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Signs and Symptoms of a Stressed System: How to Recognize and Address Child Maltreatment in the Home

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Abstract

The fact that the disabled are at high risk for maltreatment is well documented (Goldson, 1998; Sullivan & Knutson, 2000; Zeanah & Hamilton, 1998). Reynolds (2001) reported that 39-68% of girls and 16-30% of boys with developmental disabilities would be abused by the age of 18. Westcott and Jones (1999) note that identification, assessment, and prevention is complicated by the communication deficits of this population, their dependency on others, and a tendency for professionals to not report abuse. Thus, it is imperative that professionals understand the risks for abuse and maltreatment in this population. The risks factors and signs of maltreatment, as well as recommendations for intervention are reviewed. Specific recommendations for educators are offered.

Epidemiology of Maltreatment in Children With Disabilities

Rates of child maltreatment, particularly for children with disabilities are difficult to determine due to a lack of centralized data bases, a tendency to not keep consistent records of disability characteristics in cases of suspected maltreatment, and in extreme cases, because maltreatment is not acknowledged or addressed publicly (Morris, 1999). Recently, Sullivan & Knutson (1998) evaluated children in hospitals or residential programs and found strong correlations between behavioral disorders and maltreatment and cognitive impairment and maltreatment. Concerns were raised about potential bias in the sample, so Sullivan and Knutson completed a follow-up study published in 2000. The sample

included 50,278 children in Omaha who were identified by the school as needing special education services. They found that special education students were 3.4 times as likely to be maltreated as general education students. Of the children originally identified as maltreated, 22% later needed special education; conversely, 31% of the children who were in special education had a history of maltreatment. Thus, there appears to be a clear correlation between maltreatment and students in special education. The authors emphasized that they only included confirmed cases of maltreatment, which means the number is probably higher than reported. Neglect was the most common form of maltreatment, but many of the children experienced more than one kind of maltreatment. The disabled children were more likely to experience more than one kind of maltreatment and multiple episodes of maltreatment.

The Sullivan and Knutson (2000) results also indicated that children with certain disability types were at higher risk. Children with behavioral disorders were the most likely to have maltreatment histories, followed by speech and language disorders, cognitive impairment, health impairment, hearing impairment, learning disabilities, visual impairment, and physical impairment. The risk of maltreatment did not decrease with age, although children with health impairments and communication disorders were more likely to experience their first episode of maltreatment at younger ages. Disabled boys had the highest rate of maltreatment compared to all other groups. This fits with previous research (Morris, 1999; Sobsey, Randall, & Parrila, 1997; Sullivan et al., 1991), but the authors were quick to note that the rates of disability are higher in males and females and they are more likely to experience physical maltreatment, which may be more evident. Disabled girls are more likely to experience sexual maltreatment and the rates may be underreported. The rates of sexual maltreatment for disabled boys were considerably higher than for non-disabled boys, which again matched previous findings (Sobsey, Randall, & Parrila, 1997).

Definition of Maltreatment

Physical maltreatment is the use of inappropriate physical behaviors that result in substantial risk of physical or emotional harm to a child. This can include beatings; kicking; shaking; throwing; burning; stabbing, or choking a child. Extreme forms of physical maltreatment can lead to infanticide or the killing of children (Miller-Perrin, 2002).

Sexual Maltreatment generally refers to interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person. This can include: oral, anal, and genital penetration; attempted penetration; fondling of breasts or genitals, sexual kissing, and filming or photographing children for the sexual stimulation of others (Miller-Perrin, 2002). The perpetrator can be under the age of 18, and is often a person the child knows.

Neglect generally refers to deficits in addressing the child's basic needs. This includes inattention to health care needs (e.g., failure or delay in providing necessary health care), custody related problems (e.g., deserting a child without arranging reasonable care or supervision, refusing to allow a minor access to his or her home; repeated shuttling of a child from one household to another), inadequate supervision (e.g., leaving a child unsupervised for extended periods), educational neglect (e.g., permitted chronic truancy, failure to enroll a child in school, inattention to special education needs), and omissions of the physical needs of children (e.g., inadequate nutrition, clothing, or hygiene) (Miller-Perrin, 2002). This is one of the more difficult forms of maltreatment to prove.

