectory of normal development,
- Begin anytime during development up to 22 years of age,
- Last throughout a person's lifetime,
- Cause problems with major life activities such as language, mobility, learning, self-help, and independent living.

The Individuals with Disabilities Education Act (IDEA)

The Individuals with Disabilities Education Act (IDEA) is a federal law that was enacted in 1975. It mandates that public schools make available to all eligible children with disabilities appropriate public education in the least restrictive environment, according to their needs. The IDEA identifies 10 categories of disabilities that qualify children and youth for special education services between the ages of 3 to 21. The 10 categories of disabilities include: specific learning disabilities, speech or language impairments, autism, emotional disturbances, other health impairments, and physical disabilities (hearing and visual impairments, multiple disabilities, deaf-blindness, and traumatic brain injury). According to the IDEA statistics for the 2021-2022 school year, 35% of children had a specific learning disability, 21% percent had speech or language impairments, 8 percent were identified with autism spectrum disorder (ASD), 7 percent had intellectual disabilities, and 6 percent had an emotional disturbance (3). Project Ability will reference these categories of disabilities.

The graph below shows the distribution of disabilities among children and youth aged 3 to 21 who qualified for special education services during the 2021-2022 school year:



DEFINITION OF DISABILITY FOR THIS TRAINING

Professionals interviewing children about possible abuse need to know how to interview children with disabilities, but it is unrealistic to expect them to develop expertise in all of the many disabilities that occur. Instead, interviewers need to understand that regardless of the label, cause, or prognosis of the impairment, disabilities can interfere with a child's ability in four basic areas of function: communication, intelligence, behavior, and physical functioning (sight, hearing, movement, and maintaining health).

For the purposes of the Project Ability curriculum, we define disability as a medical, educational, or psychological condition that interferes with a child's ability to:

- **Speak, understand, and use language.**
- **Think and reason.**
- **Behave appropriately, socially, and emotionally, in most settings.**
- **See, hear, move, and maintain health.**

This definition is broad and includes developmental disabilities categorized in the IDEA and many of the medical and mental health conditions that affect children.

In the following chapters, we will provide information about disabilities that contribute to understanding each of the problem areas caused by disabilities, along with strategies for accommodating the child's disability.

DISABILITIES INCREASE VULNERABILITY FOR CHILD ABUSE

Disability and maltreatment statistics

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

- A systematic review and meta-analysis published in 2022 by Fang and colleagues (4) noted that children with disabilities were over ***two times*** more likely to experience many types of abuse, including physical violence, sexual violence, emotional abuse, and neglect. It is noted that youth with disabilities experienced the following types of violence.
    - Approximately 31% of children with disabilities experienced violence, including sexual, physical, interpersonal, emotional, and bullying.
    - Children with sensory impairments and physical limitations experienced higher rates of sexual violence than children who were intellectually impaired.
    - Children with sensory issues experienced higher amounts of bullying by peers.
    - Children with emotional or intellectual disabilities experienced higher rates of violence across all types of violence except for sexual violence and peer bullying.
    - Nearly 40% of children with disabilities experienced peer bullying and children with disabilities had higher odds of experiencing bullying than children without disabilities.

- The Journal of American Medical Association (2016) (5) noted that children with disabilities, as compared to children without disabilities, were approximately:
    - 14% more likely to be re-referred for concerns of abuse as compared to children without disabilities,
    - 9% more likely to experience substantiated maltreatment,
    - 4% more likely to be placed in foster care.

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

In all cases of abuse (physical, sexual, emotional, and neglect), the most frequent perpetrator of the abuse is the child's primary care provider. According to the Child Welfare Information Gateway (2018) (6) there are no single risk factors that place children at risk of abuse or neglect, but the interaction of various factors can increase the risk.

Common factors that increase the risk of maltreatment for any child, regardless of disability status, include:

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

Given that these factors can occur for any family, consider the reality that caregivers are often under even more stress when they have a child with disabilities. Some examples of the increased risk factors include:

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

Additionally, child-related risk factors that can make children with disabilities more vulnerable to maltreatment include:

- Limited communication skills to talk about and/or explain the abuse.
- Dependency on caregivers to help with daily care routines and difficulty discerning appropriate touch from abusive acts.
- Challenging behaviors that can overwhelm their caregiver.

CASCADE OF INJUSTICES

In summary, children with disabilities are at higher risk for maltreatment. We are indebted to Mary Steinberg, MD, and Judith Hylton, M.Ed. (1998) (7) for developing the *Cascade of Injustices* (below), which characterizes the ways a child with disabilities is at increased risk for further abuse and injustice.

Abuse and neglect

Not recognizing abuse and neglect as wrong

Not having a disclosure understood or believed

Not having reports of abuse investigated

Not having investigations lead to trial

Not receiving therapy for the effects of the maltreatment

Not having the therapy appropriate to their needs

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

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

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CHAPTER 2
IDENTIFYING ABILITY AND DEMYSTIFYING DISABILITY: CHILD DEVELOPMENT, ASSESSMENT, AND DEVELOPMENTAL DISABILITIES

The basis of understanding disabling conditions in children is rooted in typical child development. By learning "what went wrong" during typical development, it is easier to see what did *not* go wrong—that is, see what children with disabilities *can* do. Building upon the child's strengths and identifying adaptations and accommodations for the difficulties the child experiences enables interviewers to conduct forensically sound interviews. This chapter reviews typical child development, emphasizing four primary domains of development, which will aid understanding of the most common types of developmental problems.

TYPICAL CHILD DEVELOPMENT

People generally have formal and/or informal knowledge about children. People may be able to discuss child development informally because of their own experiences growing up, going to school, and observing how children share similarities and differences. Adults learn to understand the predictability of child development by raising children, watching others raise children, or interacting with children.

From each of these perspectives, it is apparent that all children start small and grow larger, know very little at first and learn many things very rapidly, and are often ahead or behind another same-aged child in one way or another. Hence, the *process* of child development can be sequential and predictable. The *speed* through which the process unfolds varies from child to child, but the general *sequence* through which children pass is similar. "Typical development" occurs when the process and speed of development varies little, which may be referred to as ages and stages of child development. (1)

Domains of Child Development

Child development is often described in terms of *domains*, e.g., physical development, cognitive development, and by ages and stages, e.g., the predictable process of growing from infancy to adulthood. The CDC is a helpful resource for developmental milestone information, which provides milestone markers for domains of development. (2)

Project Ability's curriculum references four primary domains of development, which are: *physical, intellectual, speech and language, and social and emotional*.

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

- Gross motor skills – use of large muscle groups for physical movement (e.g, crawling, walking, running).
- Fine motor skills (dexterity) – coordinating use of small muscles in movement, often relating use of hands and feet with eye coordination, as well as movements like grasping items and writing.

Intellectual development refers to how our brain acquires, processes, and uses information.

- Intellectual development involves both accumulation of information (learning) and processing of this knowledge.

- Development and use of reasoning and judgment are part of intellectual development.
- Intellectual development may be measured using intelligence testing as well as tests for processing and learning styles.

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

- Speech is talking, and language is a set of rules for sharing thoughts, ideas, and feelings.
- Speech begins in infancy and proper articulation of all speech sounds is usually mastered by age eight or nine.
- Language includes expressive language (messages sent) and receptive language (messages received).
- Speech and language development varies somewhat across specific languages and is certainly more complex for children growing up in bilingual homes and communities.

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

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

VARIATION IN CHILD DEVELOPMENT

Informal assessments of children's development occur often in daily life. Variation is noticeable when children do not "act their age," are taller/shorter than other children their age, or look overweight. This variation can be apparent when a child is outside expectations of how children should appear and behave at particular ages and stages. A chart of typical development is frequently used to show how close to the "age line" a particular child is. In cases where the variation is wider around the age line for a single domain, it can be explained as an *individual difference,* and the child often catches up. When the process, and/or speed of a child's development, are significantly different from most other children, it may be called a *developmental delay.* (3)

A child with a possible developmental delay should receive a formal evaluation from a health care provider, a team of multidisciplinary providers, or through school. As an interviewer, your role is *not* that of a formal evaluator; instead, it is one of recognizing the delay so you can meet the child on their developmental level and capacity.

DISTRIBUTION OF DIFFICULTIES ACROSS IDEA CATEGORIES OF DISABILITY

In order to understand the wide range of disabilities and chronic conditions, Project Ability uses categories of disability that are included in special education laws (IDEA). (4) The chart below provides examples of how disabilities can affect various domains of functioning.

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

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

VARIATION IN DISABILITIES

No disabilities affect a person's functioning in the same way. For this reason, it is important to understand that disabilities vary in severity, complexity, and frequency. For example, two children who are both diagnosed with autism spectrum disorder (ASD) can have vastly different scope, functioning and abilities. One child with ASD may have limited communication skills, sensory difficulties, gastrointestinal problems, and intellectual delays. The other child may have higher functioning abilities, including normal intellect and verbal skills, no problems with digestion, but have difficulty relating socially and emotionally to others. Additionally, certain disabilities occur more frequently than others, such as children with specific learning problems vs. children with genetic disorders. The frequency of genetic disorders among children is quite low, as compared to the frequency of children identified with specific learning problems.

Disabilities also vary according to *co-morbid* or *co-occurring conditions*. (5) This means that there are clusters of disabilities that may occur together frequently enough for a statistical correlation but not occurring in all children all the time. There is also variation among children in the *number of disabilities* they have, as some children have been identified and/or diagnosed with multiple disabilities. Regardless, it is important to remember the role of an interviewer is to understand that children with disabilities are all different in presentation and abilities. Understanding the severity, frequency and complexity of the disability paves the path toward accentuating and focusing on that child's abilities and strengths.

The next chapters discuss the four basic areas of difficulty in functioning experienced by children with disabilities: communication, intelligence, social/emotional/behavioral, and physical functioning. Then there will be chapters reviewing accommodations and considerations for interviewers to make when interviewing a child with disabilities.

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CHAPTER 3
COMMUNICATION DISABILITIES: SPEAKING, UNDERSTANDING, AND USING LANGUAGE

Project Ability's curriculum focuses on four identified domains of functioning impacted by disabilities: communication, intelligence, social/emotional/behavioral functioning, and physical functioning. This chapter explains how disabilities can impact *communication.* Project Ability identifies communication-related disabilities as the developmental disabilities that interfere with the ability to speak, use, and/or understand language.

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

In situations where there is concern of abuse to a child, an interviewer's role is to elicit a narrative from the child that provides details, context, and clarification about said events in a forensically sound, non-leading, and child-focused way. If the child has difficulties with communication, the job of eliciting a narrative may be more difficult and may require accommodations by the interviewer.

This chapter will discuss ways that disabilities may impact a child's communication.

COMMUNICATION DISABILITIES

Difficulties with communication fall into two main categories – speech and language.

- ***Speech*** is the production of understandable sounds and words. Speech includes articulation (making sounds/words using mouth, lips, and tongue), voice (use of breath and vocal cords to make sounds), and fluency (the rhythm of speech).
- ***Language*** is how words are put together to share ideas, feelings, and information. Language involves both expressive and receptive processes.
    - *Expressive* language refers to how the child expresses their thoughts, ideas, and feelings.
    - *Receptive* language refers to what the child hears and understands.

A child can have difficulty with speech, language, or both. (1)

Speech and language problems range from mild to severe. These problems may include simple mispronunciations of certain sounds, not understanding spoken or written language, or damage of the oral-motor muscles and nerves used for speech and feeding. Many times, the actual cause of speech and language problems is unknown. However, hearing loss, brain injury, intellectual delays, or birth defects - such as cleft lip and palate - are associated with speech and language problems. (2)

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

1. What the child says.
2. What we hear.
3. What the child understands about what we say.
4. What we understand about what the child says.

When children experience communication difficulties, they may have challenges with learning, understanding, and using language. When these difficulties are not due to other conditions such as hearing loss or autism, a child may be diagnosed with developmental language disorder (DLD). DLD is a communication disorder that affects a child's speaking, listening, writing, and reading abilities. DLD also has been known as specific language impairment, language delay, or developmental dysphasia. DLD is quite common, affecting approximately 1 in 14 children in kindergarten, and this disorder can persist into adulthood. (3)

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

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

SPEECH DEVELOPMENT

Human speech is a series of distinct and complex parts that ends in an understandable verbal message. Children learn vocabulary quickly. By 18 months, typically developing children have up to 20 words in their vocabulary, at 24 months up to 300 words, and by age three children can have mastered as many as 1,000 words. As preschoolers, children continue to expand their vocabulary, but the greatest development occurs in the language area – grappling with grammar, syntax, the abstraction, and utility of language for communicating ideas, thoughts, and feelings. (2)

For more information on infant and toddler speech and language development, please refer to the NICDC Fact Sheet on Speech and Language Developmental Milestones. (4)

PROBLEMS WITH SPEECH

Functional Speech Sound Disorders

Functional speech sound disorders include difficulties with motor production of speech sounds and linguistic production of speech. These disorders are often referred to as articulation disorders and phonological disorders. (5) Articulation disorders include errors in the production of speech sounds. For example, a child can substitute one sound for a different sound (e.g., "wabbit" for "rabbit", or "wong thick" for "long stick"). Other common articulation errors include omissions of a sound in a word (e.g., "g_een _ees" for "green trees"), distortions of words in which a child produces a sound in an unfamiliar way ("men" for the word "pen"), and addition of sounds within a word (e.g., "runuh" for "run").

