Communicating With and About People with Disabilities

Information for this fact sheet came from the Office of Disability Employment Policy; the Media Project, Research and Training Center on Independent Living, University of Kansas, Lawrence, KS; and the National Center for Access Unlimited, Chicago, IL.

The Americans with Disabilities Act, other laws and the efforts of many disability organizations have made strides in improving accessibility in buildings, increasing access to education, opening employment opportunities and developing realistic portrayals of persons with disabilities in television programming and motion pictures. Where progress is still needed is in communication and interaction with people with disabilities. Individuals are sometimes concerned that they will say the wrong thing, so they say nothing at all—thus further segregating people with disabilities. Listed here are some suggestions on how to relate to and communicate with and about people with disabilities.

WORDS

Positive language empowers. When writing or speaking about people with disabilities, it is important to put the person first. Group designations such as "the blind," "the retarded" or "the disabled" are inappropriate because they do not reflect the individuality, equality or dignity of people with disabilities. Further, words like "normal person" imply that the person with a disability isn't normal, whereas "person without a disability" is descriptive but not negative. The accompanying chart shows examples of positive and negative phrases.

Affirmative Phrases	Negative Phrases
person with an intellectual, cognitive, developmental disability	retarded; mentally defective
person who is blind, person who is visually impaired	the blind
person with a disability	the disabled; handicapped
person who is deaf	the deaf; deaf and dumb
person who is hard of hearing	suffers a hearing loss
person who has multiple sclerosis	afflicted by MS
person with cerebral palsy	CP victim
person with epilepsy, person with seizure disorder	Epileptic
person who uses a wheelchair	confined or restricted to a wheelchair
person who has muscular dystrophy	stricken by MD
person with a physical disability, physically disabled	crippled; lame; deformed
unable to speak, uses synthetic speech	dumb; mute
person with psychiatric disability	crazy; nuts
person who is successful, productive	has overcome his/her disability; is courageous (when it implies the person has courage because of having a disability)

ACTIONS

Etiquette considered appropriate when interacting with people with disabilities is based primarily on respect and courtesy. Outlined below are tips to help you in communicating with persons with disabilities.

General Tips for Communicating with People with Disabilities

- When introduced to a person with a disability, it is appropriate to offer to shake hands. People with limited hand use or who wear an artificial limb can usually shake hands. (Shaking hands with the left hand is an acceptable greeting.)
- If you offer assistance, wait until the offer is accepted. Then listen to or ask for instructions.
- **Treat adults as adults.** Address people who have disabilities by their first names only when extending the same familiarity to all others.
- Relax. Don't be embarrassed if you happen to use common expressions such as "See you later," or "Did you hear about that?" that seem to relate to a person's disability.
- Don't be afraid to ask questions when you're unsure of what to do.

Tips for Communicating with Individuals Who are Blind or Visually Impaired

- Speak to the individual when you approach him or her.
- State clearly who you are; speak in a normal tone of voice.
- When conversing in a group, remember to identify yourself and the person to whom you are speaking.
- Never touch or distract a service dog without first asking the owner.
- Tell the individual when you are leaving.
- Do not attempt to lead the individual without first asking; allow the person to hold your arm and control her or his own movements.
- Be descriptive when giving directions; verbally give the person information that is visually obvious to individuals who can see. For example, if you are approaching steps, mention how many steps.
- If you are offering a seat, gently place the individual's hand on the back or arm of the chair so that the person can locate the seat.

Tips for Communicating with Individuals Who are Deaf or Hard of Hearing

- Gain the person's attention before starting a conversation (i.e., tap the person gently on the shoulder or arm).
- Look directly at the individual, face the light, speak clearly, in a normal tone of voice, and keep your hands away from your face. Use short, simple sentences. Avoid smoking or chewing gum.
- If the individual uses a sign language interpreter, speak directly to the person, not the interpreter.
- If you telephone an individual who is hard of hearing, let the phone ring longer than usual. Speak clearly and be prepared to repeat the reason for the call and who you are.
- If you do not have a Text Telephone (TTY), dial 711 to reach the national telecommunications relay service, which facilitates the call between you and an individual who uses a TTY.

Tips for Communicating with Individuals with Mobility Impairments

- If possible, put yourself at the wheelchair user's eye level.
- Do not lean on a wheelchair or any other assistive device.
- Never patronize people who use wheelchairs by patting them on the head or shoulder.
- Do not assume the individual wants to be pushed —ask first.
- Offer assistance if the individual appears to be having difficulty opening a door.
- If you telephone the individual, allow the phone to ring longer than usual to allow extra time for the person to reach the telephone.

Tips for Communicating with Individuals with Speech Impairments

- If you do not understand something the individual says, do not pretend that you do. Ask the individual to repeat what he or she said and then repeat it back.
- Be patient. Take as much time as necessary.
- Try to ask questions which require only short answers or a nod of the head.
- Concentrate on what the individual is saying.
- Do not speak for the individual or attempt to finish her or his sentences.
- If you are having difficulty understanding the individual, consider writing as an alternative means of communicating, but first ask the individual if this is acceptable.

Tips for Communicating with Individuals with Cognitive Disabilities

- If you are in a public area with many distractions, consider moving to a quiet or private location.
- Be prepared to repeat what you say, orally or in writing.
- Offer assistance completing forms or understanding written instructions and provide extra time for decision-making. Wait for the individual to accept the offer of assistance; do not "over-assist" or be patronizing.
- Be patient, flexible and supportive. Take time to understand the individual and make sure the individual understands you.

Remember

- Relax.
- Treat the individual with dignity, respect and courtesy.
- Listen to the individual.
- Offer assistance but do not insist or be offended if your offer is not accepted

Parent/Guardian Policies

- Whether your child attends Treasureland or one of the Reflectors Classrooms, it is up to you, the parent/guardian, whether or not you would like to stay with your child on the first visit. We encourage parents to participate in the main worship service, but want to be flexible to your preference. We do ask that you fill out a First Time Families Card so that we have your basic information.

- If you know that you will *not* be able to attend on a particular weekend, please (if possible) give some type of notice in advance. It can be in-person, by email, phone call, etc. This will help in the volunteer preparation process. Thank you!
    - vadams@faithchurchonline.org
    - 219-864-0300 (ext. 197)

For regularly attending families, there are 2 forms that we ask be filled out at your earliest convenience to help us best serve your child / family member:

- Individualized Worship Plan (IWP)
- Medical Waiver/Consent Form

    - The information disclosed in all of these documents may only be shared with the ministry leader, the individual's 1-on-1 Buddy, and classroom teacher.

- A once-a-month Parent Support Group is offered at the Dyer Campus on the 2nd Saturday of each month. Please contact Pam VanderMeer if you are interested in participating.

Dyer Worship Venues

The Worship Center

This is where the majority of the people of Faith Church come for their worship experience. The Worship Center is an auditorium that seats about 1000 people. There is a live band and a message from a pastor of Faith Church.

The Well

Located in the atrium, the Well is a venue that shows the worship service happening in the worship center on a large screen. This setting is more relaxed and offers easier access to other parts of the building.

Private Living Room

Located in the far west hallway, the living rooms are available for any family that desires a secluded, comfortable place to watch the worship service on a TV.

Treasureland

Treasureland is a setting for children from birth to 5th grade. It is available at all weekend services and allows children to worship and learn Bible lessons at their level in large and small group settings.

Reflectors BLUE Classroom

Located in the east hallway, this self-contained-style classroom is designated for teens and adults with intellectual disabilities where a teacher presents an adapted lesson from the Bible and individuals participate in modified activities. **11:00 service only*

Reflectors GOLD Classroom

Located in the far east hallway, this self-contained-style classroom is designated for children with intellectual disabilities where a teacher presents an adapted lesson from the Bible and individuals participate in modified activities. **11:00 service only*

REFLECTORS *Individualized Worship Plan*

Individual's Name: _____ D.O.B. ___ / ___ / ___

Parent(s)/Guardian(s): _____

Address: _____

Primary Phone: _____ Secondary Phone: _____

Email (if applicable): _____

Disability type: _____

Strengths: _____

_____

Challenges: _____

_____

Preferred/enjoyed Activities: _____

_____

How does the individual communicate best? _____

_____

When this person needs assistance with re-direction, what:

Works well: _____

Does not work well: _____

Is there a behavior plan in place for the individual at home, school, or work? *(If yes, please fill out a "Behavior Plan" form)* _____

Goals for today/this upcoming season (social/spiritual/behaviorial/etc.)