Psychological/Emotional Maltreatment pertains to "serious mental injury" or acts that communicate to a child that he or she is worthless, unloved, or unwanted. These acts can be emotionally neglectful or emotionally abusive. Emotionally neglectful behaviors include: nor providing the appropriate amount of nurturance or affection, exposing the child to spousal abuse, allowing the child to abuse drugs or alcohol, encouraging delinquency, and refusing or being lax in providing psychological care. Emotional maltreatment entails: tying or binding children; verbally belittling,

denigrating, threatening, or rejecting children; deliberately withholding basic needs as a form of punishment; and economic exploitation (Miller-Perrin, 2002).

Risk Factors and Indicators of Maltreatment

It is important to note that the presence of one or more risk factors does not necessarily indicate the presence of maltreatment (Sidebotham, 2003). These risk factors are associated with a majority of outcomes. In addition, risk factors can vary depending on the type of maltreatment in question, the child's age and gender, and the disability status of the child. Furthermore, the absence of these risk factors does not remove the possibility of maltreatment. However, knowledge of risk factors enhances awareness and aides in prevention.

According to Bronfenbrenner's ecological theory (Berk, 2000), children do not grow up in a vacuum, but rather in a group of interrelated systems that have bi-directional influence. The first system is the individual. For children with disabilities, there are a number of risk factors involved. Disabled children often lack the skills to avoid, escape or resist maltreatment. There is a tendency for this population to be overly compliant, and to have an increased number of caregivers. A number of studies have concluded that children who require more support in activities of daily living, and exhibit aggressive or other challenging behaviors are at higher risk for maltreatment (Prevent Child Abuse America, n.d.; U.S. Department of Health and Human Services, 2001; Walker, 2002; Vig & Kaminer, 2002). In addition, it is not uncommon for the perpetrator to coerce a child into feeling guilty or fearful, or to convince a child that no one will believe an accusation of maltreatment. Children with cognitive impairments may be particularly vulnerable to coercion and may agree to sexual maltreatment to be liked, to feel normal, or to receive rewards (Tharinger, Burrows-Horton, & Millea, 1990). Given that most of the children know their perpetrators, they may be encouraged to recant their accusations. Children with multiple impairments, who have several caregivers touching them for intimate care needs

throughout the day, may become desensitized to inappropriate touch (American Academy of Pediatrics, 2001).

The next level is the micro system. This level includes the family, school, and neighborhood. Research has found a high correlation between risk factors such as parental substance abuse, poverty, poor parental education, corporal punishment, and single parent homes, and both violence and disability in children (Burrell, Thompson, & Sexton, 1994; Sullivan & Knutson, 2000; Verdugo et al., 1995; Vig & Kaminer, 2002). There is also an increased likelihood that these kids will live in foster homes, residential schools, and institutions Additional parental factors offered by the U.S. Department of Health and Human Services (2001) are poor coping and impulse control, a history of violence, low self-esteem, depression, a childhood history of victimization or neglect, and parental disability. Parental attitudes associated with higher risk consist of viewing the child as different, ongoing focus on the loss of a normal child, and seeing the disability as embarrassing or as punishment (Gaudin, 1993; U.S. Department of Health and Human Services, 2001). Disruptions in attachment often coincide with these parental factors or may be the result of frequent hospitalizations or even negative messages from professionals (U.S. Department of Health and Human Services, 2001). Vig and Kaminer (2002) point out that what many would consider appropriate care for a normally developing child might be considered neglectful for a child with disabilities. Therefore, it is not uncommon to find a neglected disabled child in a home with non-neglected non-disabled children. Large families also present a higher risk for neglect (Gaudin, 1993), as do families who experience prejudice, discrimination, or have language barriers that inhibit knowledge and access to resources.