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

Diagnoses Associated with Speech Problems
In preparation for an interview, certain diagnoses related to speech problems might be noted in available records. If so, it may be helpful to research the diagnostic criteria and characteristics for such diagnoses. Speech resource information can be found through the American-Speech-Language-Hearing Association (www.asha.org), the National Institute of Deafness and Other Communication Disorders, (https://www.nidcd.nih.gov/) and the National Institutes of Health at www.nidcd.nih.gov.

Examples of specific speech disabilities include diagnoses such as Apraxia and Dysarthria.

Apraxia, sometimes called dyspraxia, is a motor disorder where children have trouble planning and making the very precise movements of the lips, tongue, jaw, and palate that produce understandable speech sounds. Some common characteristics associated with apraxia include difficulty making and maintaining sounds, vowel distortions, limited repertoire of consonants and vowels, and problems completing certain sounds in the beginning, middle, and/or end of a word.

Dysarthria is a more involved articulation problem caused by oral and facial muscle weakness or paralysis. Children with dysarthria often have a history of feeding problems and may have other medical conditions as well.

PROBLEMS WITH LANGUAGE
During interviews, the child's language abilities may affect how they can relay their experience in a way that is understandable and clear. The interviewer's use of language is equally important. Interviewers are expected to ask clear questions in a child-friendly and developmentally-appropriate manner to elicit narratives from the child about their experience.

Two types of language are necessary for communication to occur. These types are *expressive* language and *receptive* language. Difficulties with expressive and/or receptive language are considered speech and language disorders (7).

Expressive Language
Children with expressive language disorders have difficulty with verbally expressing their thoughts and feelings. They may have limited accessible vocabulary or have difficulty articulating complex sentences and/or remembering words. Common symptoms and characteristics of a child with an expressive language disorder include:

- Provides shorter, less complex sentences when expressing themselves than their same-aged peers.
- Has difficulty finding words needed to express thoughts.
- Uses "empty" words, such as "this," "that," "thing," instead of using descriptive words.
- Uses words in the wrong context or in confusing ways.
- Hesitates to answer questions or provides minimal-word responses to questions.
- Talks in circles without clearly making a point.
- Repeats or "echoes" a speaker's words.

Children experiencing difficulties with expressive language can experience lower self-esteem, learning problems, and social isolation. If they are often misunderstood or have difficulty articulating their thoughts, then they may be less likely to provide running narratives or have the patience to continually correct people who cannot understand them. However, it is important to know that a child who has difficulty with expressive language may have age- and developmentally-appropriate receptive language skills. Their comprehension of language may be normal without any impairment. Therefore, it may be necessary for children with expressive language skills to receive appropriate services, such as speech and language therapy, as needed. (6)

Receptive Language
Receptive language involves attending to, processing, understanding, retaining, and integrating a spoken message into context. Children with receptive language deficits may have difficulty understanding directions or they may struggle filtering out background sounds and conversations to concentrate on what is being said to them. Some characteristics of receptive language issues include:

- Difficulty remembering strings of words said or following complex/compound questions.
- Difficulty comprehending the context of what is being said or conveyed.
- Difficulty understanding subtle social and nonverbal forms of communication such as body language, facial expressions, and taking turns in conversations.
- Difficulty maintaining attention long enough to fully take in what is being said to them. (8)

Children with receptive language deficits can sometimes mask their lack of comprehension because their expressive language skills could be developmentally appropriate.

SPECIFIC DIAGNOSES ASSOCIATED WITH COMMUNICATION DISABILITIES
Many of the symptoms associated with expressive and/or receptive language are part of the diagnostic criteria for various disabilities, such as autism spectrum disorder (ASD), learning disabilities, and attention deficit hyperactivity disorder (ADHD). Please note that this curriculum is not meant as a diagnostic tool or guide. Interviewers do not need to diagnose disorders; instead, interviewers must understand areas of functioning that a disability may impact so they can find ways to accommodate and help the child.

Autism Spectrum Disorder (ASD)
Autism spectrum disorder (ASD) is a neurodevelopmental disorder that impairs a child's ability to communicate and interact with others. (9, 10) In 2013, the American Psychiatric Association's Diagnosis and Statistical Manual of Mental Disorders (DSM-5) incorporated several previously separated disorders into this single disorder. The disorders previously considered separate included autism, Asperger's syndrome, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (PDD-NOS) (9).

Criteria for ASD includes two domains of impairment: 1) Social interaction and social communication, and 2) restricted interests and repetitive behaviors, which includes sensory differences and challenges (9). Fact sheets and more information can be found on the Centers for Disease Control and Prevention website at www.cdc.gov/ncbddd/autism/facts.html (11) and the National Institute on Deafness and Other Communication Disorders (NIDCD) website at www.nidcd.nih.gov/health/autism-spectrum-disorder-communication-problems-children. (12)

Symptom severity and frequency can vary widely between individuals diagnosed with ASD. Signs and symptoms of ASD typically are present before age three and include the following:

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

ASD can impact all four domains of functioning identified in Project Ability's curriculum as illustrated in the table below.

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

Table 2. Effects of ASD by developmental domain

In this section, we will focus on the communication aspects of ASD. However, it is important to remember that the distinction between communication problems and social and emotional difficulties is artificial because of the interrelationships of these developmental domains. Please refer to Chapter 4: Social and Emotional Disabilities, for more information regarding ASD's impact on social and emotional development.

Communication difficulties for children with ASD

Children with ASD may have difficulties developing language, understanding what others say to them, and using and/or interpreting facial and non-verbal gestures, making communication quite challenging. As stated previously, communication skills and capacities vary greatly among individuals with ASD. Some children may have a rich vocabulary and can discuss topics of interest in great depth while other children may have minimal vocabulary. Most children with ASD do not have problems with speech and pronouncing words, but almost all children with ASD have some difficulty with expressive and receptive language skills.

Some hallmark communication challenges for children with ASD include the following: (12)

- ***Repetitive language*** – A child with ASD may use words without any context or meaning within a conversation. For example, a child may list models and makes of cars when asked about their day.
- ***Echolalia*** – A child repeats words or phrases heard over and over; the repeated words may be immediately echoed, or there can be a delay before the child repeats the words. Children with ASD may use echolalia when they do not understand what has been said to them and/or when they are unable to make a response using more appropriate speech. An example of echolalia would be a child repeating "How are you?" when asked about his or her day.
- ***Unusual tone or speech pattern, lack of eye contact*** – Children may speak in a monotone way, without inflection or emotion noted in their speech. They may have pressured speech and may appear disengaged although this might not be the case.
- ***Narrow interests and exceptional abilities*** – Some children may be able to converse in-depth on topics of interest but cannot engage in a two-way conversation about this topic. For example,

the child interested in cars can provide all details about the cars of interest, but when asked which car is their favorite, the child is unable to respond or continue the conversation.

- ***Unable to read non-verbal cues, understand abstract concepts, or understand sarcasm*** – Common slang, "dry-humor," and subtle gestures can be very difficult for a child with ASD to understand. Generally, people with ASD are concrete in thought and understand literal concepts. Thus, talking about a person having a "chip on their shoulder" may be interpreted literally by the person with ASD as a person who has a potato chip placed on the shoulder.
- ***Difficulty providing personal narratives of events, social situations, and experiences*** – A narrative (also called a story) includes the use of written or spoken words or images presented in a sequential manner that connects events, actual or imaginary, coherently. A child with ASD may have difficulty providing a personal narrative because they have difficulty connecting events in a personally meaningful way and then relaying that information in a familiar and cohesive way to another person. (13)(14)(15)

Social (Pragmatic) Communication Disorder

The DSM-5 (2013) (16) identifies Social (Pragmatic) Communication Disorder (SCD) as a condition in which children persist with difficulties with social verbal and nonverbal (pragmatic) communication. In the past, children with SCD often were identified with ASD, Pervasive Developmental Disorder - Not Otherwise Specified (PDD-NOS), or Asperger Syndrome. This new disorder's important distinction from ASD is that children with SCD do not present with repetitive behaviors or restricted interests in the way ASD does. In summary, children with SCD have challenges understanding and engaging in socially relevant conversations. The DSM-5 indicates the following difficulties: (9)

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

Learning disabilities

Learning disabilities are neurologically based processing problems that can interfere with the ability to read, write, and understand math. Additionally, learning disabilities can interfere with organizational skills, time management, abstract reasoning, comprehension, attention, and memory (long-term, short-term, and working memory). (17)

According to the IDEA statistics (2021 -2022), children identified with specific learning disabilities are the largest group that qualify for special education services in public schools. Learning disabilities are often identified when a gap is noticed between a child's potential for achievement and the actual level of performance. Learning disabilities are not a result of low intelligence but rather a function of how the brain receives, processes, and responds to information. People with learning disabilities often have average to above average intelligence. Children with learning disabilities can often master strategies for success. These strategies can mask the difficulties, which lead to learning disabilities often referred to as "hidden disabilities" because the child looks and acts "normal." (17)

Learning disabilities include:

- Dyslexia – trouble understanding written words; reading disability.
- Dysgraphia – trouble forming letters or writing in a defined space.
- Dyscalculia – trouble with mathematical concepts and arithmetic.
- Auditory and visual processing disorders – trouble understanding written or spoken language despite normal vision and hearing.

- Nonverbal learning disabilities – discrepancy between stronger verbal skills and weaker gross or fine motor skills, visual-spatial abilities, and social skills; often there are difficulties interpreting non-verbal cues such as understanding facial expressions.

Learning disabilities also can impact a child's working memory. *Working memory* involves retaining pieces of information and processing this information together at the same time in bigger chunks (18). For instance, when a child reads, the child's working memory holds onto the words, then the sentence, and then the paragraph, to process the content of what is read. When a child has difficulty with some facet of memory storage and retrieval, learning and processing of information can be negatively impacted.

It is important to remember that learning disabilities are not always apparent or reported. Indicators that a child with a learning disability may be struggling with processing information include:

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

Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD)'s essential diagnostic feature is a "persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development." (16) In the past, children either received a diagnosis of ADHD if they presented with hyperactivity and/or impulsivity, or they received a diagnosis of ADD (attention deficit disorder) if the child did not show signs of the hyperactivity. Now, ADHD is used as the primary diagnostic label, but has three types: (19)

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

ADHD will also be discussed in Chapter 4 on Social and Emotional Disabilities, as this disorder can affect impulse control, social skills, and behavior. In this section we will highlight ways ADHD can impact a child's communication abilities.

Deficits with attention can certainly interfere with communication (20). When a child lacks attentional skills, the child may not be able to focus on a sentence, paragraph, or conversation long enough to hear the entire message, let alone keep the message in mind long enough to develop a response, send a meaningful reply, and then wait for the next message. Also, the multitude of stimuli in our environment can compete for the child's attention during a conversation, thus causing the child to easily distract off topic and have difficulty being redirected back to the conversation at hand.

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

- **Hyperactivity and impulsivity** – The hyperactive child struggles with maintaining attention while tuning out the surrounding stimuli. The child can be fidgety, loud, and fast moving. Children with hyperactive tendencies often have trouble sitting still in class and following appropriate public behaviors if movements are supposed to be suppressed. They also may be impulsive in nature and unable to process consequences before acting on the impulse.

- **Distractibility** – A child does not need to present with hyperactivity to struggle with attention. A child may be easily distracted because their train of thought is interrupted by other thoughts or external distractions. This child might seem lost in thought or is considered a daydreamer.
- **Hyperfocus** – This attentional problem involves "getting stuck" on a topic or activity (hyperfocus) to the exclusion of all other stimuli. With hyperfocus, children have difficulty changing their focus from one topic or activity to another. A child may talk on and on about very small and specific details of a topic and not be able to move smoothly to another question or different aspects of the topic. If the child's hyperfocus is prematurely interrupted, it can be very difficult for the child to transition to a different topic or activity.
- **Saliency** – Children with ADHD also struggle with the saliency (meaning and relevance) of a detail. This can be described as a "figure-ground" problem. The interviewer may ask an open-ended question to which the child provides numerous responses. However, the child who struggles with saliency has difficulty knowing what the topic at hand is (foreground) and what is less relevant (background). Thus, the child's responses to the open-ended question may be off-topic or a non sequitur to what was being asked.

It should be noted that children often can be identified to have both ADHD and learning disabilities. The general characteristics of learning disabilities mentioned above are frequently seen in children with ADHD, resulting from both the inattention feature of ADHD and the associated learning difficulties. These children struggle when answering complex or vague questions. They may use filler words such as "um," "thing," or "stuff" while searching for the correct word, and they may provide a confusing order of words, numbers, or sequence in a story. However, these children can give a detailed account of their experiences if given time, structure, and accommodations to do so.

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CHAPTER 4
SOCIAL AND EMOTIONAL DISABILITIES: SOCIALIZING, FEELING, AND BEHAVING

INTRODUCTION

Social and emotional development begins at birth and drives human behavior. It includes a child's ability to understand and process their own experiences, manage their emotions, express their internal states, needs, and desires, and develop positive relationships with others. (1)

Emotional development

Emotional development includes the ability to understand one's own feelings and accurately perceive and relate to other's emotions. Emotional development also involves the ability to regulate one's emotions and behaviors, expressing themselves in a socially-acceptable manner. In other words, children learn that if they act out certain feelings, such as love, then generally this produces a positive response in others. Conversely, acting out feelings of selfishness or hate usually creates a negative response in others. Children learn that even when one "feels" a certain way, they should still "behave" in a socially acceptable manner, thus learning that feelings can be controlled by thinking before acting.