1. _____

   _____

2. _____

   _____

Additional Comments/Requests: _____

_____

_____

Parent/Guardian Signature: _____ *Date:* _____

REFLECTORS

Medical Waiver Form

Name of Participant: _____ Age: _____
Address: _____
Name of Parent/Legal Guardian: _____
Primary Phone: _____ Secondary Phone: _____
Medical Insurance Company: _____
Policy Number: _____ Hospital: _____
Physician: _____ Phone Number: _____
Hospital Address: _____

Additional emergency Contact: _____
Relationship: _____ Phone Number: _____

Please list any physical disabilities, health concerns, limitations, allergies, dietary restrictions:

_____
_____
_____
_____

Please list any medication currently being taken:

_____

Statement of Release and Liability Agreement

"I have disclosed, to the best of my knowledge, all pertinent information for my child's personal safety and appropriate medical attention. In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by those in charge of the Faith Church Disability Ministry to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medications for my child.

I will also take full responsibility for any charges incurred during medical treatment and do not hold Faith Church liable for any injuries that may occur to my child, and I agree to contact Faith Church in order to keep my child's records up-to-date."

Parent/Guardian: _____ *(print name)*
_____ *(signature)*
_____ *(date)*

REFLECTORS *Behavior Management Plan* **if applicable*

Individual's Name: _____

Parent(s)/Guardian(s): _____

Targeted Behavior(s) with descriptions (*what behaviors need to be changed?*)

_____

_____

_____

Antecedents/Triggers (*what causes the behavior(s)? what are some warning signs?*)

_____

_____

_____

Replacement Behavior(s) (*what behaviors would we like to see instead?*):

_____

_____

_____

Proactive Strategies to get there (*e.g. token/reward system, scheduled breaks, etc.*):

_____

_____

_____

Plan for Reacting to the Targeted Behavior (*e.g. ignore, remove from area, etc.*):

_____

_____

_____

Additional Comments/Concerns/Requests: _____

_____

_____

Parent/Guardian Signature: _____ *Date:* _____

Child Safety Policy

Mandate

The New Testament makes clear that as Christians we continue in a covenant relationship with God and with the whole community of faith. We must live just and generous lives, following the great commandments set forth by Jesus Christ. Jesus plainly taught that children were to be included and provided for within the community of Faith. (See Luke 18:15-17 and Matthew 18:5-6.) Throughout the history of the Christian church, children have been included in the worship and ministry of the community of faith. Today, the church may be the only place where some children find the unconditional love and care they so desperately need to grow, to thrive, and to become faithful people. As Christians, we must take our responsibility to our children very seriously, always attending to their spiritual growth and nurturing. We fail in our responsibilities if we neglect to take adequate precautions against child abuse in our churches. It is unlikely that we can completely prevent child abuse in every circumstance, yet it is possible for us to greatly reduce the risk by following a thorough and practical policy of prevention.

Purpose

It is the purpose of the members and staff of Faith Church to provide a safe and secure environment for preschoolers, children, youth and mentally handicapped persons entrusted to our care. We do this to encourage those preschoolers, children, and youth and their families to grow in their relationship with God and one another.

A safe and secure environment includes a formal, written policy to help prevent the occurrence of child abuse. The following policy and procedures are for the protection of our preschoolers, children, youth, employees, volunteers and our entire church family at Faith Church.

Scope

This policy shall apply to all current and future workers, compensated and/or volunteer, who will have the responsibility of supervising the activities of preschoolers, children, youth, and mentally handicapped persons.

Definitions

Adult:	Any person 18 years of age or older.
Children or youth:	Any person 0 to 18 years of age. Whenever either the term child(ren) or youth is used the guidelines apply to both (unless otherwise indicated).
Emotional Abuse:	Attempting to control a child's life through words, threats, and fear; destroying a child's self worth through harassment, threats, and deprivation, which reinforce a sense of helplessness and dependence on the abuser.
Ministry, ministering, minister:	Includes teaching, leading, mentoring, chaperoning, or any other activity that brings people in contact with children or youth.
Physical Abuse:	Any intentional means of inflicting injury on another person whether a one-time event or a chronic pattern. Physical abuse may occur regardless of whether there is a cut, wound, mark, or bruise.
Physical Neglect:	Not doing what one is supposed to be doing to meet the physical needs of someone in his or her care, which interferes with or prevents a child's normal development.
Sexual Abuse:	Sexual exploitation or forced sexual intimacy with a person regardless of age or circumstance, which may or may not include physical contact.
Volunteer:	Any one working under the guidance and supervision of the church for a church function.
Youth/Teen:	A child who is approved by their parent and the supervisor to be a volunteer helper. They need to be at least 10 years of age to help in Treasureland and 11 years of age to help in the nursery.

Objectives of Child Protection

Protect the Children The creation of a safe and secure environment is of utmost importance! Children (and parents) need to know that when they come to church, all children are well looked after. Also, when children feel safe they are more likely to hear the message being taught or to see "Jesus with skin on."
Protect the Adults By completing the reference checks that we do and developing appropriate guidelines and boundaries, we may be in a better position to ward off false accusations. We are also in a better position to not place a volunteer in a position where they may be consciously, or unconsciously, tempted to sin.

Ministry Support If a child comes to worship or to serve, and they are worried about the person they are working with, their mind is going to be on every word or gesture or touch coming from that person. They will miss the lesson being taught or the Christ-like examples of servanthood being exhibited all around them.

Also, the completion of the child protection process enables the ministry to know the level of accessibility to children that each volunteer is given. It helps ministries gain a level of trust in each volunteer, which permits them to focus on their calling from God.

Protect the Church God calls us to be good stewards of the resources that He has given us: both our financial AND our people resources. Should we ever have an incident occur that we could have prevented, that could jeopardize some of those resources. We believe that God is asking us instead, to use our resources to expand our current ministries and to create new ministries so that we can reach even more lost people and bring them to know Christ.

Four Components

Screening
LEVEL 1
- Volunteers serving one time, for a Special Event, involving minors, that include:
- a large contained group
- **And** volunteers will not be alone with a child
- **And** the two adult rule is applied

Examples: Christmas or Easter help; a one time serve, conferences
Training: Not mandatory; no application required.

LEVEL 2 (APPLICATION AND ONE SOLID REFERENCE CHECK)
Volunteers serving less than one time per month but more ongoing than a one-time Special Event person, i.e. substitutes
- **And** the 2 adult rule is applied
- Criminal Background Check required

Requires elder approval

Examples: Volunteers on a 6-week rotation or serving once every 3-4 months
Training: MANDATORY.

LEVEL 3 (APPLICATION, ONE SOLID REFERENCE CHECK & INTERVIEW)

- Volunteers serving one time a month or more
- In a group setting
- Criminal Background Check required
- **And** the two adult rule is applied

Examples: Mini-Church leader, large group leader, student helper.
Training: MANDATORY

LEVEL 4 (APPLICATION, THREE REFERENCE CHECKS, INTERVIEW & CRIMINAL BACKGROUND CHECK)
All paid staff and volunteers whose work with minors shall be at level 4 (i.e. involve regular one-on-one supervision, mentoring and/or overnights) shall sign a Background Screening Authorization Form allowing Faith Church to do a Criminal Background Check.

Volunteers serving as a leader or sponsor but who also may have the following situations:

- Isolated contact with a minor - i.e. being alone with a minor out of visual range of their ministry staff or volunteers
- Custody of a minor - i.e. being alone with a minor while you are in full control of them.
- Supervision over a minor - i.e. having authority in the ministry to direct a minor into an isolated location.

Examples: Student ministry and children's leaders or staff who work with minors
Training: MANDATORY
*Note: If moving from LEVEL 3 to LEVEL 4, then **2 more Reference checks will be needed.**

Training
To raise awareness of child abuse
To learn what to do and not to do while in ministry with kids
Supervision
Staff and Leaders look for anything less than 100% appropriate
Reporting
Report any suspicious behavior whether occurring inside or outside the church

The Guidelines

Basic Rule of Supervision

The most basic rule of supervision for those who work with kids is the "two adult rule." Never be alone with a child. This means that there must be a minimum of two adults at all times when interacting with kids. This simple rule provides protection for children by not giving opportunities for adults to have sustained time alone with a child or student. It also protects staff and volunteers in situations in which a child or student with some significant emotional needs may misinterpret adult interaction or may make false statements about an adult's behavior toward them. By following this rule, many potential problem situations are prevented.

1. No adult who has been convicted of child abuse (either sexual abuse, physical abuse, or emotional abuse) will be allowed to volunteer to work with children or youth in any church-sponsored activity.