Mesosystem concerns represent the relationship between Microsystems. Problems arise when the Microsystems do not agree on goals or demands, or there is a breakdown in communication. This lack of agreement or communication can put the individual at risk due to unrealistic/competing expectations, or missed opportunities for intervention. This problem can be particularly prevalent in

regard to suspicions of maltreatment. Nunnelley and Fields (1999) note a study conducted by the National Center on Child Abuse and Neglect that found that 40% of the professionals mandated to report maltreatment failed to report their suspicions of abuse. This coupled with a tendency to be reluctant to bring up maltreatment concerns with families exemplifies a mesosystem problem.

The exosystem involves issues that indirectly affect the individual (e.g., parent's work). The extra demands of caring for a child with disabilities can be overwhelming. Researchers disagree as to the extent that these demands impact the risk for maltreatment. In a healthy, well-adjusted parent, the burden of care giving may not result in maltreatment; however, when other, exosystem stressors are present, the probability that the parent will rely on ineffective coping and parenting strategies increases. Common responsibilities reported are: frequent medical appointments, service providers often present in the home, lack of coordination between different service organizations, increased financial demands-with one parent often unable to work, lack of support from family and friends, concerns about non-disabled siblings, concerns about long term care, concerns about the disabled child's peer relationships and later intimate relationships (Heiman, 2002; Struck, 1999; Vig & Kaminer, 2002).

The final level is the macrosystem. The macrosystem is made up of cultural and societal influences on the individual. Sobsey (2002) summarized a number of societal attitudes that make disabled children more vulnerable. Distancing is the idea that disabled people are not like everyone else, devaluation means that the lives of disabled people are worth less or that their quality of life is very low, and blaming the victim occurs when a child does something that provokes the maltreatment (e.g., exhibits challenging behaviors). Goldson (1998) suggested additional societal values that may play a role. These include: condoning violence to resolve conflict, not celebrating differences, viewing children as property, and minimizing the impact of maltreatment on disabled children. The U.S. Department of Health and Human Services (2001) proposed a number of myths associated with the disabled population

that may facilitate maltreatment. One is that disabled children are not vulnerable to maltreatment because all caretakers are good. Two is that disabled individuals are asexual and therefore need no sexual education. Three is that the disabled cannot control their own behaviors and require excess control. Four is that the maltreatment experience does not hurt the individual with disabilities physically or psychologically.

Specific Indicators of Maltreatment

As aforementioned, indicators can be symptoms of many problems, not only maltreatment. Indeed the indicators overlap significantly regardless of the type of maltreatment. For example, withdrawal, depression, aggression, anxiety, frequent absences, psychosomatic complaints, peer relationship problems, lack of concentration, self-injurious behavior, stereotyped behavior, hyperactivity, regression in skills, and sudden changes in behavior or achievement are associated with multiple forms of trauma. It is also important to note that children have individual responses to maltreatment based on factors such as disability status, temperament, and age. These indicators can be considered in relation to the many risk factors noted above. Specific indicators related to specific forms of maltreatment are listed in Table 1. The indicators listed in were obtained from multiple sources (Crosson Tower, 1992; Gaudin, 1993; National Resource Center for Respite and Crisis Care Services Fact Sheet # 36, n.d., pg 2; Powell, 2003; Struck, 1999).

Interventions

Barriers

Kendall-Tackett (2002) proffered a number of barriers to intervention. Out of home placements are difficult to find, particularly when the child has a severe disability. Diagnostic overshadowing is a common occurrence, as the injury or symptoms of maltreatment are often masked by the disability. These children frequently experience communication deficits and/or lack the knowledge or awareness that they are indeed being maltreated. Additional barriers noted in the literature include resistance to

services by the family or the child and cognitive or emotional impairment in the parent (Struck, 1999; Verdugo et al., 1995).