Social development

Social development determines how we integrate our personal needs and desires with the desires and needs of the group. Social behaviors include how we greet and treat people, how we function in a social order, and how we respond to authority. Children learn social behaviors through imitation, instruction, practice, and occasionally, through traumatic events.

Social behaviors include actions that demonstrate:

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

Clearly, one's culture influences social development, but the above social guidelines exist in most cultures.

Development of social and emotional difficulties

Some children demonstrate atypical development in social and emotional domains. This can be due to biological and/or neurological differences. They can also result from a child not receiving appropriate modeling and reinforcement of the social norms or ways to regulate emotions. (2)

The following situations demonstrate examples of this:

- Children are exposed to and imitate socially-unacceptable behavior. Alternatively, they lack appropriate instruction about how to address their needs being met in a socially appropriate context.
- Children experience loss or trauma, creating feelings and needs that override their ability to moderate their behavior.
- Children are exposed to multiple stressors over a long period of time including poverty, residential instability, abuse and neglect, discrimination, oppression, and parental stress.
- Children experience a disturbance in brain biochemistry.

Behaviors that suggest difficulties in social and emotional domains include:

- *Externalizing behaviors* (acting-out behaviors) – non-compliance with directions or with people in authority. The behaviors can include oppositional behaviors such as hitting and fighting, destroying property, and stealing.
- Internalizing behaviors (opposite of aggression) – depression, mood and anxiety disorders, somatic complaints, and self-harm.
- Inability to regulate or calm themselves when upset.
- Poor social skills – unable to make and maintain friends and/or immature and atypical behavior for age (acting much older or younger than chronological age).
- Difficulty making or maintaining eye contact when interacting with others.
- Impulsivity and lack of awareness about their behavior's impact on others.

Of note, children with social and emotional difficulties often experience difficulties with social interactions, relationships with parents or authority figures, and school performance. These deficits can have long-lasting impacts on physical health problems into adulthood. (2)

Useful resource information on children's mental health disorders and social and emotional disabilities can be found on the Centers for Disease Control and Prevention (CDC)'s website (3) located at http://www.cdc.gov/childrensmentalhealth/basics.html.

COMMON DIAGNOSES AND PRESENTATIONS IN SOCIAL AND EMOTIONAL DIFFICULTIES

Anxiety Disorders

Symptoms of anxiety disorders may include an elevated state of worry or tension, rumination, and increased irritation. Children with these symptoms may not be able to articulate their anxieties or just "not worry about it." The anxiety may also be accompanied by physical manifestations (somatic symptoms), including fatigue, headaches, insomnia, irritability, and gastrointestinal complaints.

Some common anxiety disorders in children include: (4)

- *Generalized anxiety disorder* – General worries and concerns about numerous aspects of their lives including school, family, and impending disasters.
- *Panic disorders* – Episodes of physical symptoms that accompany feelings of terror or extreme worry, including sweating or chills, tingling or numbness, and dizziness or fainting.
- *Social anxiety disorder* – Persistent fear of negative experiences in social settings or with other children, including worrying about judgment by others or doing something that causes embarrassment or shame.
- *Obsessive*-compulsive disorder (OCD) – Experiencing intrusive (obsessive) thoughts and use of rituals (compulsions) to control anxiety, but over time the rituals end up controlling the child. Examples of rituals include counting things, insisting on a specific order or sequence of a certain activity, or washing hands excessively.
- *Posttraumatic stress disorder (PTSD)* – A child experiences or witnesses trauma, then re-experiences the trauma through images, sounds, odors, and/or feelings associated with the trauma.

Trauma

As noted above, PTSD is categorized as an anxiety disorder. (4) Not all children who experience trauma will develop PTSD. Trauma reactions are not homogeneous and can differ between two children who experienced the same traumatic event. The way a child expresses their distress also depends on the child's age and level of development. (5) However, a child who presents with trauma symptoms can also present with social and emotional difficulties.

Common signs and symptoms of trauma reactions in children include:

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

Depression

Depression is characterized by feelings of sadness, isolation, hopelessness, pessimism, guilt, and/or worthlessness that can interrupt enjoyable activities and interests. Other symptoms of depression include changes in appetite (overeating vs loss of appetite), fatigue, insomnia, difficulty concentrating or maintaining attention, and difficulty making decisions. Children with depression may demonstrate mood swings, resist going to school, and have increased irritability or aggressive behaviors. (6)

Attention Deficit Hyperactivity Disorder (ADHD)

Children with ADHD often struggle socially due to the behaviors associated with this disorder. (7) As a result of behavioral challenges, children are at risk of social isolation from peers, poor academic achievement, low self-esteem, substance abuse disorders, behavioral difficulties like delinquency and oppositional behaviors, and development of mood disorders like depression or anxiety. (8)

Examples of behaviors that interfere with social development include:

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

Oppositional Defiant Disorder (ODD)

The hallmark feature of oppositional defiant disorder is persistent and frequent pattern of an angry, agitated, and/or irritable mood, often with the presence of argumentative, defiant behaviors and vindictiveness. (4) Children with this disorder often act stubborn, are disobedient, deliberately annoy others, and shift blame from themselves to others. Such behaviors can be present only in certain situations, such as at home or with family members, but the pervasiveness of symptoms across aspects of daily life (in public, at school, etc.) is indicative of the disorder's severity. ODD often co-occurs with ADHD. (9)

Autism Spectrum Disorder (ASD)

Autism spectrum disorder characteristics are discussed in Chapter 3: Communication Disabilities. Briefly summarizing, children with ASD present with difficulties in two domains of functioning: 1) social interaction and social communication, and 2) restricted interests and repetitive behaviors, which includes sensory differences and challenges. (4)

Difficulties in social interaction and communication pose challenges when interviewing children with ASD. (10)(11)(12) The deficits include:

- Difficulty providing and articulating narratives of personally-experienced events.
- Difficulty relaying episodic memories from free recall prompts.
- Difficulty understanding socially relevant, salient details of historical events.
- Difficulty understanding nonverbal communication.

- Difficulty with gist representation of an event (pairing a “meaning” to an event versus providing concrete, specific details that are not connected to emotion or relatability).
- Tendency to incorporate unrelated events during autobiographical narratives.

Children with ASD also display emotions in a variety of ways. When overwhelmed, a child may or may not articulate their feelings. The child may display increases in repetitive and/or restrictive behaviors, such as a child who flaps their hands in front of their eyes. If the child becomes increasingly agitated, stressed, or uncomfortable, the child might begin flapping their hands more frequently and intensely instead of using their words to express such feelings. Other children might disengage from the conversation or activity and retreat to something more desirable to them.

Such difficulties with social and emotional communication and behaviors does not mean a child cannot have a meaningful interview. Research shows that children with ASD can provide accurate narrative accounts of historical events, but often require communicational supports, such as more focused and direct questions. (11)(12)(13)(14) Please refer to Chapter 10 for appropriate accommodations interviewers can make to support children during forensic interviews.

Social (Pragmatic) Communication Disorder (SCD)
Social (Pragmatic) Communication Disorder (SCD) was also reviewed in Chapter 3, Communication Disabilities. SCD is a condition in which children persist with difficulties in social verbal and nonverbal (pragmatic) communication. (4) SCD’s distinction from ASD is that children with SCD do not present with repetitive behaviors or restricted interests like children with ASD. In summary, children with SCD have challenges understanding relevant topics within a conversation or can struggle engaging in communication that fits within a socially-accepted context.

The DSM-5 indicates the following difficulties: (4)

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

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CHAPTER 5
INTELLECTUAL DISABILITIES: THINKING AND REASONING

Intellectual disabilities (ID) are characterized by limitations in intellectual functioning and adaptive behaviors. Intellectual functioning refers to one's general mental capacity (thinking, learning skills) and reasoning or problem-solving skills. Adaptive behavior is the development of conceptual, social, and practical skills utilized in daily life. (1) Intellectual disabilities typically occur during the developmental period (birth to age 22) and persist throughout one's lifetime.

Intellectual disabilities are heterogeneous conditions that are either congenital (a condition present at birth) or acquired (e.g., a severe infection such as meningitis or a traumatic brain injury). Terms previously used for ID include mental retardation, cognitive disability, or cognitive impairment.

Often when referring to a child with ID, there is mention of "mental age" versus chronological age. For the purposes of Project Ability, a child's "mental age" is associated with current academic functioning as compared to peers who are the same chronological age. Sometimes, when a child is referred for a forensic interview and an intellectual disability or difficulty is noted, a child might be identified as functioning at a lower "mental age" (performing at a lower grade level in some or all of their academic functioning than their chronological age). (2) For example, a 12-year-old child is working academically at a 1st grade level and is described as having a "mental age" of six. Depending on the source of this information (IEP vs quick assessment by someone who just met a child), this can be quite variable and possibly inaccurate. This 12-year-old child may have a strong vocabulary and have the emotional development closer to their same-aged peers but may have difficulty with reading and math skills. Thus, gathering as much information as possible regarding the child's strengths and understanding their areas of difficulty is important. It is critical that any professional working with a person with ID treat them with respect and do not infantilize the person (e.g., talking and/or treating the child like they are much younger than their chronological age) given their intellectual functioning. However, the child's intellectual functioning information can be helpful in assessing and planning for current communication abilities and conceptual (thinking/reasoning) abilities for the interview. (2)

Children with ID are particularly vulnerable to maltreatment due to a myriad of difficulties including (3):

- Social skills.
- Ability to assess for risk.
- Reliance on others for daily care needs.
- Communication skills.

Depending on the severity, the DSM-5 (3) categorizes ID in the context of intellectual and adaptive functioning as mild, moderate, severe, or profound. The categories include:

Severity Level	Thinking and Reasoning Abilities	Social Functioning	Practical Functioning
Mild	Difficulty with academic learning (reading, writing, math, problem solving) Difficulty with abstract concepts (time, money)	Immature interactions with others compared to same-aged typically developing peers, which includes: - Difficulty understanding social cues from peers - Simple concrete language	May have age-appropriate personal care skills. May need support with complex daily living tasks when older, such as:

	Poor executive functioning skills (planning, organization, prioritizing) Short term memory and working memory deficits	- Immature emotional regulation and behaviors - Gullible and at risk of being manipulated Able to develop strong friendships and relationships.	- Grocery shopping - Transportation - Nutritious food preparation - Banking/money management
Moderate	Throughout development, child's intellectual functioning is noticeably behind peers Academic progression develops slowly and is limited compared to peers As adults, academic skill development is often at an elementary level	Social judgment, decision making skills, and social communication are markedly different and immature compared to peers Simple, non-complex language skills Able to develop close relationships and develop romantic relationships when older	During childhood, may need adult assistance with daily care routines and hygiene Extended period of education and training needed to become self-sufficient in daily care routines Will need support from others for complex tasks (money management, etc.)
Severe	Limited ability to understand written language or numerical concepts (math, time, money)	Vocabulary and grammar is quite limited and simple. Verbal skills may include using single words or phrases Use of augmentative communication may occur with simplistic representations of items or needs Relationships with family and friends are very positive and a source of pleasure	Caregivers provide extensive support for daily care routines and adaptive skills throughout their lifetime
Profound	Very limited capacity for learning and symbolic processing	Very limited language skills and ability for symbolic communication	Reliant on others for daily care routines and adaptive skills

		Expresses needs and desires through simple nonverbal gestures and sounds	throughout their lifetime

In general, children with mild to moderate ID can participate in forensic interviews. Research indicates that children with ID can recall forensically-relevant, accurate accounts when best practices are utilized, including the use of open-ended free-recall prompts without the use of repeated, suggestible questions. (2)(4)(5) Unfortunately, biases against children with ID, including the concern for increased suggestibility and presenting as poor eyewitnesses, have led to under-reporting and prosecution of abuse cases against children with ID. (2) For interviewing best practice and accommodations, please refer to Chapter 11: Accommodations – Intellectual Disabilities.

General Presentation

As compared to typically-developing, same-aged peers, common presentations of children with ID are dependent upon the severity of the condition, including:

- Immature conversation style (simple vocabulary, shorter sentences, concrete in thought).
- Immature social behaviors (seems younger in presentation than chronological age).
- Difficulty with abstract concepts (time, complex humor).
- Literal interpretation of words and gestures.
- Limited or immature problem-solving skills.
- Tendencies toward compliance and pleasing adults.
- Impulsivity in decision making.
- Difficulty with short-term memory and working memory.
- Normal sexual development but may lack ability to perceive danger or manipulation in relationships.

Specific diagnoses associated with ID

Down syndrome is a genetic condition with a duplication of chromosome 21. Physical characteristics include low muscle tone, flat nose, small mouth and ears, slanted eyes, short arms, and a large head. In addition, people with Down syndrome are at increased risk of heart disease, sleep apnea, and hearing loss. Down syndrome may cause delays in physical development and intellectual functioning. However, functional capacities vary greatly among individuals with Down syndrome. (6) Many people with this syndrome can live independently, build healthy relationships, and maintain jobs.