2. Adult survivors of child abuse need the love and support of our congregation. Any adult survivor who desires to volunteer in some capacity to work with children or youth is encouraged to discuss his/her willingness with our Care Team before accepting an assignment.

3. All adult or youth/teen volunteers involved with children or youth of our church must have been an attender or member of the congregation for at least six months before beginning a volunteer assignment. An exception may be made for people transferring from another church of the reformed faith who have a good reference from their former church. These people should be placed on a probationary status for three months.

4. Children or youth should, at all times, have adult or youth/teen supervision. In certain cases an exception may be made for older children or teens, but only if prior permission from a parent is obtained.

5. Children ages 0 to 5th grade should always be brought to and picked up from a children's activity by a parent or the adult/teen that is responsible for them. It is important that parents pick up their children in a timely manner.

6. Youth groups should not meet in isolated locations if there is only one adult leader present. An isolated location is anywhere that no other people are present or an area of the building out of sight or hearing distance of others. Small groups that meet in the homes of leaders must have two unrelated adults present.

7. Doors to rooms should be kept open unless there is a window through which the activity in the room can be observed. Supervisors may choose to make rounds observing the activities going on in the classrooms.

8. When children are supposed to be in a children's program or activity, they must

not be allowed to leave the room and wander through the building without the adult responsible for them.

9. There should be at least two adult volunteers that are not related or married to each other in the children's ministry rooms when children, other than their own, are present. Exceptions may be made for at least one adult and one youth/teen volunteer who are unrelated. Note: two volunteers may be related to each other and have a third person who is unrelated also volunteering at the same time.

10. When children under the age of 6 use the bathroom they are to be escorted by a female adult 18 years & older. Another available option is to allow the child to walk to the bathroom while observing them through the doorway of the classroom - as long as the child is in the bathroom alone. The adult or youth/teen helper is not to go into the bathroom stall with the child. If in an emergency a child needs help in the bathroom or other isolated situation, whenever possible, at least 2 adults who are not related to each other should be involved in helping the child. Additional help should be sought to help or notify the parent depending on the severity of the situation.

11. OFF-CAMPUS TEAM/ MINISTRY SLEEPOVER GUIDELINES FOR STUDENT MINISTRIES
    a. Signed permission slips must be obtained from the parents.
    b. The "Two Adult" rule needs to be followed. Two leaders must be present if there are up to sixteen (16) students. An extra leader must be included if there are seventeen (17) or more students, and there must always be a leader-to-student ratio of no less than one leader to eight students.
    c. The sleepover must be cleared through the ministry leader.
    d. As long as any students are awake, one of the leaders must also be awake to ensure monitoring of safe behavior.
    e. Separate sleeping quarters must be designated for males and females.
    f. Appropriately modest sleeping attire must be worn.
    g. Information sheet regarding emergencies must be obtained from the parent(s) including phone numbers and locations where parents can be reached.
    h. Mini-Church leaders must request permission from parents after getting approval from the ministry leadership team to view a PG or PG-13 movie. No R rated movies.
    i. Other items/ devices which could be harmful to a student (e.g. Fireworks, etc.) should not be brought along.

12. Meetings between one adult and one child should be avoided.
    a. When counseling with a child/youth, another person should be asked to sit in, or parental permission should be obtained prior to the meeting or counseling should occur within sight of others. Counseling can take place in the church office when more than one person is in the area or building, but the door should remain open in the case of no one nearby.

b. If only one adult or youth/teen volunteer is available for a class or group, that group should join with another one or parental permission should be sought to continue. In the case that the class/group will continue then the door must remain open during the entire class so proper safety and supervision can be monitored more easily.
c. Only a LEVEL 4 adult leader may drive a child (youth) of the same gender to or from their home during a church function if it involves the adult being alone in the vehicle with just one child/youth. An adult and a young person of the opposite gender should never be in a car alone. If a LEVEL 4 is driving a single child of the same gender to or from home, the adult must have:
    i. Verbal parental approval
    ii. A log kept by the driver of the time spent in the vehicle and locations traveled to and from.
    iii. Require the young person to wear a seat belt.
d. It is acceptable for a LEVEL 4 TRL (jr. high) or Crossroads (high school) leader to take one of his/her group members individually to an activity. However, the following information must be discussed with the parent before going on the one-on-one activity:
    i. Verbal parental approval must be given.
    ii. The location and nature of the activity.
    iii. Emergency numbers.
    iv. A curfew or expected time of return must be set with the parent(s) and upheld.

13. The following guidelines apply to physical contact:
    a. There is to be no corporal (physical) punishment or disciplinary restraint of children.
    b. Physical restraint may only be used if a child is in danger of causing harm to self or others (such as running away from supervision or attacking other children).
    c. Being a Christian community, embracing, holding hands in prayer and other affirming ways of touching are used. Among adults, the usual societal and Christian standards apply that touching should never be done if it is unwelcome, demeaning, or sexually suggestive or explicit.

    In the case of contact between adults and children, it should be remembered that the adult is always responsible for maintaining proper conduct. Even if the minor child or youth initiates inappropriate contact, the adult leader is still the responsible and accountable person. All of these incidents need to be reported to the supervisor and child's parent.

    To a great extent proper behavior depends on common sense and decency as well as believing that Christians are to be pure and above reproach in their conduct with one another. Rules and definitions

cannot adequately substitute for those qualities. Nevertheless to make some attempt and minimal definition of proper contact, physical contact should be limited to the arms, hands, shoulders and head. It should not be done in one-on-one situations (isolated situations are to be avoided anyway). Hugging should not be in any way suggestive.

14. If it is foreseen that an adult, because of ministry situations may at some time be alone with a child/youth, that adult must have an approved background check on file in the church office. (This information is kept confidential.)

15. If an adult or youth/teen volunteer who ministers with children/youth does not abide by these guidelines, that adult or youth/teen volunteer may be removed from a position of working with children/youth.

16. Adult and youth/teen volunteers shall immediately report to their supervisor any behavior that seems abusive or inappropriate.

17. In the case of any alleged or verified occurrence of child abuse, the church will notify the appropriate police and welfare authorities as required by law.

Reporting

Possible indicators of abuse and reports of abuse of a minor need to be taken seriously. (See APPENDIX A). A volunteer/staff person should not conduct an investigation of the matter. They should follow the established reporting procedure.

This does not mean that those people required to report abuse pursuant to state statute no longer have an obligation to do so, but that the church will not be involved in the reporting process.

If any member or non-member can provide information verifying that a volunteer or staff member has had formal charges filed against them for child abuse, the Senior Pastor or one of his designees should be informed immediately.

A. <u>Responding to a Report of Abuse</u>

1. Take the child seriously when he/she tells the story. Write down as much of the account as you are able to do as soon as you are able to do so.

2. Reassure the child. Remind the child that you care about him/her.

3. Remain emotionally calm in the presence of the child.

4. Make no promises to the child that you will not tell what has been shared. Do not offer a reward for telling story. Do not tell the child

he/she has been abused. Do not talk about police. Do not investigate the story. Repeat the story only to the Senior Pastor or Executive Administrator.

5. Remind the child that is was good to tell someone and that it was not his/her fault.

6. Observe whatever is accessible without removing clothing. Do not ask the child for permission to check beneath his/her clothing.

7. See APPENDIX B for greater detail in responding to report.

B. Policy for Reporting Suspected or Alleged Abuse

1. All staff, leaders, or teachers are required to report any suspected or alleged incidence of abuse to Children's Ministry Director or Student Ministries Director within 24 hours. In the Children's Ministry Director's absence (or if he/she is the accused), the report is to be made to the Senior Pastor (ASAP). In the pastor's absence (or if he is the accused), the report is to be made to the Executive Administrator. It is not the responsibility of the reporting person to substantiate or investigate the alleged or suspected abuse.

2. The parent(s)/guardian of the victim must be informed immediately by the Senior Pastor or his designee of the information that has come to light about their child(ren) in a face-to-face meeting. See APPENDIX D.

3. The Executive Administrator should handle matters such as filing a report with authorities, informing the liability carrier, establish a care plan for the child and family, preparing for disclosure to the church if deemed necessary, etc.

4. When the alleged or suspected victim is a minor child, the person receiving the report will be mandated to report this to the local police department. It is our responsibility to comply with state child protection laws.

5. All volunteers and staff should be aware of the signs and symptoms of abuse, whether abuse is emotional, physical, and/or sexual. See APPENDIX A.

6. When a child reports an incident of abuse or a volunteer/staff person observes signs or symptoms of abuse, the volunteer/staff person must write a report indicating the specifics of the child's report, the specifics of the abuse, the date when signs/symptoms appear, or report as soon as possible. See APPENDIX E.