From an ecological perspective, interventions can occur at multiple levels. Several researchers have noted the importance of skill building in the disabled population. Programs designed to increase independence and decision-making abilities, as well as self-advocacy are frequently mentioned. Sex education is critical for these groups, particularly for individuals with cognitive impairment. (Patterson & Kratz, 2002; U.S. Department of Health and Human Services, 2001; Westcott and Jones, 1999).

At the microsystem level, professionals should work to provide more information about the child's disability and development, increase respite care services, involve parent in organizations to reduce isolation, strengthen parent skills, and improve early intervention services (Prevent Child Abuse America, n.d.; U.S. Department of Health and Human Services, 2001). Counseling for the parent is critical to enhance coping and anger management. Heiman (2002) found that well-adjusted parents of children with a variety of disabilities use a number of consistent coping mechanisms. In her study, parents reported: maintaining a routine, using the support of friends and relatives, obtaining psychological services and continuing to use them, attending support groups, believing strongly in their child and balancing optimism with realism, maintaining regular contact with professionals, and keeping a bond with their spouse. Finally, parents need education on how to react to reports of maltreatment. Ignoring, denying, or becoming angry in response to suspected maltreatment is neglectful in and of itself and can lead to long term consequences for the child.

It is critical that administrators carefully screen staff for residential, professional or educational services, as well as train staff in positive behavior management, disability information, methods of reporting and responding to maltreatment. It is important for educational and residential programs to keep the staff/client ratio low, give the staff realistic expectations and supervision/support, make an explicit commitment to child protection, and allow unannounced site visits from objective investigators

to ensure safety of the children (Ellis & Hendry, 1998; Prevent Child Abuse America, n.d.; U.S. Department of Health and Human Services, 2001). These interventions may have the added benefit of addressing mesosystem problems, by increasing communication between systems and improving the likelihood that professionals will report suspected maltreatment.

Usually the needs of these families are multifaceted and ecosystemic, so programs designed to address a variety of problems are the most effective (Gaudin, 1993). These programs may include services such as: financial assistance, transportation, behavioral training, home management skills, parent aides, support groups, employment assistance, temporary shelter, home based services, legal assistance, parent-school coordination, and mental health services.

The first step to intervening at the macrosystem level is to confront prejudice, provide services indiscriminately, remove oppression, close the gap between agencies, avoid diagnostic overshadowing, involve experts in the assessment of maltreatment, and improve the awareness of the legal system (Buchele-Ash, Turnbull, & Mitchell, 1995; Manders, 1998; U.S. Department of Health and Human Services, 2001; Westcott & Jones, 1999). Better training for mental health professionals is critical (Zeanah & Hamilton, 1998). Kendall-Tackett (2002) proposed a number of societal recommendations. The Child Abuse Prevention and Treatment Act should be modified to require that states collect information on disability status when investigating allegations of abuse (only 19 states collect such information currently). The third NIS study did not amass information on disability status, which is odd considering the results of the second study mentioned earlier. Future NIS studies should always gather this data. Community based support programs for violence and sexual assault should include interventions that consider the special needs of disabled children who have been maltreated. In addition, the foster care system should be improved to accommodate abused and neglected children with disabilities (American Academy of Pediatrics, 2001).

Intervention Tips for Educators

First, be wary of the desire to hesitate on making a report. Crenshaw, Crenshaw, and Lichtenberg (1995) reviewed concerns often noted by educators who needed to make a report of suspected maltreatment. Selected items are listed as follows: no tangible evidence, fear of making matters worse, uncertainty about policy, difficulty in defining symptoms, fear of parental retaliation, lack of trust in child protective services, lack of support from administrators, concerns about infringing on rights of child or parents, concerns of cultural bias, concerns about damaging the relationship with the child or parent, and a belief that emotional maltreatment is not reportable.