Children with Down syndrome are likely to have expressive language difficulties, including limited vocabulary, shorter utterance length, simple sentence structure, and difficulty with articulation. They may also have difficulties with short-term memory and limited attention span. (7) In contrast, their receptive language skills, including non-verbal skills, are an area of strength, albeit possibly still behind compared to same-aged typically developing peers. (2)

Autism spectrum disorder (ASD)

ASD has been discussed throughout Project Ability. ASD can impact several domains of functioning including communication, social-emotional behaviors, and intellect. It should be noted that approximately 30–40 % of individuals with ASD also have identified ID. (8)

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CHAPTER 6
PHYSICAL DISABILITIES: HEARING, VISION, MOVEMENT, AND HEALTH

The fourth category of disability identified in Project Ability's curriculum deals with conditions directly related to physical functioning – hearing, vision, movement, and maintaining health. This area is diverse. It includes broad categories from the Individuals with Disabilities Education Act (IDEA), such as "orthopedic impairment," "hearing impairment," and "other health impairment." (1) Numerous chronic physical conditions may affect a child's performance in school and their ability to participate in an interview. For example, a child with physical disabilities who takes medications can experience side effects from the medications that may influence their speech and attention more than the underlying conditions themselves.

Definitions and classifications of physical disabilities vary widely. The IDEA categorizes disabilities that impact a child's movement or the structure of their body under "orthopedic impairments," which typically include orthopedic and neuromuscular disorders. The IDEA uses the term "other health impairments" to describe conditions that cause special health care needs or health disabilities for children. (2) These conditions affect a child's physical functioning, as well as their alertness to the stimuli in their environment, which ultimately can affect their educational performance. (3) Conditions in this category include chronic heart problems, asthma, attention deficit hyperactivity disorder (ADHD), diabetes, traumatic brain injury, epilepsy, lead poisoning, sickle cell anemia, and Tourette syndrome. Other types of physical disabilities involve difficulties with seeing and hearing. Both visual impairment and hearing impairment are complex disorders with varying degrees of severity and the need for support (such as assistive technology including computer screen readers, hearing aids, or cochlear implants).

SELECTED DIAGNOSES AND PRESENTATIONS IN PHYSICAL DISABILITIES

Vision impairment and blindness includes difficulties with vision that adversely affects a child's educational experience and performance, even when visual correction (e.g., glasses) are used. (4) This term encompasses low vision (also referred to as partial sightedness) and total blindness.

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

Most people experiencing vision impairment and blindness have some form of sight or ability to see light and dark, while approximately 15% of the visually impaired population experiences total blindness. (4)

Deaf or hard of hearing includes the impairment of hearing, either permanent or fluctuating, that adversely affects a child's educational experience and performance. (3) The IDEA notes that deafness involves hearing impairment so severe that the child's processing of linguistic information through hearing, with and without amplification, is impaired. (5) Deafness is a term that generally refers to one's inability to hear speech without a hearing aid, and hearing loss is a term that describes reduced hearing acuity. Depending upon the severity of hearing loss, deafness can range from mild to profound. (6) Variations of deafness include the level of hearing, age of onset, communication methods, and cultural identity. It is important to note that the deaf and hard of hearing community is diverse. However, when a person refers to themselves as Deaf (with the uppercase usage), this refers to a group of people who share a common language (e.g., American Sign Language [ASL]), heritage, and culture. (7) The use of the lowercase "deaf" refers to an audiological condition in which a person has profound hearing loss, implying very little to no hearing. (8)

Children who are deaf or hard of hearing are at increased risk of abuse, including neglect, emotional abuse, physical abuse, and sexual abuse. (9) There is a myriad of reasons for this increased vulnerability, including social isolation due to:

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

As interviewers, it is important to understand how the child who is deaf or hard of hearing communicates and what accommodations are needed to enhance communication with the child. For details, please refer to Chapter 12 on accommodations for physical disabilities.

Cerebral palsy is a group of disorders that affect movement, posture, and sometimes speech. Cerebral palsy is caused by a brain injury early in life, most often before, during, or soon after birth. The primary injury is in the brain and it is static; the degree of impairment does not change, but complications or secondary conditions may result in decreased function over time. (10)

Cerebral palsy's effects can range from mild to severe, and most often affect the child's mobility. Many children with cerebral palsy can walk unaided and are able to enjoy most activities of childhood. Other children who are affected more profoundly may require mobility aids such as braces or a wheelchair. In addition, a child with cerebral palsy may present with:

- Speech and articulation difficulties, such as dysarthria (articulation problems caused by oral or facial muscle weakness).
- Drooling (due to difficulty with swallowing, not because of excessive saliva production).
- Learning disabilities or intellectual disabilities due to brain injury.
- Difficulty managing impulse control or difficulty focusing (associated with ADHD).
- History of feeding difficulty resulting in poor nutrition. (10)

Children with speech and communication difficulties associated with cerebral palsy may use augmentative communication devices that can aid with communicating.

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CHAPTER 7
GENERAL ACCOMMODATIONS FOR CHILDREN WITH DISABILITIES

All forensic interviewers should adhere to current best practices when conducting forensically sound interviews of children. Accommodations for children with disabilities build upon established interview guidelines. In Oregon, interviewers should follow the Oregon Child Forensic Interviewing Guidelines (OIG, 2024). Please note, this chapter reviews important interview preparation questions and considerations as well as general interview accommodations for any child with disabilities. Subsequent chapters will expand upon the general accommodations and will review more specific accommodations depending upon the area of functioning (communication, social/emotional, intellectual, and physical) that is most impacted by the child's disability.

PREPARING FOR THE INTERVIEW

The goal of Project Ability curriculum is to simplify one's thinking about disability as it pertains to the four primary domains of development. Regarding forensic interviewing for children with disabilities, preparation for the interview is important. These questions were developed for interviewers to use as a guide when preparing for and thinking about interviewing children with disabilities. They are meant to rethink disability and place emphasis on understanding and capitalizing upon the child's strengths. By asking these preparatory questions, the interviewer can quickly organize what is known about the child and what is still needed to be known before proceeding to an interview.

The interview preparation questions are:

Does this child have a disability or difficulty with:

Speaking, understanding, and/or using language? (Communication)

Socializing, feeling, and behaving? (Social and Emotional)

Thinking and reasoning? (Intellectual)

Hearing, vision, movement, and maintaining health? (Physical)

How does the disability affect *this* child's functioning?

What strengths and abilities does the child have?

What accommodations are established for this child (at home or

Question 1: "Does ***this child have a disability or difficulty with…?"*** relates to the four domains of functioning discussed throughout Project Ability. Consider what areas are most impacted for the child. When referencing the child, always use person-first language, which means that you acknowledge the child/person who has a disability instead of identifying the disability first. So, you would say "Emmy who has autism" versus "autistic Emmy."

Question 2: "***How does this disability affect this child's functioning?"*** explores more detailed information about the child's current level of functioning, presentation, and how significant the effects of the disability are. This question should be a starting point for obtaining more specifics about the child's functioning. Examples of questions that stem from asking about the effects of the disability's impact on functioning within each domain, include:

- Communication – What does the difficulty look like for this child? Does the child have expressive communication issues (talking, being understood) and/or processing challenges (understanding questions or instructions)?
- Behavioral issues – What does it look like when the child is stressed/overwhelmed? How do they handle transitions or changes in their routine?
- Intellectual – What is the child's current reading level? Math level? Do they play with kids their own age, or younger? Are they receiving special education services or do they require academic support at school?
- Physical – Does the child require assistance with walking, talking, hearing, seeing? Do they have any chronic medical conditions? Does the child take medications? If so, when do they take them? Are morning or afternoon appointments better?

One can find answers to the above questions by asking caregivers and adults who work and interact with the child. If time and access allow, additional information can be found in school records, such as an Individual Education Plan (IEP), which documents level of functioning, current strengths, weaknesses, and academic/behavioral accommodations at school. Other resources could include medical records or collateral reports, like police reports or Child Protective Services (CPS) reports.

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

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

Caregiver input should never be overlooked. Caregivers typically have the best understanding of how the child communicates, functions, and the current accommodations established for the child. Other adults who know the child – such as extended relatives, teachers, and therapists – also can provide similar input.

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

- Ask the guardian what the child does well at school or home.
- Ask about special interests and areas in which the child finds success and/or pride.
- Ask about the child's preferred communication styles.

Finding out about these strengths and talking to kids about them shows respect, but also can help build rapport and trust, and provide important information for how the interviewer will structure their questions and interactions with the child.

Question 4: ***"What accommodations are established for this child (at home or at school)?"*** Learning about the accommodations the child has at home and/or at school can help guide what

accommodations should be considered for the interview. Parents and/or caregivers typically have knowledge of beneficial accommodations for a child. Some sample questions that could assist in identifying accommodations for children within the four domains of functioning include:

- Communication – What is the best way to communicate with your child? Do they use short sentences? Do they need extra time to think after questions are asked? Do they have an augmentative and alternative communication [AAC] device? If they have an AAC – what do they use? Can you bring it to the clinic? Is there an online tutorial about this device?
- Behavior – What strategies are in place when your child's behaviors escalate? How do they calm themselves? Do they have fidgets or other calming items they can bring? How do you help the child with transitions?
- Intellectual – Does your child do well with their current academic accommodations in school? How do they express themselves when they are confused or tired? Do they have anything they can bring that helps them feel comfortable in new surroundings? Do they need preparation for transitioning between activities?
- Physical – Ask about any physical accommodations the child would need in the clinic. Inquire about medications that the child takes and how the medication(s) affects the child. Ask what time of day is best for the interview (for example, when are the medications at peak performance?).

Question 5: ***"What would help this child during the interview?"*** This question focuses on the accommodations and preparations specific to the forensic interview process. Some examples of questions include:

- Would the child like to watch a video about the Children's Advocacy Center (CAC) prior to the evaluation (if available)?
- Would the child benefit from a storyboard that explains the evaluation (picture of the waiting room, picture of the examination room, picture of the interview room).
- When should the interview occur if the child takes medications? For instance, schedule the child for a morning evaluation if the child is on a short-acting ADHD medication.
- Give a tour of the CAC's rooms before the actual start of the interview. For example, have the child and guardian walk through the waiting room, exam room, interview room and observation room so they have a better understanding of the space and what is to be expected during their evaluation.
- Use a floor lamp instead of overhead fluorescent lights if the child is sensitive to certain lighting.

CONSIDERATIONS FOR THE INTERVIEW SETTING

Important considerations that can often be helpful for children with disabilities:

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

INTERVIEW GUIDELINES

All forensic interviewers should adhere to current best practices when conducting forensically sound interviews of children. Accommodations for children with disabilities should build upon the interview guidelines established within Oregon. The structure of the interview should remain the foundation of any interview of a child; however, accommodations can be made at any time and as needed when the standard process for the interview is not meeting the child's needs.

In Oregon, interviewers should follow the Oregon Child Forensic Interviewing Guidelines (OIG, 2024) (1). Refer to the OIG for more information.

GENERAL ACCOMMODATIONS FOR CHILDREN WITH DISABILITIES

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

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

During the interview:

- Review roles, introductions, and aspects of the interview room again, even if these were reviewed when meeting the child in the waiting room.
- Use the child's name frequently throughout the interview to maintain attention.
- Spend time establishing rapport.
    - Use this time to listen to the child's speech and language as well as the child's ability to respond to open-ended, more abstract questions.
    - Notice if the child has difficulties providing details and/or running narratives regarding neutral topics or interests.
    - Rapport also allows the child to relax and feel safe.
- Clearly review ground rules and answer options. Consider slowing down the explanation of the ground rules and answer options, reviewing them one at a time.
    - Give the child time to process each question before moving to the next answer option.
    - Practice with the child if developmentally appropriate.
    - Reinforce accurate answers.
- The narrative practice is a very important component of the interview. If the child provides few responses and/or is unable to provide long, sequential narratives to an open-ended invitation (e.g., "Tell me everything"), the interviewer can use cued invitational prompts to scaffold questions. Cued invitational prompts are considered within the continuum of open-ended prompts but provide the cue to the topic at hand (2). For instance, a cued invitational prompt incorporates something the child said or a specific piece of information that cues the child to the topic to be discussed. An example could be asking the child to tell you everything about a specific event like a recent birthday. If the child provides some information, then the interviewer can scaffold questions using the child's words to elicit more details. However, continually return to open-ended and/or cued invitational prompts as much as possible. When scaffolding questions, use the child's words as cues and incorporate them in a way that organizes the narrative's direction. For example:
    - Interviewer: "Sam, tell me everything you did during your birthday party."
    - Sam: "Ate cake, opened presents."
    - Interviewer: "Ok, so tell me the first thing that happened at your birthday party."
    - Sam: "My friends came over."
    - Interviewer: "Your friends came over, then what happened next?"