7. The Senior Pastor (or his designee) shall maintain the records of reported incidents and will keep such records confidential, accurately and completely documenting all efforts at handling the incident.

8. The church will provide appropriate and necessary assistance to the victim, the offender, Child Protection Services (CPS), and local law enforcement agencies.

9. So far as it is consistent with our legal duties as well as our spiritual concern for all involved, we will work to maintain confidentiality.

C. Policy Regarding Alleged Offenders

1. If the child's parent/guardian is the suspected abuser, the CPS or police will be notified and will in turn notify the parent/guardian of their investigation.

2. If staff or volunteer is the suspected abuser, the alleged offender must be informed of the allegations and must be suspended from participating in all service roles in the church until an investigation is done by the proper authorities.
3. If the allegations are found to be false, the censure on service will be lifted. If the allegations are found to be true, the offender must continue under the censure of service and be dealt with by the pastor and elders.

4. If a paid employee is the alleged offender, salary and other benefits will be continued during the period of suspension and investigation. If the allegations are found to be true, salary and all other benefits will be discontinued immediately.

D. Policy Regarding Response to Media

1. If an incident of abuse becomes a public matter such as at the time of arrest, the media has the right to report such incidents. This policy intends to assist Faith Church's leadership to thoughtfully prepare for and respond to the media's awareness of an abusive event, while protecting the victims of such attacks and facilitating the legal process.

2. The identity of the victims or survivors of such circumstances ought to be held confidential, especially minors. Only an adult victim or adult survivor can give consent to release his/her name for publication.

3. Any report of child abuse made to the police directly or to the police via Child Protection Services becomes a felony investigation. Information in the form of a media release, news conference, or prepared statement on

a felony investigation must be prepared and released by the Policy Department.

4. Legal advisors, police department's media officer, and other experts should be consulted before any statements are read or made.

5. The Senior Pastor (or his designee) will be the official spokesperson for Faith Church for any media responses. Statements to reporters or to the media may not be made by the church's staff or volunteers regarding any ongoing investigation of child abuse or neglect.

APPENDIX A

POSSIBLE INDICATORS OF ABUSE

Note: Children rarely exhibit just one sign that they are the victims of abuse. Some symptoms may represent typical development changes or the aftereffect of traumas in their lives other than abuse. Conversely, it is possible for abuse to be taking place without the appearance of noticeable symptoms because of the child's ability to mask or deny what would otherwise be very confusing and painful to acknowledge. Generally, several signs observed over a period of time suggests that a child may be suffering from abuse. This highlights the need for training among volunteers, staff, and program leaders.

A. Infants and Preschool Children

1. Regression to an earlier state of behavior development. Example: baby talk, thumb sucking, or bed-wetting.
2. Change in social behavior that is not associated with normal development. Example: excessive crying, clinging, becoming aggressive or withdrawn.
3. Physical manifestations such as loss of bowel control, bed wetting, frequent urination, headaches, stomachaches, breathing difficulties, sore throats accompanied by gagging, stains on the child's undergarments.
4. Exhibiting signs of fear around a family member or a familiar person or fear of a familiar place or object.
5. Fear of being touched, shying away from physical contact. Resistance to being diapered or assisted in the bathroom.
6. Use of explicit language or sexual behavior that is beyond the child's comprehension or life experience.
7. Attempting sexual behavior with other children or attending adults.
8. Unexplained injuries or bruises, repeated injuries blamed on carelessness, multiple bruises sustained in one event, bruises to child's midsection, back, head, or back of thighs, signs of scalding, burning, or distinctive bruising, such as in the shape of a belt buckle, multiple bruises in various stages of healing.
9. Name calling toward other children, bullying behavior, sulking, or brooding.
10. Fascination with fires, playing with matches or a lighter.

B. School-age Children

1. Same as physical manifestations above coupled with complaints of pain, irritation, soreness, redness on the child's bottom, smearing feces on walls or objects.
2. Pattern of injuries, multiple injuries, injuries about the face or neck, failure to complain about or explain an obvious physical discomfort.
3. Unusual fears such as with a familiar person, a particular room, a particular object, or fear of new experience.

4. Poor concentration in classroom.
5. Exhibiting adult-pleasing behaviors, striving for perfection, acting miserable if failing.
6. Engaging in self-injury, engaging in excessive masturbation, masturbation in public setting.
7. Acting enraged and out of control, expressing anger through destruction.
8. Shyness about physical touch.
9. Exhibiting sexual behavior beyond comprehension or maturity level, behaving in a sexual manner with other children or adults.
10. Exhibiting signs of needing to be in control of others or situations, bullying others.
11. Hostility and distrust of adults, mood swings and irritability, violent disruptions.
12. Acting out, including hoarding food and toys, lying, stealing, assaulting.
13. Frequent absences from school or other scheduled events either because of being punished or to hide bruises.
14. Low self-esteem, particular sensitivity to criticism.
15. Hyper-vigilance. Excessive and suspicious watching of other people. Easily startled.
16. Preoccupation with fire and setting fires.

C. Adolescents

1. Eating disorders, use of laxatives, unexplained and dramatic changes in weight.
2. Changes in sleep patterns, including excessive sleeping, sleeping during the day, or insomnia.
3. Performance in school plunges.
4. Perfectionist behavior, excessive self-criticism, attempting to please adults, overreacting to any form of criticism or complaint.
5. Sexually provocative or asexual behavior, denial of body changes and sexual development; for females, seeking affection from older males.
6. Experimentation with drugs and alcohol.
7. Self-abusive behavior including cutting self, preoccupation with danger and weapons, suicide attempts.
8. Truancy from school.
9. Cruelty to animals, bullying younger children.
10. Emotional numbness, inability to be emotionally supportive of others.
11. Having few friends; changing friends often.
12. Depression and other signs of withdrawal and avoidance.
13. Pregnancy.
14. Refusing to attend to basic hygiene.
15. Rectal and vaginal infections.
16. Hyper-vigilance/excessive watching and suspicion of other people. Easily startled.

D. Neglect

1. Appearing to be underfed, constantly hungry, underweight for size and age.
2. Begging for food, stealing food, hoarding food.
3. Lack of supervision, underage child supervising another child or children.
4. Chronic absenteeism from school, unattended educational needs.
5. Unattended medical and dental needs.
6. Consistent or frequent lack of hygiene or lack of cleanliness resulting in odors.
7. For infants, failure to thrive.

E. Parental Behaviors and Home Life

1. Not attending meetings about the child, not showing an interest in the child, critical of the child, uncomplimentary.
2. Constantly putting child down, using harsh words to describe child, using threats and unflattering language.
3. Describing child as underachiever, complaining that he/she lets people down, is unmotivated, achieve less that brothers and sisters.
4. Speaking of child in a way that sounds too romantic, too grown-up, too sugary, too perfect.
5. Hostile, close-minded, overprotective, isolating, doesn't let others in the house, won't participate in activities with other parents, makes excuses about failing to do tasks, talks about things not being good at home.
6. Reports of past/other suspicious behavior, reports that an older brother or sister may have been mistreated.
7. Chemical dependency by one or both parents.
8. Sudden and dramatic changes in family's financial security.

APPENDIX B

RESPONDING TO A CHILD'S REPORT OF ABUSE

1. Take the child seriously when he/she tells the story.
2. Avoid judgmental statements such as, "I think you just had a bad dream."
3. Do not appear frightened or disgusted by the child's story. This may cause the child to stop talking or to believe you are upset with the child.
4. Do not try to convince the child that the story isn't true or that it did not happen the way the child reported it.
5. Do not make promises to the child that you will not tell anyone what has been shared with you.
6. Remind the child that whatever happened was not his/her fault.
7. Assure the child that it was a good decision to tell someone what happened to him/her.
8. Tell the child that you want to find help so it doesn't happen again.
9. Do not offer a reward to the child for telling the story or promise a gift if the child tells another adult.
10. Reassure the child that he/she does not deserve to be hurt by anyone.
11. Do not frighten the child by talking about police involvement or about medical examinations. Share that other people need to know what happened and they will talk to the child later.
12. Do not ask the child to show any bruises that are beneath underwear or clothing; only observe those bruises that are accessible.
13. Do not investigate the child's story; rather listen to the story, and take notes immediately afterwards while fresh in your memory.
14. Do not tell the child that he/she has been abused.
15. Offer to support the child and remind the child that you care about him/her.
16. Report abuse - See APPENDIX C.