Educators often fear making a false allegation that would harm the child or the relationship with the family (Deisz, Doueck, & George, 1996). False allegations occur when: adults misunderstand what the child is trying to convey, the report becomes distorted as it is transferred to investigation agencies, a disturbed child makes a false report or a disturbed adult makes an allegation on behalf of the child, when one adult wants revenge on another, the child is asked leading or inappropriate questions repeatedly, or when a family is attempting to receive services via malingering (Crosson-Tower, 1992). In many of the aforementioned cases, the allegations will not proceed very far. The larger ethical dilemma lies in not reporting suspected maltreatment. Educators and other professionals legally obligated to make reports are protected from liability should an allegation prove to be incorrect. The time to evaluate individual barriers to reporting is before the need to report occurs. The reality is that these fears are rarely realized and more importantly not sufficient to ethically inhibit a professional from reporting.

Before making a report: Document suspicions. Consider the signs and symptoms that are leading personnel to suspect maltreatment. Consult other professionals to test impressions. Review school policy and meet with administrator. Gather necessary information (name, age and address of child, parent name and address, details of suspected maltreatment, any prior incidences of maltreatment

observed, name and location of reporter) (Crosson-Tower, 1992; Struck, 1999). Another way to protect oneself is to carefully document unusual behaviors, injuries, verbalization, and interactions with the child. This documentation provides supporting evidence to maltreatment reports and also indicates the careful thought that went into the decision to file a report. Documentation is particularly important in cases of neglect, which are often difficult to prove.

When maltreatment is suspected and more information is needed, obtain only enough information to make a report. Avoid multiple interviews. Determining the veracity of the report is not the role of an educator (Buchele-Ash, Turnbull, & Mitchell, 1995). Allow the child to speak to a person he or she trusts and respects, at the same time ensure that the person who is most competent in interviewing children is at least present. Avoid groups of people. Conduct the conversation in a quiet, private, nonthreatening place, without interruptions. Sit next to the child, not behind a table (Crosson-Tower, 1992; Struck, 1999). It is critical to assure the child he/she is not in trouble and is not responsible for the maltreatment. Inform the child that the conversation is confidential in that it will not be shared with classmates or every other teacher in the school; however, be very clear with the child that maltreatment must be reported to the appropriate authorities so the child and the family can receive help (Crosson-Tower, 1992; Struck, 1999). The worst-case scenario is making a promise not to tell and then having an investigation ensue without the child being appropriately prepared. What can be promised to the child is that the support of the educator will be unwavering.

While talking to the child, use a language the child can understand, explain technical terms or formal terms for body parts if the child seems confused. Have the child point if there is ongoing confusion (Crosson-Tower, 1992; Struck, 1999). A child who uses a communication board or sign language to communicate needs to be interviewed using these modalities.

Do not press for details the child is unwilling to give. Do not suggest answers. If there is any suspicion the child has been influenced by questioning procedures or coached in any way, legal prosecution of the perpetrator could be impacted (Crosson-Tower, 1992; Struck, 1999).

Do not be afraid to view the injuries if a child wants to show them. Do not insist on seeing injuries. Never force a child to remove clothing (Crosson-Tower, 1992; Struck, 1999).

Resist the urge to be horrified in front of the child. Do not make disparaging comments about the caregiver. Do not ask the child to conceal the conversation from parents. Explain to the child what will likely happen once a report is made (Crosson-Tower, 1992; Struck, 1999).

If there is there is concern that the child will be harmed if the parent discovers the disclosure, the report should be made immediately. The concern should be mentioned in the report. If a caseworker comes to the school and wants to remove the child, request a written release from the caseworker (Crosson-Tower, 1992; Struck, 1999).

Some schools will attempt to contact the parents to discuss the allegations and notify them that a report has been made. It is inappropriate for the school to question the parent extensively to attempt to prove the maltreatment occurred. If there is concern for the child's safety, it may be wise to not immediately speak with parents (Crosson-Tower, 1992; Struck, 1999). It is important to inform the parents of the school's continuing support and concern for the family. Do not rebuke the parent. Inform the parent of the school's legal obligations and the limitations of confidentiality should he/she begin to offer details about the maltreatment (Crosson-Tower, 1992; Struck, 1999).