    - Sam: “We played.”
    - Interviewer: “You played, then what did you do?”
    - Sam: “Mom got the cake.”
    - Interviewer: “After the cake, then what happened?”
- If cued invitations and scaffolding questions helped during the narrative practice, this structure most likely will be needed when exploring the topic of concern. If limited details are provided in response to the cued invitations, then ask focused questions to elicit details. However, utilize open-ended prompts/questions as much as possible. For example,
    - Interviewer: “Jake, how come your mom brought you to the clinic today?”
    - Jake: “Joey touched (points to genitals).”
    - Interviewer: “What do you call that part where you are pointing?”
    - Jake: “My private.”
    - Interviewer: “Jake, tell me all about Joey touching your private.”
    - Jake: “He touched it with his hands.”
    - Interviewer: “Where were you when Jake touched your private?”
    - Jake: “I was in my bedroom.”
    - Interviewer: “Tell me all about Joey touching your private from start to finish.”
    - Jake: “He came in, pushed me down, and touched it.”
- It may be necessary to directly introduce the topic of concern if the child does not transition to the topic of concern. For instance, the interviewer may need to ask about a particular action without introducing the actor. Or the interviewer can introduce the name of the person (actor) without stating the action. For example:
    - Interviewer: “Sue, how come you came to the clinic today?”
    - Sue: “I don’t know.”
    - Interviewer: “Sometimes kids come here if someone is worried about them. Is anyone worried about you?”
    - Sue: “No.”
    - Interviewer: “Sometimes kids come here if someone is worried that a kid has been hit or hurt on their body. Is anyone worried about that happening to you?”
    - Sue: “No.”
    - Interviewer: “Ok, so, you know I talked with your mom today. She said she was worried about a bruise on your arm.”
    - Sue: “Oh yeah, this one.” (Shows upper arm bruise).
    - Interviewer: “Tell me how you got the bruise.”
- Using tools during the interview can also help elicit details about the concerns. Tools can help ground and organize a child’s narrative. Tools include maps, drawings, or asking the child to use gestures or show body positioning.
    - **Maps** help organize location and can focus the child. The interviewer can refer to the child’s map to help structure questions, including where the child and/or alleged person of concern (POC) were, who else was there, and peripheral details of the surroundings (sounds, smells, details of the room).
        - Reassure the child that the maps (or drawings) can be simple and do not need to be perfect.
        - Asking the child to articulate what they are drawing can elicit additional details.
        - If the child has difficulty drawing, offer to draw for them but have them provide the details to include in the map. Do not assume or add any details on the map without the child’s input. The map could be a box with an X to indicate where the child was and where the POC was.

- **Drawing pictures** of the abuse incident. As the child draws, the interviewer can periodically check-in with the child and ask about the drawing (e.g., "What is this?" "Bed.") Or, if the child is able, have them narrate out loud what they are drawing. Use open-ended/cued invitational prompts regarding their drawing. For example:
  - Interviewer: "John, you said this was the bed. Tell me about the bed."
  - John: "I on it." (John then draws an X on the bed and a bigger X by the bed).
  - Interviewer: "John, tell me about this big X. (Point to the big X. Do not make assumptions about the drawings. Always inquire what the child is drawing and use the child's language).
  - John: "That uncle."
  - Interviewer: "Tell me about Uncle."
- The use of **anatomically detailed dolls** can be quite helpful for a child to show what happened (such as body positioning, clothing positioning, force, body movement, etc.). Dolls should be used only after a disclosure has been made.
  - ***The interviewer should be trained in appropriate protocols within their jurisdiction on the use of anatomically detailed dolls before utilizing these tools.***
- **Gestures** include showing body movements and actions. For instance, a gesture can include the child showing how they were hit (fist, open hand, etc.), where they were touched (pointing to the specific body part), or body positioning (show on the floor how your body was facing).

- Introducing evidence is another consideration when cueing a child's memory and transitioning to the topic of concern. However, interviewers should review appropriate protocols and discuss with MDT partners before introducing evidence. There are trainings available that address how to introduce evidence. Examples of evidence include police reports, text messages, journals, and photographs.
- Be patient and **PAUSE** often!!
  - Allow the child time to speak, process questions, and express themselves before posing the next question.
  - Resist filling in the blanks for a child if they are not speaking in full sentences.
  - After the child's narrative, pause then use part of their statement without adding more words. For instance:
    - Child: "Steve had the belt, and it was black."
    - Interviewer: "Steve had the belt… (long pause)."
    - Child: "Yeah, and then he started whipping it around".
    - Interviewer: "Show me how he whipped the belt around."
- When posing questions, remember:
  - Use short sentences with only one idea per sentence.
  - Start with open-ended and cued invitational prompts. If these are difficult for the child, then move toward focused questions. Move back to open-ended and cued invitational prompts whenever possible.
  - Use yes/no (closed ended questions) sparingly. If the child provides an affirmative response, follow-up with open-ended questions as much as possible.
  - Avoid or use multiple choice (closed ended questions) sparingly, and again follow-up with open-ended questions.
  - Avoid using double negatives.
  - Avoid asking "why" or "if" questions.
  - Use the child's words whenever applicable and clarify terms the child uses. For example: "Addy, you said daddy was mean. Tell me about Daddy being mean."

    - Allow the child to express their feelings, or to express no emotions at all.
    - Allow for long silences.
    - Avoid infantilizing the child (e.g., “baby talk”).
- As best practice dictates for any interview, avoid asking the number of times any incident occurred. Focus on specific events, which can ground the child and help them provide idiosyncratic details of that event.
    - If a child uses descriptive words indicative of multiple events, “always, every time, etc.”, ask the child about a time something different happened, including different locations.
    - Avoid asking about dates or when something happened. Instead, ask about the location of the event (what house, what did the house look like, any other home), or the location of others.
- Pay attention to the child's responses to questions. Are they patterned (always responding with “I don’t know,” or if multiple questions were posed, continually picking the last answer)? Patterned responses could indicate that the child is fatiguing or avoiding the topic, or they do not understand the question. Consider checking in with the child.
- If a child is showing signs of fatigue or their attention is waning, consider having the child return for a follow-up interview.

Multiple interviews/extended assessments

The use of multiple forensic child abuse interviews historically has not been included in forensic interviewing guidelines but is now considered potentially beneficial for some children who have been abused, including for children who experienced multiple types of maltreatment, children reluctant to disclose, preschool-aged children, and children with disabilities. (3) Multiple interviews about an abusive event can elicit more details over several sessions and can provide more complete accounts of the event. (4)

Multiple interviews/extended assessments should follow best practice guidelines (open-ended questions, cued invitational prompts, etc.), and avoid leading and suggestive interviewing techniques. (3)(4)(5). Some benefits resulting from multiple interviews of children with disabilities include:

- If a child is too distressed, multiple interviews offer the child the opportunity to build trust and rapport with the interviewer across interviews.
- If a child has a short attention span, multiple interviews accommodate by allowing for shorter interviews.
- Multiple interviews, when conducted with open-ended and cued invitational prompts, tend to elicit more recall of new information about abuse.

Multiple interviews should occur if your CAC and multidisciplinary team are supportive of this practice. Follow best practices and consider additional training on how to conduct multiple interviews before utilizing this strategy. Additional considerations for multiple interviews of children with disabilities will be discussed in the upcoming accommodation chapters.

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CHAPTER 8
ACCOMMODATIONS: COMMUNICATION DIFFICULTIES

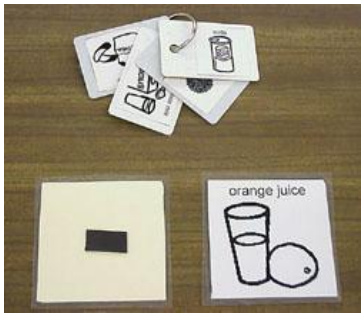
The accommodations discussed below are based upon current best practices for forensic interviews. In Oregon, interviewers should follow the Oregon Child Forensic Interviewing Guidelines (OIG, 2024). The information contained in this chapter builds upon the accommodations discussed in Chapter 7: General Accommodations for Children with Disabilities.

The interview approach for children with communication disorders will depend on the type and extent of the disorder. Use the 5 interview preparation questions outlined in Chapter 7 to help identify what difficulties the child experiences and what additional information may be helpful when interviewing the child.

Preparation considerations specific for communication disabilities

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

- Does the child have *speech or articulation* problems?
    - If so, ask for clarification on what speech or articulation difficulty is present. What does this sound like? Does the child compensate for the speech difficulties? If so, how?
    - Ask how the child typically responds when misunderstood. Will they become frustrated, or will they correct the adult?
- Does this child have *receptive or expressive language* difficulties? How will the interviewer know if something said is not understood by the child?
- Does this child communicate in other ways (gestures, writing, needs extra time to process, etc.)?
    - Exploring this question gives insight into the child's personal adaptations to their challenges and identifies their strengths.
- Does this child use communication tools or aids, known as *augmentative and alternative communication (AAC)* devices? An AAC is the supplement for, or replacement of natural speech, writing, or unaided symbols (3). If the child uses an AAC, interviewers should try to familiarize themselves with the tool used and have the child demonstrate how they use it before the interview begins as well as during the rapport building phase of the interview.
    - AAC can range from simple systems (pictures) to very complex computer programs that generate speech from typed words or images. (2)(3) Examples include:
        - **Picture point communication systems**. These are boards that include pictures, photos, or other visual aids. They are sometimes on boards or on computer apps, which the child can refer to and point to. These boards help children with expressive language skills.
        - **Picture Exchange Communication Systems (PECS)**. The child uses visual representations (e.g., pictures or photos) to give to someone so that the child can receive said object. For instance, the child has several photos of food and/or drinks available. The child picks the photo of the drink he wants and hands it to his teacher in order to receive that item.
        - **Break cards**. The child can use a break card when needing a break from an activity, or when



needing some quiet time. The child uses this card as an appropriate way of communicating this message rather than becoming increasingly anxious or frustrated in the moment.

        - **Social Story Board.** Use of pictures or icons to tell a story or communicate information. For the purposes of an interview, it may be helpful to have pictures taken of the building, entrance, waiting room, exam room, and/or interview room in the sequence the child will enter throughout their evaluation. Laminating them and putting them on a board or in sequential order can help communicate what the child should expect for the evaluation. Use of these social story boards can help provide clear, concrete information to the child while also giving a visual guide, so they feel more prepared and less worried about the unknowns of the evaluation process. (4)
    - Another form of assisted communication is ***facilitated communication*****.** Facilitated communication involves a facilitator assisting an individual with a severe communication problem by physically guiding their hand to type or write so that the person can provide responses to questions and relay desires/needs. Facilitated communication is controversial and has been discredited as a reliable form of communication by numerous experts and in much literature. ***Facilitated communication should not be used to conduct a forensic interview*****.**

INTERVIEW ACCOMMODATIONS FOR COMMUNICATION DIFFICULTIES

Interviewing children with disabilities should begin and progress in a similar manner to interviewing a typically-developing child. The accommodations discussed in this chapter should occur as needed and/or when the interviewer notices the standard protocol for the interview is not meeting the child's needs. Even with the accommodations recommended, interviewers should attempt to use open-ended prompts as much as possible, which allows the child to relay their story in the most accurate manner. Cued-invitational prompts should be used if general open-ended prompts are too vague for the child. (5) The cued-invitational prompt incorporates words the child used (e.g., "You talked about your birthday, tell me all about your birthday"). Use of focused questions (e.g., "Wh" questions) may provide some children with the organization and structure needed to help them tell their experience in a cohesive and concise way and provide clarifying details. (6)(7)

Accommodations for speech and articulation difficulties

- Minimize distractions in the interview room.
- Look at the child when they speak. Notice if they seem to use hand gestures with words when they speak.
- In the beginning of the interview, explain that the child's words might be repeated by the interviewer to ensure they are being understood. Also, explain that the interviewer's role is not to guess about what is being said.
    - For instance, tell the child, "Susie, it's my job to make sure I don't guess about words you say. I may repeat the words you say to make sure I heard you correctly."
- Positively reinforce the child if the child corrects the interviewer when misunderstood.
- Offer the child the option to write or draw a picture of their response.
- Allow the child to stutter, stammer, and pause.
- Resist temptation to "fill-in" the word that the child is trying to say.

Accommodations for receptive and expressive language difficulties

Receptive Difficulties:

- After any question is posed, **PAUSE!** Pausing gives a child with processing difficulties time to understand the question and formulate a response.
- Use the child's name. This helps ground the child in the moment. It also lets the child know you are listening and interested in them.
- Ask one question at a time. Give the child a chance to answer the question before moving to another question.
- When reviewing ground rules and answer options, stress the importance of stating if the child does not know an answer. Practice a question the child might not know. For example:
    - Set up the practice by clearly stating: "It's ok to tell me if you do not know an answer. Let's practice. What if I asked, "What's my cat's name?" Pause to give the child a chance to answer.
    - If the child guesses a name, it is fine to clarify with them that they actually do not know the cat's name. Then consider practicing again. Ask the same question. If the child says, "I don't know," then positively reinforce this answer.
- Pay attention to eye contact, body language (squirming, grimacing), and other cues, such as the child changing the subject or providing a non-sequitur response (response that does not answer or follow the question). This might be indicative of the child not understanding a question.
- Periodically check-in with the child to make sure they understood the question. For example:
    - "Sam, was that a hard question to understand?" If he says yes, then offer to ask the question in a different way. Or the interviewer can say: "That was a hard question. Let me ask it in a different way."
    - Consider having the child repeat your question in their words but avoid sounding punitive. If they cannot do this, then the child might not have processed the question. Regardless, thank them for trying and rephrase the question.