APPENDIX C

REPORTING ABUSE TO AUTHORITIES

State statute requires that any person, volunteer or staff, in the position of care-provider for children is considered a "mandated reporter." A mandated reporter must report child abuse or neglect if it is suspected.

A. If the victim is a minor child, the care giver must notify the Children's Protective Services (CPS) themselves as a "mandated reporter" when:

1. Symptoms of abuse or neglect are suspected outside of the church's setting (See APPENDIX A, page 11).
2. There is no danger of placing a child back into an imminently dangerous situation.

B. If the victim is a minor child, the care giver as "mandated reporter" must follow the church's guidelines (guidelines, page 8; reporting form Appendix E, page 17)) for reporting if:

1. The abuse is suspected to be happening within the setting of the church by staff or volunteers.

C. If the victim is a minor child, notify the local police (911) department when:

1. The care giver needs to control an immediate or imminent conflict or incident regarding a child that cannot be controlled by the care giver. For example, a child being taken by an unauthorized person, or a parent or guardian reacting immediately to a child in an uncontrollable manner.
2. Placing the child in the custody of the parent(s)/guardian will increase or continue the risks of abuse to the child.

NOTE: The police will respond immediately should the situation or information require that type of response. CPS is required by law to respond within 24 hours of reporting.

CPS phone number: 1-800-800-5556 (for anywhere in Indiana)
Dyer Police 219-865-1163

APPENDIX D

RESPONDING TO PARENTS WHO ARE NOTIFIED ON AN ABUSE REPORT

1. Remain calm and nonjudgmental.

2. Anyone who makes a report to the police or CPS authorities is usually granted anonymity; do not identify the reporter unless you are given permission to do so.

3. Do not share any statements made by the child with a parent or relative who is implicated by the child as an abuser. Do not share the child's statements with anyone other than the authorities until the identity of the abuser can be determined and authorities have determined whether or not the child can be protected from contact with that person.

4. Do not attempt to convince a parent that the alleged abuse happened or did not happen. Do not attempt to discredit the child or cast suspicion on the alleged abuser.

5. Do not investigate with a parent what may be happening in the home; and do not share information with a parent that has not been shared with authorities.

6. Do not make promises to a parent about the outcome of the investigation.

7. Listen to any information a parent or guardian may offer about the incident and record it immediately after the conversation. Report additional information to authorities through the reporting procedure outlined in this policy.

8. Offer parents spiritual and emotional prayer support.

9. Suggest resources for parents including books or literature that you know may be personally helpful to them.

10. Allow parents to express their disbelief, anger, and grief. (Parents may be in shock or denial at the mention of abuse allegations).

11. Do not minimize the type of abuse or embellish the abuse, its impact on the child, or its harm to the child.

12. Assure parents of the confidential nature of the report and the need to maintain confidentiality unless disclosure is necessary to protect the well being of other children.

APPENDIX E

REPORT OF SUSPECTED INCIDENT OF CHILD ABUSE

1. Name of worker (paid or volunteer) observing or receiving disclosure of child abuse: _____

2. Victim's name: _____

   Victim's age/date of birth: _____

3. Date/place of initial conversation with/report from victim:
   _____

4. Victim's statement (give your detailed summary here):
   _____
   _____
   _____
   _____

5. Name of person accused of abuse: _____
   Relationship of accused to victim (paid staff, volunteer, family member, other): _____

6. Reported to pastor: _____
   Date/time: _____
   Summary: _____
   _____
   _____
   _____

7. Call to victim's parent/guardian: _____
   Date/time: _____
   Spoke with: _____
   Summary: _____
   _____
   _____

8. Call to local children and family services agency: _____
   Date/time: _____
   Spoke with: _____
   Summary: _____
   _____
   _____

9. Call to local law enforcement agency: _____

Date/time: _____
Spoke with: _____
Summary: _____
_____
_____

10. Other contacts: _____
Name: _____
Date/time: _____
Summary: _____

APPENDIX F

REDUCING THE RISK APPLICATION CHECKLIST
(To be completed by clergy/professional staff persons)

In the case of an allegation of child/youth sexual abuse, the volunteer or clergy staff person who observes or to whom the information is given is required by Faith Church and by the state law to complete the tasks listed below. Date and initial as each step is completed.

Date: _____ _____	Initial: _____ _____	1.**For clergy and paid professional staff:** remove the accused from the situation and suspend the accused from duties involving children/youth. **For volunteers:** Remove the accused from the situation and immediately notify the closest available clergy/professional staff person who will suspend the accused.
Date: _____	Initial: _____	2. Make a written documentation of everything done and said. If the person reporting the allegation is a volunteer, both the volunteer and the clergy/professional staff to whom the volunteer has reported will document the procedures taken.

The procedures after this point will be administered by ministerial staff persons only.

Date: _____	Initial: _____	3. Immediately notify the parents/guardians of the alleged victim and respond to their questions and concerns.
Date: _____	Initial: _____	4. Immediately notify state authorities. Failure to report any suspected, alleged or witnessed abuse is a crime.
Date: _____	Initial: _____	5. Immediately notify the minister in charge.
Date: _____	Initial: _____	6. Make written documentation of persons contacted and action taken to this point.

Date: _____	Initial: _____	7. The clergy/professional staff person will immediately notify a member of the Soul Care response team to begin the internal and pastoral care process.
Date: _____	Initial: _____	a. notify the insurance carrier of the incident immediately and comply with its investigation, if any;
Date: _____	Initial: _____	b. cooperate with legal and state authorities in their investigations, if any;
Date: _____	Initial: _____	c. prepare a written statement and designate a spokesperson to respond to media inquiries;
Date: _____	Initial: _____	d. provide assistance to the alleged victim and his/her family in obtaining counseling or referral to a mental health professional, if needed;
Date: _____	Initial: _____	e. respond to the needs of the families of the alleged victim and the accused to seek a redemptive solution for all involved;
Date: _____	Initial: _____	f. inform the affected volunteer(s) and paid staff members of the need for confidentiality, and;
Date: _____	Initial: _____	g. consider and respond to the concerns of other parents.
Date: _____	Initial: _____	8. Within five (5) days of the alleged abuse, the clergy/professional staff person who made the original report will prepare a written report and send one copy to the state agency and will give one copy to the senior pastor.

Date: _____	Initial: _____	9. Make written documentation of persons contacted and action taken.

APPENDIX G

PROFILE ON A CHILD ABUSER

SEXUAL ABUSE

Men 18 and up

- Low self-esteem
- Need for power and control
- Poor family relationships, though the relationships often look okay from the outside
- Difficulty in interpersonal relationships...relates to others immaturely both socially and emotionally...may not be involved with peers or engage in adult group recreational activities.
- Difficulty with impulse control
- History of past physical/sexual victimization...80-95% of child molesters where themselves molested as children
- Primary interests are in children
- May be involved in youth activities such as group leaders or coaches
- May be single or married...if married, they are often experiencing marital difficulties...they have difficulty in developing satisfying, supportive, intimate relationships with adults
- May have a specific age of children they prefer to work with
- May be of any sexual orientation or preference
- May have been insecure in childhood with frequent moves, early physical illnesses and marital difficulties between parents
- Many are less of a team player
- Difficult time asking for help with his problems
- Don't admit to stress or recognize a need to have a plan to deal with it
- Use children to fulfill their needs or validate their sense of competence and well-being
- Highly skilled at gaining the trust and confidence of children
- Sensitive to children's needs and have a way of putting children at ease
- Move frequently and unexpectedly
- Seeks opportunities to be alone with children
- Has an idealistic perspective of children...may refer to them as objects
- Often good at convincing others about their competence and caring

Adolescent

- Lack of contact with peers
- Few or no extracurricular activities
- Generally feels powerless and inadequate
- May feel more comfortable with children younger than themselves
- Males, in particular, may be frequently chosen to baby-sit because they make themselves available and relate well to young children
- May come from a family where there has been physical or sexual abuse
- May seem socially immature for their age

- May lack a close relationship with a father figure

Women
- May have married young
- Reared in a very strict home
- Her family was/is very religious
- Her husband is gone frequently and is not very supportive
- Is sexually naïve and immature
- Is very dependent on father figure
- Frequently the victim of physical abuse
- Has low self-esteem
- The husband exaggerates his masculinity in dress, work, and with peers and usually has drug or alcohol problems that affect his sexual performance
- Is lonely
- Does not have much tenderness in her life

PHYSICAL ABUSE
- Negative attitude about life and people
- Labeled as having a "hot" temper
- Blames others: "he made me," "it was her fault"
- History of child abuse as a child
- Uses harsh, age inappropriate discipline
- Offers illogical or unconvincing excuses for what occurred
- Exhibits out of control behavior

EMOTIONAL ABUSE
- Blames and belittles children
- Cold and rejecting
- Withholds love

CAUTION: A profile list such as this can be misleading because many of the characteristics here can describe men/women who do not molest. Having more than one or even all of these items does not necessarily increase the odds of that person being a molester. Although this profile has some value in pointing out particular needs of people and risks associated with them, great caution should be used when assigning this profile to any one individual. Few molesters ever report the characteristics listed here. Neither are interviewers trained to properly elicit this information. Individuals with abusive personalities are often more subtle and skillfully manipulative in their approach to their employers, as well as their approach to children. This makes it essential for those responsible for hiring or enlisting volunteers to gain information from collateral resources such as past employers, friends, families, and criminal background checks.