Finally, support for the individuals making the report is critical. Educators are often anxious and preoccupied after this experience due to concerns about the outcome. Some educators have had negative experiences with reporting in the past (i.e., nothing was done or nothing changed). Nunnelley and Fields (1999) recommended that schools develop support groups for educators and social workers and allow time for the professionals to attend meetings. These groups could be a forum for expressing

concerns, sharing stories, and providing sustenance through these difficult experiences. Administrative backing is invaluable and should involve protecting the educator as well as the child.

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Table 1

Specific Indicators of Maltreatment by Type

Physical	
Present in Child	Present in the Parent
Burns in the shape of cigarette and may be on palms, soles of feet, back or buttocks	Lack of parenting skills
Immersion burns that look like socks or gloves	Ignorant about child development
Bruises in various stages of healing (red, blue, black-purple, green, yellow)	Reports a desire to harm the child
Bruises in unusual areas such as back, buttocks, upper arms, face etc.	Complains about the child
May wear long sleeves or pants to hide bruises	Has a negative attitude about the child; frequently speaks negatively about the child
Frequent unexplained injuries	Unusually Punitive
Marks that reflect the shape of the instrument used (electrical cord, hanger, belt)	Changes doctors or schools frequently
Bite marks	Offers illogical or unconvincing explanation of the child's injury
Reports receiving a lot of spankings at home	Attempts to hide injury
Complains that parent is always angry	
Acts out abuse in play	
Frequently absent from school	
Unusual fears	
Craving for attention	
Wary of physical contact	
Afraid to go home	
Destructive to self and others	
Fatigue, soreness	
Lack of concentration	

Table 1 (continued)

Specific Indicators of Maltreatment by Type

Sexual	
Present in Child	Present in the Perpetrator
Psychosomatic symptoms	History of sexually assaulting others
Regression	History of childhood sexual abuse
Obsessive about hygiene	Immature social relationships
Withdrawal	Sexual deviancy, attracted to children
Resists touch	Power and control issues
Difficulty walking or sitting	Extremely protective or jealous of the child
Torn, stained or bloody underclothing	
Pain or itching in genital area	Isolated from others
Bruises or bleeding in genital area	Substance abuse problems
Venereal disease or pregnancy	Cognitive Impairment
Unexplained money or gifts	Rationalization/Denial
Excessive concern about homosexuality (boys)	
Nightmares	
Anxiety	
Sexualized behavior or sexual knowledge beyond what is developmentally appropriate	
Sexually assault others	
Eating disorders (teens)	
Self injurious behavior	
Aggression	

Table 1 (continued)

Specific Indicators of Maltreatment by Type

Neglect	
Present in Child	Present in the Parent
Always hungry, sleepy, or irritable	Misses meetings
Child hoards food or steals clothing, class materials, etc.	Fails to return calls or notes sent home
Child seems disorganized in thinking, continuously lacking in needs (comes to school without materials, appropriate attire, glasses, permission slips, etc.)	Substance Use/Abuse
	History of neglect in childhood
	Psychological problems such as depression or psychosis
Child has poor hygiene.	
Repeated lice infestation	Cognitive Impairment
Medical needs neglected	Frequent moves
Dental needs neglected	Lack of consistent housing
Child reports being home alone often or caring for siblings often and for long periods of time	Unemployment
	Isolated
Frequent absences	Poor educational background
Learning problems	
Repeating grades	
Extended stays at school	
Delinquency	

Table 1(continued)

Specific Indicators of Maltreatment by Type

Emotional/Psychological	
Present in Child	Present in the Parent
Developmental lags	Parent may have psychological problems
Learning problems	Childhood history of abuse
Psychosomatic symptomology	Overwhelmed or have a significant number of stressors
Speech disorders (e.g., stuttering)	
Nonorganic failure to thrive	Unrealistic expectations
Verbally abusive to others	Blame the child for problems
Regressive behaviors	Ignores or rejects child
Overly compliant or aggressive	Withholds love, affection or approval
Can be very demanding or attempt to go unnoticed	
Self destructive	
Cruel	