Expressive Difficulties:

- After any question posed, **PAUSE!**
    - The child may require extra time to formulate their thoughts and responses to questions before they are able to state them.
- If the child has difficulty expressing their thoughts, ask if they prefer to write or draw instead of speaking. Offer the child different communication tools, such as writing their response, drawing a picture, drawing a map, using anatomically detailed dolls, or using gestures to show what happened.
    - For details regarding these tools, please refer to Chapter 7: General Accommodations for Children with Disabilities.
- Repeat the child's statement periodically to make sure they were understood. Positively reinforce the child if the child corrects the interviewer.
- Clarify pronouns and use identifiers and/or proper nouns whenever possible.
    - If the child continually says "he" when talking about an incident, the interviewer should ask who "he" is. The interviewer should then use the name of the person during follow-up questions. ("You said Uncle John hit. Then what did Uncle John do?")
- Not all children will speak in full sentences. Resist the temptation to fill in the blanks in sentences. If the child did not finish a sentence, it is ok to repeat what they said and pause. For example:
    - Child: "Then Aunt Becky did…" (Pause).
    - Interviewer: "Then Aunt Becky did…" and wait for the response. If no response, the interviewer can say "Aunt Becky did what?"

- If a child responds to multiple questions with automatic responses, such as "I don't know," check-in with the child. Ask them if the question was a hard question. Offer to state the question differently, or just ask the question in a different way. For example:
    - Interviewer: "You said Fred hit you, tell me all about Fred hitting you."
    - Child: "I don't know."
    - Interviewer: "Is that a hard question?"
    - Child: "Yes."
    - Interviewer: "Ok, let me ask it differently. Where did Fred hit you?" Child points to arm. "Show me how Fred hit you" Child shows a punch to the arm.
    - Interviewer: "What did Fred hit your arm with?" Child shows a fist.
    - Interviewer: "Show me how Fred hit" Child demonstrates a punch to his arm.
- Another option for addressing a child who frequently responds to questions with "I don't know" is to ask the child "Tell me what you do know."
- Pay attention to signs of fatigue, agitation, or frustration. If the child is showing signs of fatigue, consider bringing the child back for a follow-up interview.
- Before concluding the interview, check-in privately with MDT partners. The partners might hear information said by the child differently than the interviewer, which is important to know. The people monitoring the interview may have helpful suggestions on re-wording difficult questions or other communication accommodations helpful for the child.

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

Accommodations for children with learning disabilities

- Offer different modes of communication to relay narratives (orating the narrative as well as inviting the child to show what happened by gestures, positioning, pointing).
- Allow for silence. The child may need additional time to process.
- Ask one question at a time.
- Avoid asking the number of times any incident occurred. Focus on specific events, which can give context to the child and help them provide idiosyncratic details of that event.
- If a child uses non-descript "empty words" during narratives (e.g., that, there, those, thingy, etc.), ask for clarification on each non-descript word. For example:
    - Alex: "He hit me with that and then those things happened."
    - Interviewer: "Who hit you?"
    - Alex: "Joe."
    - Interviewer: "Joe hit with what?"
    - Alex: "He hit me with the belt."
    - Interviewer: "Joe hit you with the belt, then what happened?"
    - Alex: "Those things happened."
    - Interviewer: "Tell me what those things were that happened?"
    - Alex: "You know, those things."
    - Interviewer: "Alex, it's my job not to guess. I wasn't there, so help me understand what you mean when you say "those things."
    - Alex: "Like tying me up and yelling at me."
    - Interviewer: "Tell me all about being tied up."

ADHD:
As stated previously, children that have attentional issues do not necessarily present with hyperactive traits. Therefore, it is important for the interviewer to explore details about the child's attentional challenges. In this chapter, accommodation strategies for ADHD relate to how the attentional challenges affect communication.

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

Accommodations for children with hyperactivity

- Limit distractions in the interview room.
- If a child speaks loudly and at a quick pace, be patient. The child might not possess the self-awareness necessary to regulate their voice or pace in the moment. If the child's pace or loudness is not disrupting their narrative, sit patiently and listen.
- If a child speaks in long-running, fast narratives that are difficult to track, check-in with the child periodically to make sure you are understanding them.
- Take notes of salient details in the narrative. When a child pauses or finishes their narrative, check-in with the child. Cue the child using the piece of salient detail and ask them to clarify or provide more information.
- The interviewer can also summarize what the child said using the child's own words afterward. Always remind the child that they should correct the interviewer if they got something wrong. Use the child's language from their narrative when summarizing. Summarizing can help organize the child and direct them to continue a more cohesive narrative. For example:
    - Hazel: "I went into the room. It was dark and spooky. Things seemed to be everywhere, and I was totally freaked out. I am running around, bumping into things, and I kept hearing them. They were crazy loud. I didn't know what to do and bumped into the bed, then fell on some shoes. I was crying and my leg hurt. There was crashing and I kept trying to find my phone. I couldn't because it was dark. I get freaked in the dark. It still was loud, and I was scared."
    - Interviewer: "Ok Hazel, let me make sure I understood you. You said you went into a dark room and heard them. Who did you hear?"
    - Hazel: "Mom and Dad."
    - Interviewer: "So you heard Mom and Dad, and they were loud. You said you were trying to find your phone in the dark, then you heard crashing. Is that correct?"
    - Hazel: "Yes."
    - Interviewer: "Tell me all about the crashing."
- Allow opportunities for the child to move and squirm in their seat or move about the room. Children with hyperactive tendencies often struggle with the internal need for movement (kinesthetic energy) vs having to expend mental energy to focus on a conversation. When children have opportunities to release the kinesthetic energy, they are actually better able to attend to conversations.
    - Offer fidget toys or Play-Doh so the child can fidget and/or play with the Play-Doh while talking.
    - Consider allowing the child to sit on a pillow or something that has some movement under them. This allows them to move in their seat.
    - Have the child draw or color a picture during the interview.
- Allow the child to move about the room as long as the child is not putting themselves at risk of injury (e.g., jumping off table).

    - Give the child opportunities for movement during the interview.
    - It is ok to remind them not to jump off things or move in a way that compromises their safety or yours.
- If you sense the child is too distracted, say the child's name and ask them to look at you. Repeat your question when they look at you.
    - Interviewer: "Jimmy." Child continues to run around the room and does not respond.
    - Interviewer: "Jimmy, please look at me." The interviewer pauses and waits for the child to look. Child continues to move but looks at the interviewer.
    - Interviewer: "Jimmy, how did X make you feel?"
- Pick your battles. Having a child moving around the room may be distracting to you as an interviewer, but having the child sit still – especially if they are talking about something that is upsetting or distressing – could negatively compromise the productivity of the interview.

Accommodations for children with attention issues without hyperactivity

- Provide clear interview instructions. Check-in with the child to make sure they are following you and understand interview expectations. This allows the interviewer a chance to assess how well the child is attending.
- Pay attention to the amount of time you are speaking vs the child is speaking. If you as the interviewer are speaking more than the child, then there is potential for the child to lose interest or become distracted.
- Use the child's name to ground the child and retain their attention.
- Ask the child to repeat a question if there are concerns for inattention. For example:
    - Interviewer: "Dylan, I want to make sure you understood my question. Tell me in your own words what I just said."
- Do not use compound questions. Try to keep questions to one thought at a time.
- Listen for patterned responses from the child, which may indicate the child is tuning out of the interview and/or disengaging from the process. If you sense patterned responses, pause and ask the child how they are doing. Reinforce the opportunity for the child to state if they do not know an answer or to ask for clarification if needed.
- Consider concluding the interview if you feel the child has disengaged. Ask the child if they would want to come back on a different day to talk more about the concerns.

CHAPTER 8 REFERENCES

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CHAPTER 9
ACCOMMODATIONS: SOCIAL AND EMOTIONAL DISABILITIES

The accommodations discussed below are based upon current best practices for forensic interviews. In Oregon, interviewers should follow the Oregon Child Forensic Interviewing Guidelines (OIG, 2024). The information contained in this chapter also builds upon the accommodations discussed in Chapter 7: General Accommodations for Children with Disabilities.

The interview approach for children with social and emotional disabilities will depend on the type and extent of the disability. Use the 5 questions outlined in Chapter 7: General Accommodations for Children with Disabilities to help identify difficulties the child experiences and any additional information that may be helpful when interviewing the child.

Preparation considerations for social and emotional disabilities

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

- What are the child's baseline behaviors at home or when in neutral settings?
- Does the child present with specific difficulties and/or behaviors? For example:
    - Verbal perseverations
    - Compulsive behaviors
    - Self-harming behaviors
    - Assaultive behaviors (to self or others)
    - Sexualized behaviors
    - Hyperactive behaviors
    - Oppositional behaviors
    - Withdrawal
    - Sensitivity to environmental stimuli (noises, mirrors, crowded rooms, etc.)
- What behaviors and/or reactions does the child have when stressed or anxious?
    - Does the child articulate feeling stressed or anxious?
    - Does the child act aggressively when upset, or does the child regress or shut down?
- What coping mechanisms does the child use when upset? Can these techniques be used during the interview?
    - Does the child have a calming object, like a stuffed animal, that they can bring to the interview?
    - Does the child articulate when they are tired or when they need to stop an activity?
- Does the child take medications for their disability? If so, when are the medications administered and when does the medication tend to wear off?
    - Consider scheduling the evaluation when the medications are at peak performance.
- Can the child tolerate sitting still for an interview, or will they do best when given the opportunity to move about the room?
- Are there current accommodations in place for the child that can be replicated during the forensic interview?
    - Do the caregivers or school personnel utilize a particular strategy to identify difficult behaviors and help the child de-escalate?

General accommodations during interview

Beginning the interview:

- After introductions in the waiting area and an explanation of the interview process, allow the child to ask questions about what to expect and details about the interview room.

    - Consider giving the child a tour of the interview room, and the rooms where people are monitoring the interview, before starting the interview. This can alleviate anxieties and help establish the ground rule that nothing is kept secret from the child.
    - If the child has difficulty separating from the caregiver, spend more time with the caregiver and child together, or invite the caregiver to transition the child to the interview.
- Once the interview starts, review roles and ground rules clearly.
    - Explain that the interviewer's role is to ask questions to get to know the child.
    - Review the ground rules slowly and one at a time.
    - Practice answer options, if developmentally appropriate. Reinforce answers, such as "I don't know" responses, and the child correcting the interviewer.
        - If the child corrects the interviewer during the interview, thank the child for making the correction.
    - If the child is difficult to understand or speaks quietly, explain to the child that you might repeat what they say to make sure they were understood and not because they got something wrong.
- Spend time building rapport.
- Conduct the practice narrative.

During the interview, consider the following:

- If a child provides long-running rambling narratives, remain patient. Listen for salient details during the narrative that you can address in a follow-up question. Use the child's words if possible.
- Allow for silences between questions or after the child provides a narrative. Silence can evoke additional details from the child.
- Be patient and flexible with the child. Follow the child's lead and structure questions accordingly.
- Allow the child to move, crawl, wiggle, or fidget as kinetic activity may be a way for the child to calm themselves.
    - If the movement or behaviors become disruptive for the child or the interview, set limits with the child in a gentle but firm manner and redirect the child if necessary. For example, if a child is attempting to jump off the chair during the interview:
        - Interviewer: "Sage, please don't jump off the chair. I don't want you to hurt yourself. It's ok to move about the room if you want."
- Power struggles with children who have behavioral challenges tend to shut down any productive interaction.
    - Pick your battles; set clear and reasonable boundaries.
    - If the child is too distracted or reactive, consider offering the child an opportunity to return on a different day to talk about the concerns.
- If the child is teary, seems distressed, or is very quiet, consider acknowledging the difficulty of discussing the topic at hand by saying, "It seems hard to talk about." If it is, consider taking a break from the subject to talk about something less difficult, then return to the subject when the child seems composed.
    - If it is too difficult for the child to continue, offer the child the opportunity to return for a follow-up interview.
- If the child seems agitated, offer the child other tools of communication, such as mapping out a room, drawing a picture of the event, or showing what happened using demonstration or body positioning.

- If available, consider the use of a facility or therapy dog. This dog should be certified, and the interviewer should be trained in proper use of the dog. The facility/therapy dog can help a child with behavioral or emotional difficulties ground, regulate, and focus.

Considerations for specific disabilities

Anxiety Disorders and Trauma Reactions: If a child has a history of anxiety, gather as much information as possible about the child's presentation when anxious and what techniques the child uses to calm down if anxiety escalates. Trauma reactions can occur with or without a diagnosis of PTSD. Interviewers should have a basic understanding of common trauma reactions in children. Trauma reactions include physical reactions (somatic complaints, increased heart rate, changes in eating or sleeping patterns), intellectual/cognitive changes (difficulty concentrating, difficulty with transitions, hypervigilance, intrusive thoughts), emotional reactions (increased fears and worries, dysregulation, sadness, numbing emotions, and withdrawal), and behavioral reactions (increased impulsivity, increased aggression, self-harm, and substance use). (2)

If the child does not have a diagnosed anxiety disorder, but the child becomes anxious (either visibly or by stating such), then consider the following:

- Encourage the child to take a few deep breaths before continuing.
- Say the child's name and ask them to make eye contact. This can help the child ground themselves if they are disassociating or experiencing emotional numbing.
- Ask the child how they are doing and/or if it is hard to talk about. Ask if it is ok to continue talking about what happened.
    - If the child can continue, consider moving away from the abusive or traumatic event and instead ask more neutral questions, such as questions regarding details about the room, or where the incident occurred. Return to abuse related questions if the child seems calm.
    - If a child expresses increased distress when talking about the incident, or it is apparent that the child is becoming reactive, consider changing the subject to an unrelated topic. For example, if the child talks about sexual abuse by father but is becoming overwhelmed, seems flooded by emotion or memory, etc., ask the child what they liked about their father. Or change the subject totally to a neutral topic. Return to discussing the abuse concern if the child calms and/or the child articulates they can continue talking about the topic.
- Consider bringing the child back on a different day to continue the interview. Ask the child if this is something they could do. For more information on multiple non-duplicative forensic interviews, please refer to the OIG (2024).