Table of Contents

WHAT IS A DEVELOPMENTAL DISABILITY?

Developmental disabilities may be any one of a diverse group of chronic conditions that result from mental or physical impairments. Developmental Disabilities (DD) may impact activities of daily living (ADLs), and other major areas such as language, learning, mobility, self-help skills, self-regulation, and independent living. DDs may begin anytime from the pre-natal stage through age 22. These delays usually last throughout an individual's lifetime; most have no cure, but symptoms may be successfully managed.

Teaching Tips for Children with Developmental Disabilities

- Give children with warnings before transitions; provide countdowns to the next activity.
- Set your expectations high for students.
- Treat children with empathy, not sympathy; children do not want your pity.
- Capitalize on children's strengths. Get to know the students and the areas in which they excel.
- Find out what students can do independently and with what they need assistance.
- Allow extra processing time in between your questions and a student's expected answer.
- Post visual schedules to assist in processing.
- Allow extra time and space for mobility limitations or lack of dexterity.
- Be patient with behaviors, and try to look for the underlying source of frustration (ex. inability to communicate), instead of writing it off as "problem behavior" and simply treating the outward symptoms.
- Maintain a positive outlook and encourage the students whenever possible.

WHAT IS AN EMOTIONAL DISABILITY?

An emotional disability is often referred to as mental illness or behavioral disability. Many times this category of disability is called "hidden disabilities" or "invisible". A hidden disability is defined as an emotional, behavioral, or developmental disability that has no outwardly-apparent symptoms. Children with an ED (Emotional Disability) have extreme difficulty at home, at school, and with peer relations. It is estimated that at least 1 in 10 children suffer from an emotional disorder severe enough to experience some level of impairment. (DHHS, 2006) These children are often very intelligent, and have the cognitive skills to complete their school work; however, their behavioral issues and challenges are perplexing to family members, peers, and professionals in the community. Some of the common characteristics of ED are high degrees of impulsivity, extreme anger or outbursts, mood swings that change quickly and without notice, poor grades (behaviors can interfere with the learning process), and inflexibility when dealing with change.

The most common emotional disorders affecting children are ADD/ADHD, Personality Disorder, Childhood Depression, Schizophrenia, and eating disorders.

Tips for Teaching Children with Emotional Disabilities

- Provide a structured classroom and environment.
- Set routines and schedules.
- Post classroom rules and schedules.
- Catch students doing the "right thing", and reward appropriate behavior.
- Have a behavior management plan developed.
- Consider using adult buddies for support if necessary.

WHAT IS AN INTELLECTUAL DISABILITY?

An intellectual disability is characterized both by a significantly-below-average score on a test of mental ability or intelligence, and by limitations in the ability to function in areas of daily life (ADLs), such as communication, self-care, social situations, and school activities. Intellectual disabilities are also called cognitive disabilities. Until recently it was common to refer to an intellectual disability as mental retardation; however, the label "mental retardation" has been done away with, due to the negative connotation and stereotype. A child with an intellectual disability may have a very mild diagnosis, and still be able to do many of life's activities independently, or may be very involved and need much support and assistance in the classroom and at home. A child with an intellectual disability may be born with it, or it may develop throughout the lifespan.

Some of the most common intellectual disabilities are Down Syndrome, Fragile X Syndrome, and Fetal Alcohol Syndrome (FAS), all of which occur before the baby is born. Most intellectual disabilities are not preventable, other than FAS. Some conditions are metabolic in nature and occur due to imbalances in the child's body or system, such as Phenylketonuria (Abbrev. PK – Genetic disorder in which the body cannot process the Phe protein, which leads to an excess of this protein and results in ID.) or congenital hypothyroidism. Still, there are other disabilities that occur due to serious head injury, stroke, or infections like meningitis. It is not uncommon for a child to have both physical and intellectual disabilities; many children have multiple disabilities.

Teaching Tips for Students with Intellectual Disabilities

- Learn students' strengths and interests; create opportunities for success.
- Teach in concrete terms; avoid abstract concepts.
- Vary modalities when teaching; demonstrate or show lessons with visuals and objects.
- Give students more time to complete tasks or activities.
- Break down multi-step projects into smaller, easier tasks.
- Post visual schedules and rules in classroom.
- Keep classrooms neat and organized.
- Help students with transitions by preparing them for change (i.e. give verbal warnings or provide countdowns).
- Create buddy systems or supports for students that need additional supports.
- Adapt materials to meet students' cognitive abilities.

WHAT IS A PHYSICAL DISABILITY?

Physical disabilities and impairments include orthopedic, neuromuscular, blindness, deafness, pulmonary, and cardiovascular disorders. Many individuals with physical disabilities may require the use of assistive devices, such as wheelchairs, walkers, or crutches, to assist with or attain mobility. Children can be born with disabilities, or they can occur shortly after birth or result from injury later in life.

Some of the more common physical disabilities are cerebral palsy, muscular dystrophy, and limb deformation. Some physical disabilities are not visible to the eye. Disabilities such as pulmonary disease, respiratory disorders, epilepsy or seizure disorders, and other limiting conditions have no outward characteristics.

Teaching Tips for Children with Physical Disabilities

- Children with physical disabilities want to be treated as normally as possible.
- Set your expectations high for students.
- Treat children with empathy, not sympathy; children do not want your pity.
- Make physical adjustments to classrooms so children's wheelchairs and equipment fit.
- Capitalize on children's strengths. Get to know the students and the areas in which they excel.
- Encourage peer-assisted learning and team work to assist students with physical disabilities.
- Find out what students can do independently and with what they need assistance.
- Teach other children in the room acceptance of all students.
- Provide easy access to and from classrooms.

ANGELMAN SYNDROME

Angelman Syndome is a neuro-genetic disorder first diagnosed by English physician Harry Angelman in 1965. It occurs in 1 in 15,000 live births. Angelman is often mis-diagnosed as Cerebral Palsy or Autism. Angelman Syndrome characteristics include: developmental delays, lack of speech, seizures, and mobility and balance issues. Individuals with Angelman Syndrome do not have the faculties to live independently, and will need lifelong care.

Common Symptoms and Features:

- Minimal to no expressive, verbal, communication (inappropriate alternative communication strategies, i.e. hair pulling)
- Developmental delay
- Delayed development of the head, resulting in a smaller-than-usual head size (microcephaly)
- Seizures beginning before age 3
- Hyperactivity, short attention span
- Puberty delayed by 1-3 years

Causes:

Angelman Syndrome is caused by deletions on the maternally-derived chromosome 15q, 12 region. Angelman may also be caused by having two copied of the paternally-derived chromosome 15. The Angelman gene is called UBE3A; abnormalities in this gene cause neural developmental impairment.

Strengths:

- Happy disposition (frequently laughing and smiling)
- Development is delayed, but forward (once skills are gained they, typically, are not lost)
- Receptive language higher than expressive (levels will vary from person to person)

Limitations:

- Dependent in all areas of daily living (ADLs)
- Feeding issues, especially during infancy
- Sleep disturbances, which may result in attention difficulties or issues in other areas of life due to excessive sleepiness
- Balance issues, lack of coordination

ASPERGER SYNDROME

First described by Dr. Hans Asperger in 1944, Asperger Syndrome (AS) is characterized by impaired social interaction that ranges in severity from mild to profound. AS is categorized as a pervasive developmental disorder (PDD) and falls within the autism spectrum. Children with AS have typical patterns of language and cognitive development and are likely to mature into independent adults. Treatment of AS focuses on minimizing symptoms through medication, psychotherapy, behavior modification, social skills training, and educational interventions. Asperger Syndrome is sometimes referred to as "high-functioning Autism".