Oppositional Defiant Disorder (ODD): If a child has oppositional behaviors, avoid power struggles during the interview. Interviewers should follow interviewing best practices (reviewing roles, interview process, rapport building, reviewing ground rules, etc.) as this provides children with clear information and expectations. Additional considerations include:

- Allow the child to move about the room as long as they can remain safe.
- Do not emotionally react to oppositional behaviors. Pick your battle; set clear and reasonable boundaries.
    - For instance, if a child is throwing Play-Doh hard against a mirror in the room, but is not hurting the mirror, consider allowing this action if it is not too distracting. If the child throws Play-Doh at the interviewer, ask the child not to do this as this could cause an injury. Redirect the child to coloring or another safe activity.

- If the child continues to be disruptive and/or is unsafe, consider ending the interview and rescheduling for a different day.

Autism Spectrum Disorder (ASD) and Social (Pragmatic) Communication Disorder (SCD): Social and emotional accommodations, as well as communication accommodations for children with ASD and SCD, are discussed in Chapter 10: Accommodations: Autism Spectrum Disorder (ASD) since difficulties with both communication and social/emotional functioning are hallmarks for this disorder.

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CHAPTER 10
ACCOMMODATIONS: AUTISM SPECTRUM DISORDER (ASD)

The accommodations discussed below are based upon current best practices for forensic interviews. In Oregon, interviewers should follow the Oregon Child Forensic Interviewing Guidelines (OIG, 2024). The information contained in this chapter also builds upon the accommodations discussed in Chapter 7: General Accommodations for Children with Disabilities.

Children with ASD have a wide range of abilities, challenges, and presentations. Regardless of their presentation, children who have been diagnosed with ASD experience difficulties in two domains of functioning: communication and social/emotional functioning. Thus, accommodations for interviewing children with ASD will be discussed in this chapter as it relates to communication difficulties as well as social and emotional difficulties.

Preparation considerations specific for ASD

Prior to interviewing, use the 5 interview preparation questions found in Chapter 7 to gather information on the child's communication abilities and their social and emotional functioning abilities, as well as additional information which may be helpful when interviewing the child.

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

- Does this child engage in conversations, or does the child present with echolalia and provide minimal personal narratives about his or her experiences?
- If a child does present with echolalia, how does the *echolalia* occur?
    - Does the child repeat statements several times, but provides a response if given time, or does the child utter repeated statements that are non-sequitur to the topic discussed and cannot provide any additional information during conversations?
    - Does the child use Augmentative and Alternative Communication (AAC) devices and services for communication? These AAC devices can range from simple systems to very complex computer programs that generate speech from typed words or images. (1) For examples of AAC devices, including Picture Point Communication Systems, Picture Exchange Communication Systems (PECS), and Break Cards, please refer to Chapter 8: Accommodations: Communication Disabilities.

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

- Does the child have difficulty expressing their emotions? Can they express simple emotions, such as bad, mad, sad, or happy?
- Does the child react to different sensory input from their environment (e.g., fluorescent lighting that makes a "humming" sound; ticking clocks)?
- Does the child have difficulty with crowded rooms or loud children (such as the waiting room)?
- Does the child have difficulty with changes in routine? If so, what helps them prepare for a change in their routine? Would the child benefit from a social story board about the Children's Advocacy Center?
- If a child becomes agitated or fatigued, how does this present (rocking back and forth, increase in echolalia, verbalize feeling stressed)?

Gather history about the child's strengths/abilities. Such strengths may include:

- The child attends a main-stream classroom with little adult support.
- The child is performing academically at grade-level.
- The child uses communication aids to express themselves.
- The child does best in one-on-one interactions, so a quiet interview room may be suitable for the interview to take place.
- The child has an object (such as a "pet rock") that the child can hold to help them feel calm.
- The child has a special interest or expertise on a certain subject. This might be a nice neutral topic to first discuss in the interview when building rapport.
- The child needs extra time to understand processes and routines, but once they understand the child can participate in the activity.

Prepare the interview room so that potential distractions are decreased as much as possible. For instance,

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

Ideally, the interviewer should introduce themselves to the child and briefly explain the interviewer's role before transitioning to the interview room. Consider offering a tour of the interview room and any observation room before beginning the interview. This could help alleviate anxieties or difficulties with transitions or of unknown situations.

The Interview

Follow forensic interviewing best practices to include reviewing roles, aspects of the room, and interview expectations. Consider being very concrete and specific about the interview process. Allow the child to ask lots of questions about the room or about your role. Continue the interview by doing the following:

- Clearly review answer options and expectations.
    - Consider having the child practice answering questions if developmentally appropriate.
    - Review ground rule instructions, reinforcing correct responses such as stating "I don't know" or correcting the interviewer. (2)
- Build rapport and attempt to discuss a neutral topic.
    - If the child can do this, capitalize on the opportunity to ask open-ended and/or cued invitational prompts. Ask clarifying questions to determine the communication style, abilities, and any difficulties the child may have.
- Conduct a practice narrative. Use a concrete event.
    - Start with a free-recall prompt (e.g., "Tell me everything that happened"). With free recall/open-ended invitations, the focus is not on any particular type of information requested. (7) It is broad and open in nature. Children with ASD may not provide as much narrative response to free-recall prompts. If the broadness of a free-recall prompt is difficult for the child, use a cued-invitational prompt, which is still considered open-ended but uses previously disclosed content from the child (e.g., a name, activity, place, or action). (7) For example, if the child had a recent birthday, a cued-invitational prompt would be, "You said you had a recent birthday. Tell me everything you did on your birthday." Open-ended free-recall prompts and cued-invitational prompts are associated with accurate, detailed, and uncontaminated narratives regarding an experienced event. (3)(4)

- Children with ASD often benefit from cued invitations as they help the child refocus their attention on previously mentioned details (their own words) and these cues can help elicit additional narratives. For children with ASD, these cued-invitational prompts often elicit accurate and core details about the child's experiences, just as they do for typically-developing children. (4)
- Children with ASD may require more cued-invitational prompts than typically-developing children. Focused questions can also assist with gathering additional details, but the interviewer should strive to limit focused questions throughout the interview. Also, the interviewer should minimally use closed-ended questions. (4)(5)(6)
- If a child does not provide running narratives that include a beginning, middle, and end, help guide the child through the narrative with scaffolded-cued prompts. For example:
  - Interviewer: "Joey, tell me everything you did today from the moment you opened your eyes until you got to this doctor's office."
  - Joey: "I got up and then came here."
  - Interviewer: "Tell me the first thing you did when you got up."
  - Joey: "I got up and peed."
  - Interviewer: "After you got up and peed, then what did you do?"
  - Joey: "I got dressed."
  - Interviewer: "You got dressed, then what did you do?"
  - Joey: "I ate breakfast then did computer codes."
  - Interviewer: "You did computer codes, then what?"
  - Joey: "We drove here."

- Avoid use of metaphors, sarcasm, or slang. Children with ASD and SCD are literal and often lack skills associated with understanding language nuances. For instance:
  - The saying "It's raining cats and dogs outside" might be literally interpreted by the child, who then wonders if cats and dogs are truly falling from the sky.

Transitioning to the topic of concern:

- Invite the child to provide narratives in whatever capacity the child is able by asking open-ended and cued-invitational prompts.
  - Please note that children with ASD often have difficulty relaying episodic memories and often have deficits in memory processes that require social awareness and reciprocity. (8) Thus, the information the interviewer is trying to elicit with the open-ended prompts might not be relevant to the child.
  - If this is the case and the child's responses are off topic, consider using cued-invitational prompts. For example, if you ask the child "Tell me about coming to this clinic," and the child provides details about the transportation process to get to the clinic, the interviewer could then preface the transition to the substantive phase of the interview by explaining the clinic, such as: "This clinic is a place where children come if someone is worried that a child has been hit, hurt, or touched on their body." Then the interviewer could ask if someone is worried about the child. If they respond with "yes" or an answer something like "my mom," then the interviewer could follow-up by asking, "Tell me all about your mom being worried about you." If the child replies "I don't know" to the cued invitation, the interviewer could remind the child that their caregiver mentioned they have worries about the child and follow up with, "Tell me what you know about your mom's worry for you."
  - Note that children with ASD may include non-relevant details within their narrative that are extraneous or confusing. If this happens:

        - Refrain from interrupting the narrative.
        - Listen for the salient details about the topic discussed.
- If a child seems unable to move beyond special-interest topics (such as talking about the mechanics of the roller coaster instead of about the overall experience of Disneyland), allow the child to complete their thought and description. This may take a lot of patience.
- Once a child completes the special-interest narrative, redirect the child back to the topic at hand using focused questions, if necessary, and cue the child to the salient details.
    - For example, a 10-year-old girl with high functioning ASD was referred due to sexual abuse by her father that occurred two days prior. When the interviewer asked her why her mom brought her to the clinic, she replied, “My daddy licked my private.”
    - Interviewer: “Tell me everything that happened when daddy licked your private.”
    - Susie: “He licked it, then he left.”
    - Interviewer may ask some focused questions including what is her private (Susie identified her private as the part she peed from), where this happened (Susie said in her bedroom).
    - Interviewer: “Ok, so you told me that the licking happened on your bed. Tell me about being on your bed when Daddy licked your private.”
    - Susie: “I was asleep and then daddy came in and woke me. He made me cold. I don’t like cold.”
    - Interviewer: “Tell me about Daddy waking you.”
    - Susie: “I get cold at night. I get cold in morning. I need my blanket. I don’t like cold.”
    - Interviewer: “You don’t like being cold.”
    - Susie: “No, I hate cold. It is cold in Antarctica. I could not live in Antarctica.”
    - (Child continues to relay how cold it gets in Antarctica and various details of Antarctica's weather. This takes several minutes in which the interviewer listens patiently. Child pauses after the last detail, as does the interviewer).
    - Interviewer: “Ok Susie, you do not like cold. You said Daddy made you cold when he woke you. Tell me about Daddy making you cold.”
    - Susie: “Daddy sat on my bed and took off my covers. I was cold. I don’t like it cold.” Cold bothers me. Cold makes me sick.”
    - Interviewer: “Daddy took off your covers and you were cold. Then what happened?”
    - Susie: “Daddy pulled off my pants. That made me cold too. I don’t like that.”
    - Interviewer: “Then what happened after Daddy pulled off your pants?”
    - Susie: “Daddy licked my private, and I was cold.”

Additional considerations

High functioning ASD (includes children formerly identified with Asperger’s Syndrome)

Characteristics associated with children with high functioning ASD include having: (8)(7)(3)(6)

- Normal to advanced intellect and academic skills close to, if not at, grade level.
- Strong vocabulary skills and factual knowledge, but inability to provide socially- or emotionally-relevant details relating to themselves or others.
- Difficulty providing autobiographical narratives that connect relevant episodic events in meaningful ways. Children may struggle with articulating salient details of the event that the interviewer might find important.
    - This does not mean that the child cannot provide the salient details. Instead, the child may benefit from guided, general questions to elicit those details in a cohesive manner.
- Fewer responses to open-ended questions.
- Responses to questions that include idiosyncratic details not socially salient to the topic discussed.

- For instance, when discussing what the child liked about a recent trip to Disney World, the child with high functioning ASD may provide minimal details about what they liked about the trip and instead focus on the specific mechanics of a particular roller coaster.

Lower functioning ASD

Children with lower functioning ASD may present with limited verbal skills and may only speak a few words. Some children with lower functioning ASD may have age-appropriate vocabulary but are unable to process the vocabulary into conversational language. (8) These children may only be able to minimally engage in interviews, possibly answering focused and direct questions, but they may struggle to provide running narratives. They may struggle to provide peripheral, sensory, or other clarifying details that can be fruitful in an interview.

It is important for the interviewer to assess the language capacity through the available collateral information, as well as parent/caregiver reports obtained prior to the interview. Based on this information, the interviewer can attempt to structure the interview in a very specific way. Some suggestions include:

- Bring pictures of family members and relevant individuals in the child's life, including the alleged offender. The child can point to people to explain who is in his family. If they make a statement of abuse, possibly ask the child to point to the person to whom they are referring.
- Ask the child to show what happened, including pointing to body parts.
- Allow the child to speak in short utterances.
- Include the phrase or utterance in follow-up questions to help guide questioning or ask for clarification.
    - For example, if the child says “Bobby hurt.” the interviewer could ask, “How did Bobby hurt?” or “Show how Bobby hurt.”
- Assess if the child seems to comprehend questions.
- Stop if it seems that the child is not understanding the process or questions.