Common Symptoms and Features:

- Difficulty with non-verbal communication (i.e. body language, facial expressions, eye-to-eye gaze)
- Repetitive routines or rituals
- Social impairment, very focused on self
- Uncoordinated motor movements, clumsiness
- Unusual preoccupations and behaviors

Causes:

The exact cause of AS is unknown, but there is some indication it may be hereditary. Currently, there is no specific course of treatment or cure for the disorder.

Strengths:

- Excellent rote memory and musical ability
- Exceptional skill or talent in a specific area
- Rich vocabulary
- Possess average or above-average intelligence
- Will achieve most childhood milestones in a reasonable amount of time

Limitations:

- Difficulty with social interactions and peer relationships
- Intense interest in one or two subjects, sometimes to the exclusion of other topics
- May exhibit sensitivities to stimuli: sounds, lighting, clothing, and foods

ATTENTION DEFICIT DISORDER (Officially ADHD, Inattentive Type)

Attention Deficit Hyperactivity Disorder (ADHD) is a neurobehavioral disorder that interferes with an individual's ability to sustain attention or focus on a task. In some cases, ADHD may also result in an inability to control impulsive behavior. Symptoms of the disorder typically arise during early childhood and must persist for at least six months with onset before seven years of age. In addition, males are affected more frequently than females. Treatment for ADHD may include medication, behavioral therapy, education, proper nutrition, and exercise. The three common characteristics of ADHD are high-level inattention, hyperactivity, and impulsiveness.

Common Symptoms and Features:

- Difficulty remaining seated
- Difficulty awaiting turns in games
- Failure to listen to instructions
- Fidgeting with hands or feet
- Impulsive behavior
- Inattention
- Interrupting conversations and speaking excessively
- Shifting from one uncompleted task to another
- Difficulty focusing on the task at hand

Causes:

It is believed ADHD is caused by altered brain biochemistry. A landmark study in 1990 revealed the rate at which the brain uses glucose is lower in individuals with ADHD, especially in the area of the brain responsible for attention, handwriting, motor control, and inhibition responses. At present, there is no cure for ADHD.

Strengths:

- Ability to learn is not impaired
- Serious emotional disturbances are unlikely
- High level of energy and drive
- Creative thinkers: great imaginations and master problem solvers

Limitations:

- Greater likelihood of grade retention, school drop-out, and academic under-achievement
- Difficulty developing friendships due to behavior excesses and deficits of ADHD
- Usually excel in many areas, such as math, reading, and science
- May lose things easily and need frequent reminders

AUTISM

First described in 1944 by Leo Kanner, autism is a developmental disorder of brain function that affects males four times as often as females. The disorder is a spectrum disorder with a wide range, and is characterized by three main symptoms: impaired social interaction, difficulty with verbal and non-verbal communication and imagination, and unusual or limited activities or interests. These symptoms typically surface during the first three years of life. Treatment generally focuses on medication and behavior therapy but may also include the use of facilitated communication. The Centers for Disease Control and Prevention (CDC) report an average of 1 in 110 children in the United States being diagnosed with an Autism Spectrum Disorder each year.

Common Symptoms and Features:

- Absent or delayed language development
- Absent or impaired imaginative and social play
- Development of epilepsy by adulthood
- Impaired ability to initiate or sustain a conversation, or to maintain eye contact
- Impaired ability to make friends with peers
- Inflexible adherence to specific routines or rituals
- Intellectual disability may be present in some; others may exhibit average or above-average intelligence
- Preoccupation with parts of objects, as opposed to the object as a whole
- Repetitive movements, such as clapping, hand flapping, rocking, and swaying
- Restricted patterns of interests that are abnormal in intensity or focus
- Stereotyped, repetitive, literal, or unusual use of language

Causes:

Autism does not have any one single cause. It is suspected that several genes and environmental factors, such as viruses and chemicals, contribute to the development of the disorder. Research has shown abnormalities that are present in several regions of the brain, including the cerebellum, amygdala, hippocampus, septum, and mamillary bodies. Neurons in these regions of the brain are smaller than usual and have stunted nerve fibers. At present there is no cure for autism.

Strengths:

- May have unusual talents, such as exceptional rote memory, lightning calculation, and musical or drawing gifts
- Very visual learners
- Concrete thinkers

Limitations:

- Difficult to shift or divide their attention
- Express little interest in others
- Prefer solitary, repetitious play
- Difficulty engaging in make-believe play
- Sensory integration issues, causing difficulties with processing information from the five classic senses (vision, auditory, touch, olfaction, and taste), the sense of movement, and/or the positional sense (proprioception).

CEREBRAL PALSY

Cerebral Palsy (CP) is a term used to describe a group of chronic disorders impairing control of movement. The four different classifications of CP are spastic, athetoid, ataxic, and mixed forms. Of the four classifications, spastic is the most common, affecting 70-80% of CP patients. Symptoms and the severity of symptoms vary widely across classifications and individuals but do not worsen over time. Treatment of CP often involves physical, psychological, occupational, physical, and speech therapies, as well as medication, surgery, and braces.

Common Symptoms and Features:

- Delayed motor development
- Failure to thrive (delayed growth and development, despite adequate nourishment)
- Hearing abnormalities
- Intellectual disability in 66% of cases
- Muscle contractions
- Seizures or epilepsy
- Sensory impairments
- Spasticity
- Speech impairments
- Vision impairments
- Writhing movements
- Difficulty swallowing

Causes:

The exact cause of CP is not fully understood. It was long believed the condition was a result of difficult deliveries and lack of oxygen at birth; however, more recent research suggests CP may be caused by an infection. Premature births and maternal infections also raise the likelihood of CP.

Strengths:

- Incredible capacity to strive for and meet goals
- Very social, enjoy being with people
- Enjoy music

Limitations:

- Motor impairments affecting balance, movement, and posture
- Slurred or difficult-to-understand speech

CYSTIC FIBROSIS

Cystic fibrosis (CF) is a genetic disorder that affects the respiratory, digestive, and reproductive systems. CF produces a thick, sticky mucus in the aforementioned systems of the body that increases the risk for bacterial infection. As a result, CF patients often suffer from frequent or chronic respiratory infections, pancreatic insufficiency, cystic-fibrosis-related diabetes, sterility in males, and difficulty with conception in females. Treatment of the disease focuses on alleviating symptoms through medication, chest physical therapy, pancreatic enzymes, and vitamin supplements. In the United States, there are approximately 30,000 children and adults with CF. About 1,000 individuals are diagnosed with CF each year.

Common Symptoms and Features:

- Chronic cough
- Clubbing (enlarged fingertips)
- Frequent and persistent sinus infections
- Nasal polyps (growths in the nose)
- Poor weight gain and/or growth
- Recurring pneumonia
- Salty skin
- Wheezing, or shortness of breath

Causes:

CF is a genetic disease caused by a mutation in a gene that produces a protein called cystic fibrosis transmembrane regulator (CFTR). At present, there is no cure for the disease; however, significant progress is being made in the area of gene therapy.

Strengths:

- Typical cognitive and social development
- Can have a very normal healthy lifestyle as long as therapies are followed

Limitations:

- Minimal strenuous physical activity
- Dietary restrictions (CF diet should be high in calories, salt, and fat)
- May be more prone to lung infections

DOWN SYNDROME

First described by Dr. John Langdon Down in the 19th century, Down Syndrome (DS) is the most commonly-occurring chromosomal anomaly. Most individuals with DS have some degree of intellectual disability, generally ranging from mild to moderate. Infants with the disorder are generally diagnosed after birth due to the distinct physical characteristics of DS. Early intervention services are the primary means of treatment. One in 691 children is born with Down Syndrome. Down Syndrome affects the individual both physically and mentally.

Common Symptoms and Features:

- Delayed speech development
- Dysplastic ears (abnormal shape of ear)
- Flat facial profile, depressed nasal bridge and small nose
- Hyperflexibility (excessive ability to extend joints)
- Lowered resistance to infection resulting in increased respiratory infections
- Intellectual disability
- Hypotonia (low muscle tone)
- Slanting eyes with folds of skin at the inner corners

Causes:

DS is also known as Trisomy 21 because of the presence of an extra partial or complete 21st chromosome. This additional chromosome causes DS and results in a total of 47 chromosomes, rather than the standard 46.

Strengths:

- Ability to participate in the workforce
- Very social and enjoy friendships
- Reaching developmental milestones, such as walking, talking, and toilet training, only slightly later than other children of the same age

Limitations:

- Slowed physical and intellectual development
- Delayed language or verbal communication
- Hypotonia, or low muscle tone

EMOTIONAL DISTURBANCE (ED)

An emotional disability is a condition that, over a long period of time, consistently interferes with a student's learning process and adversely affects the student's educational performance. An emotional disability may include, but is not limited to, one or more of the following conditions: (1) a tendency to develop physical symptoms or fears associated with personal or school problems; (2) a general pervasive mood of unhappiness or depression; (3) an inability to learn that cannot be explained by intellectual, sensory, or health factors; (4) an inability to build or maintain satisfactory interpersonal relationships; and (5) inappropriate behaviors or feelings under normal circumstances.