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CHAPTER 11
ACCOMMODATIONS: INTELLECTUAL DISABILITIES

The accommodations discussed below are based upon current best practices for forensic interviews. In Oregon, interviewers should follow the Oregon Child Forensic Interviewing Guidelines (OIG, 2024). The information contained in this chapter also builds upon the accommodations discussed in Chapter 7: General Accommodations for Children with Disabilities.

The interview approach for children with intellectual disabilities (ID) will depend on the type and extent of the disorder. Use the 5 interview preparation questions outlined in Chapter 7 to help identify what difficulties the child experiences and any additional information that may be helpful when interviewing the child.

Preparation considerations specific for intellectual disabilities (ID)

Children with ID can provide reliable, accurate, and detailed reports of their experiences. The best indicator for their success during an interview is to understand the child's current level of functioning at home, school, and in other environments. Often, researchers identify the "mental age" of a child with a disability as a useful consideration regarding the child's ability to participate in a forensic interview. (2)(3)(4)(5) "Mental age" refers to the estimation of an individual's physical, speech/language, cognitive, and adaptive skills as compared to typically developing peers. (6) Children with ID commonly present with cognitive and adaptive skills that are equivalent to younger aged children who are typically developing. It should be noted that strictly referring to and interacting with a child with ID based upon this child's estimated mental age is strongly discouraged. Regardless of a child's intellectual functioning, they should be treated with respect and their abilities should be focused upon. (6) However, it is important for forensic interviewers to understand the child's current development and functioning capacity to best structure questions during the interview. (5) Henry, et.al. (2011) summarized bodies of research and noted "***children with mild to moderate intellectual disabilities can recall forensically accurate and useful information, and that the child's mental age is a helpful indicator for the child's performance***."(5) Thus, the "mental age" can be a useful tool for the interviewer's approach and questioning of the child.

Keep in mind that the child's presentation during the interview can differ, sometimes drastically, from expectations based upon reading past reports or developmental testing. As stated in previous chapters, a child's development can vary across developmental domains. For example, the interviewer receives records indicating that a 10-year-old girl functions like a 5-year-old. During the interview, the child's language skills are much better than those of a typically developing 5-year-old. However, this child cannot read. Therefore, the interviewer may not need to make as many accommodations when interviewing the child as first anticipated.

Information about the child's mental age and/or current academic performance for a child can be identified in several ways. For instance:

- Ask the caregiver or school staff about social functioning.
    - What are the child's interests and play behaviors?
    - Is the child's social interaction age-appropriate or younger?
    - What comparable age group plays in the same manner?
- If the child has an IEP, summaries of the child's current academic skills for reading, writing, and math are located within the first few pages.

Other important information to ascertain prior to the interview includes:

- What are the child's expressive and receptive language abilities?
    - Do they speak in full sentences?
    - Are they able to be understood?
    - Do they use augmentative communication devices (AACs)? If so, can this device be used during the interview?
    - Do they require time after a question is posed to process the information?
- Does the child have any co-occurring disabilities? If so, how do these impact the child's functioning?
    - For example, children who have down syndrome can also present with some hearing loss. Hearing loss can affect a child's receptive language skills, so the child may need additional accommodations.

Accommodations for intellectual disabilities

Interviewing children with ID should begin and progress in a similar manner as interviewing a typically-developing child. The accommodations discussed in this chapter should occur as needed and when the interviewer notices that the standard protocol for the interview is not meeting the child's needs. Always attempt to use open-ended prompts/questions during interviews but consider cued-invitational prompts if the open-ended requests seem too broad. Scaffold questions as needed to accommodate the child. Limit focused questions, using them to obtain clarifying information, then return to open and/or cued-invitational prompts. Interviewers should avoid forced choice and closed-ended questions as much as possible. Research has shown that interviewers use focused, forced choice, and closed-ended questions more frequently when interviewing children with ID. (2)(3)

The interview:

- Spend time providing clear introductions and explanations of the interview process.
    - Speak at a slow pace.
    - Explain that it is ok for the child to take a break at any time.
- Do not use "baby talk" with a child even if they have a much lower "mental age" than their chronological age. Talking down to children is disrespectful. Talk in plain but concrete language.
- Assess the child's language skills throughout the interview. This will help guide how interview questions should be posed.
    - Children with ID have been found to provide less detailed, lengthy narratives to open-ended prompts (e.g., "Tell me all about the hit."), but the information tends to be accurate as compared to children with the same "mental age." (2)(3)(5)(6)
    - Asking focused questions can elicit additional details about the event (e.g., "What happened after Johnny hit?")
    - Scaffold cued invitational prompts that include the child's words to structure the child's narrative. For instance:
        - Interviewer: "Quinn, tell me about Nanna."
        - Quinn: "Nanna hit me. It hurt. I cried."
        - Interviewer: "Tell me about Nanna hitting you."
        - Quinn: "Nanna got the spanking stick and hit me here and here (points)."
    - If a child has trouble providing narratives, use prompts such as "And then what happened?" OR "Tell me more about X" or "What did X do?" For example:
        - Interviewer: "Tell me more about the spanking stick."
        - Quinn: "It's brown and hard and has writing on it."
    - Limit specific, closed-ended (yes/no), or multiple-choice questions. Children with ID have been found to be more suggestible when specific or suggestive questions are repeated several times. (5)(7) These questions can help provide clarifying information,

but the interviewer should always follow-up with an open-ended or cued invitational prompt. (3) For example:
    - Interviewer: “When Nanna hit, was Nanna happy, sad, or something else?” (Always have the last answer option in a multiple-choice question be open-ended).
    - Quinn: “She was mad.”
    - Interviewer: “Tell me about Nanna being mad.”
- Ask one question at a time.
- Pause after asking questions. Do not rush a child if they take a long time to respond. Allow time for processing and finding the words needed to relay their experience.
- Check-in with the child periodically and ask if they understood the question. Children with ID may not readily articulate when they do not comprehend a question.
- Avoid asking “why” questions.
    - The child likely will not know the answer to “why” and may feel bad about not being able to provide an answer for you.
- Offer breaks during the interview. A break can include changing the subject to a neutral topic or stepping out to use the restroom.
    - Breaks are beneficial if the child is showing signs of stress, fatigue, or discomfort.
    - The child may not articulate their need for a break, so the interviewer should remain cognizant of possible signs of stress/fatigue and offer a break if appropriate. Signs of stress/fatigue include:
        - Withdrawal and/or not answering questions.
        - Distraction (looking around, changing topic).
        - Fidgeting, hand wringing, rocking in their chair.
        - Humming/groaning.
        - Covering face, hiding.
- Consider ending the interview and having the child return for a follow-up interview if they are too distracted or fatigued. If deemed appropriate, offer the child an opportunity to return for a follow-up interview on a different day. Benefits of having the child return for another interview include: (6)
    - The first interview established the interview process and expectations.
    - The child is familiar with the interviewer, has built rapport, and may feel more comfortable and trusting of the interviewer. Feeling more at ease with the process may help the child have access to their memories without extensive prompting.
- Reasons why a follow-up interview is contraindicated include: (6)
    - The child is too stressed or experiencing trauma reactions when having to talk about an incident.
    - If multiple, suggestive, leading questions were asked during the first interview and again in follow-up interview. This can lead to the child being more suggestible and at risk of changing answers. (8)
- If the child returns for a follow-up interview, it is important to discuss any contamination issues with community providers and with caregivers. For more information about conducting follow-up interviews, please refer to Chapter 7.

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CHAPTER 12
ACCOMMODATIONS: PHYSICAL DISABILITIES

The accommodations discussed below are based upon current best practices for forensic interviews. In Oregon, interviewers should follow the Oregon Child Forensic Interviewing Guidelines (OIG, 2024). The information contained in this chapter also builds upon the accommodations discussed in Chapter 7: General Accommodations for Children with Disabilities.

The interview approach for children with physical disabilities will depend on the type and extent of the disability. Use the 5 interview preparation questions outlined in Chapter 7 to help identify what difficulties the child experiences and any additional information that may be helpful when interviewing the child.

Preparation considerations specific for physical disabilities

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

Prior to the interview

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

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

Interview strategies for specific diagnoses

Deaf and hard of hearing

Gather information about the child's means of communication, which includes:

- When did the child acquire hearing loss (e.g, at birth, or after an infection in the recent past, etc.)?
- How do the child's parents/caregivers/school staff communicate with the child? Are the parents Deaf or hard of hearing, or are the parents hearing?
    - Children whose parents and/or primary caregivers expose them at early stages of development to sign language, such as American Sign Language, have been found to acquire normative language skills. (2)
- What communication does the child use at home and/or at school?
    - American Sign Language (ASL) may be the preferred choice, or the child may favor verbalizing their words or writing their words instead of using ASL. The child's writing may reflect the grammar and syntax of ASL more than English.
    - Deaf interpreters may be beneficial as they are specialists who provide interpretation and translation in ASL as well as for other visual and tactile communication used by individuals who are Deaf or hard of hearing. Deaf interpreters utilize a wide range of visual language and communication forms that are influenced by multiple factors including nuanced gestures, cultural and regional considerations, and education. (3)
- Does the child have hearing aids or cochlear implants? With these devices, is the child fluent with spoken language or do they use sign language as well?

- Is the child learning sign language (ASL or other)? If so, how fluent is the child with sign language?
- Does the child and/or family use special signs (home signs) not included in ASL? If the child uses ASL, what are the name signs of the child's caregivers, family members, and person of concern?

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

Deaf interpretation is best provided by a Certified Deaf Interpreter (CDI), who is an interpreter who is Deaf or hard of hearing and nationally certified by the Registry of Interpreters for the Deaf. (4) The CDI interprets the message from the individual who is deaf to the hearing interpreter (e.g., an ASL interpreter), who then interprets the content to the consumer (e.g., the interviewer). (4) The CDI has knowledge and understanding of Deafness, the Deaf Community and/or Deaf Culture, which can bring insight and expertise to the communication during the interview. The CDI will have general interpreter training, but also will have specialized training and/or experience in the use of gesture, mime, props, drawings, and other tools to enhance communication. (5) Typically, an ASL interpreter works in tandem with the CDI. Considerations for use of a CDI include:

- The child is not fluent with ASL and uses non-standard signs or gestures to communicate.
- The child uses signs particular to a given region, ethnic group or age group.
- The hearing interpreter is not familiar with Deaf Culture, which the child and family assimilate.
- The child is experiencing trauma reactions and is having difficulty communicating via ASL alone. (5)

Additional strategies include:

- The interviewer should face the child so the child and the interviewer can see each other.
- If an interpreter is being used, ensure that the child can see both the interpreter and the interviewer.
- The interviewer should always address the child directly when speaking.
- If the child draws an answer, the interviewer should pause and wait to respond or ask questions until the child finishes and looks at the interviewer.
- Touching the child's arm or shoulder to get his attention is culturally-appropriate and acceptable.
- Speak in a normal voice; yelling may distort words or interfere with lip reading.
- Check in with the child periodically to ensure they are understanding the questions posed.

Vision impairment and blindness

Do not assume that the child has no usable vision; many people who experience visual impairment can see shapes, colors, and light. To accommodate for children with visual impairments: (6)

- Ask the child how you can assist them. The child knows best what they need to move about an unfamiliar place. If the child is quite young, then inquire about how to best assist the child with their primary caregiver.
- Do not take a child's arm without permission to guide the child. Instead, offer the child the opportunity to take your arm above the elbow when guiding the child to a destination. State where you are going and what is in front of you as you move.
- Give directions with details about the room upon entry. For instance, explain that the chair is about 3 feet in front of the child and there is a table to the side of the chair.
- Do not sit the child directly in front of a light or window; have the primary light source behind the child.

- Use natural or lamp lighting if possible. Fluorescent lights can be distressing and/or distracting.
- Announce yourself when you enter or leave the room.
- Always ask before petting a service animal as this animal is not a pet, it is working.
- If possible, have written materials in other formats, such as large print, pictures, audio tapes, or Braille.
- Offer Play-Doh or molding clay to the child instead of drawing or coloring during the interview.

Cerebral Palsy

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

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

If speech and articulation is difficult for the child, consider asking them what their preferred communication is. The child might use picture/word boards or augmentative communication devices, but these devices can be time consuming and exhausting. The child may prefer to talk. If a child prefers to talk, the interviewer should respect this and be patient. Accommodations and strategies for speech and articulation difficulties are described in Chapter 8: Accommodations for Communication Disabilities.

CONCLUSION

This reference guide aims to demystify disabilities for professionals who interview children with disabilities about abuse. The information contained in this reference guide has been distilled from a large body of research and many sources. It condenses the conceptualization of disability into four categories of functioning: communication, intelligence, behavior, and physical functioning. This reference guide is not part of a research paper or article. Instead, this guide is to be used for forensic interviewers to obtain information about forensically-sound accommodations that are based on best practices.

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

The best advice for any interviewer is to remember that a child with a disability is first and foremost a child. Always treat the child with respect by acknowledging and accentuating the child's strengths and abilities while ensuring due diligence in understanding the child's challenges and limitations as effectively as possible. By doing so, the child and their family will receive a high quality of care that ultimately will enhance the child's ongoing safety and wellbeing.

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