Common Symptoms and Features:

Some of the characteristics and behaviors seen in children that have emotional disturbances include:

- Hyperactivity (short attention span, impulsivity)
- Aggression/self-injurious behavior (acting out, fighting)
- Withdrawal (failure to initiate interaction with others, retreat from exchanges of social interaction, excessive fear or anxiety)
- Immaturity (inappropriate crying, temper tantrums, poor coping skills)
- Learning difficulties (academically performing below grade level)

Children with the most serious emotional disturbances may exhibit distorted thinking, excessive anxiety, bizarre motor acts, and abnormal mood swings. Some are identified as children that have severe psychosis or schizophrenia.

Many children that do not have emotional disturbances may display some of these same behaviors at various times during their development; however, when children have an emotional disturbance, these behaviors continue over long periods of time. Their behaviors, therefore, signal they are not coping with their environment or peers.

Causes:

The causes of emotional disturbance have not been adequately determined. Although various factors, such as heredity, brain disorder, diet, stress, trauma, and family functioning, have been suggested as possible causes, research has not shown any of these factors to be direct causes of behavioral or emotional problems.

Limitations:

- Exhibit mood disorders, anxiety disorders, ADHD, conduct disorders, or other psychiatric disorders
- Co-occurrence of emotional disturbance and other disabilities may intensify students' behavioral problems and further compromise academic performance.
- Many students with emotional disturbance are at greater risk for substance abuse disorders.
- Students with emotional disturbance are particularly vulnerable to environmental changes, such as transitions, and to a lack of positive behavioral support during transitions.
- Educational programs for children with emotional disturbances need to include the provision of emotional and behavioral support as well as helping them master academics, develop social skills, and increase self-awareness, self-control, and self-esteem.

EPILEPSY

Epilepsy is a medical condition that causes seizures affecting both mental and physical functions; epilepsy is sometimes referred to as seizure disorder. A seizure occurs when the electrical system in the brain malfunctions and causes a rapid firing of electrical energy. The result may be altered consciousness or muscle contractions. There are many different types of seizures, ranging from very mild to serious, depending on which part of the brain is impacted; most seizures last only a minute or two. Medication is the most common method of epilepsy treatment, but other, holistic, methods are used, as well.

Common Symptoms and Features:

- Loss of, or altered state of consciousness
- Sudden falls without any explanation
- Rapid blinking
- Repeated muscle movements, slackened muscles
- Altered sense of taste, sound, touch
- Confused states
- "Funny" feelings; sense of "déjà vu"
- Jackknife body movements (convulsions, body contractions)
- Unusual sleep patterns

Causes:

Seizures are a symptom of abnormal brain functioning. In about 70% of persons with epilepsy, the exact cause is not known. Among the rest, there may be any number of factors, such as head injuries, lack of oxygen during the birth process, genetic conditions, abnormal brain development, toxins, or infections. Typical seizure triggers include photosensitivity, hormonal changes, sleep patterns, and stress.

Strengths:

- Most individuals with epilepsy are in the normal cognitive range, unless they have a co-occurring ID diagnosis
- Able to participate in any and all activities, taking into account the individual's safety

Limitations:

- May need to avoid certain activities that could trigger seizures
- Medications may cause lethargy, mood swings, or weight changes

FETAL ALCOHOL SYNDROME (FAS)

Fetal alcohol syndrome is the manifestation of specific growth, mental, and physical birth defects associated with the mother's high levels of alcohol consumption during pregnancy. Patients with fetal alcohol syndrome typically have multiple handicaps and require special medical, educational, familial, and community assistance.

Common Symptoms and Features:

- Growth deficiencies: small body size and low weight, slower-than-normal development, and failure to thrive
- Skeletal deformities: deformed ribs and sternum; curved spine; hip dislocations; bent, fused, webbed, or missing fingers and/or toes; limited movement of joints; small head
- Facial abnormalities: small eye openings; skin webbing between eyes and base of nose; drooping eyelids; nearsightedness; failure of eyes to move in same direction; short upturned nose; sunken nasal bridge; flat or absent groove between nose and upper lip; thin upper lip; opening in roof of mouth; small jaw; low-set or poorly-formed ears
- Organ deformities: heart defects; heart murmurs; genital malformations; kidney and urinary defects
- Central nervous system handicaps: small brain; intellectual disability that is usually mild to moderate, but occasionally severe; learning disabilities; short attention span; irritability in infancy; hyperactivity in childhood; poor body, hand, and finger coordination

Causes:

Alcohol in a pregnant woman's bloodstream circulates to the fetus by crossing the placenta. There, the alcohol interferes with the ability of the fetus to receive sufficient oxygen and nourishment for normal cell development in the brain and other body organs.

Strengths:

- Imaginative and creative (often used as a tool to get the individual out of trouble)
- Visual learners
- High energy level

Limitations:

- Attention challenges
- Possible memory weakness
- Behavioral challenges: noncompliance or defiance

FRAGILE X SYNDROME

Fragile X Syndrome is the most common genetically-inherited form of intellectual disability, with IQs of diagnosed individuals typically between 70-85. Males are 4 times more likely to be carriers of the Fragile X gene than females are. Males born with the full gene mutation are twice as likely as females to have Fragile X Syndrome. Only 50% of females born with the full gene mutation will develop features of Fragile X. Children with Fragile X appear typical during infancy but manifest delays over their lifetimes. Characteristics of Fragile X may be treated with medication, speech, physical, and occupational therapies, structured education, and counseling.

Common Symptoms and Features:

- Digestive disorders
- Double-jointed fingers
- Echolalia (repeating verbalizations of a previous speaker)
- Flat feet
- Hyperactivity
- Large or prominent ears
- Long, narrow face
- Mental impairment ranging from learning disabilities to severe intellectual disability
- Perseveration (inability to complete a sentence due to continuous repetition of words at the end of a phrase); continued focus on a specific topic of interest only to the speaker
- Puffy eyelids
- Sensory integration (difficulty processing external stimuli that can result in hypersensitivity to noise, sound, light, and/or odors)
- Tactile defensiveness (negative response to being touched)

Causes:

Fragile X is a genetic condition inherited due to a change in the Fragile X (FMR-A) gene, (found on the X-chromosome), causing it to increase in length. It is responsible for creating a protein important for brain development. When the gene changes (mutates), brain development and function are impaired. Both males and females with a history of Fragile X may be carriers of the gene; without having the disorder themselves; they will, however, have an increased chance of passing it on to their children.

Strengths:

- No serious physical issues
- Positive outlook on life
- Strong visual memory and learners
- Very social and love people

Limitations:

- Difficulty simultaneously processing information, resulting in difficulty with skills requiring sequential processing of information, such as reading
- Speech challenges (worse when anxious or eye contact is needed)
- Auditory distractibility (distraction by background and irrelevant sounds or noise) when trying to focus and attend during listening tasks)

HEMOPHILIA

Hemophilia is a rare inherited bleeding disorder in which the blood does not clot normally. This is caused by changes in the F8 gene, responsible for making a protein called Coagulation Factor VIII (in Hemophilia A), or Factor IX (in Hemophilia B). These are the proteins that help an individual's blood to clot after a bruise, scratch, cut, or hard hit. These two major forms of Hemophilia occur mainly in males. Type A occurs in 1 in 4,000 – 5,000 male births, and Type B occurs in 1 in 20,000 male births.

Common Symptoms and Features:

- Many large or deep bruises
- Joint pain and swelling caused by internal bleeding
- Unexplained bleeding or bruising
- Blood in urine or stool
- Prolonged bleeding from cuts or injuries or after surgery or tooth extraction
- Nosebleeds with no obvious cause
- Tightness in joints

Causes:

The lack of necessary proteins to assist in blood clotting cause an individual to bleed uncontrollably from even a minor cut. There is no way to introduce or replace this protein in the body, and individuals with hemophilia must be very careful not to be cut or scratched in such a way that would cause heavy bleeding.

Strengths:

- Typically developing in the cognitive sense
- Can lead a normal life with caution

Limitations:

- Physical activity restrictions: no contact sports
- Pain: acute (sudden onset) or chronic (long-lasting)

HYPOTONIA

Hypotonia is a medical term used to describe decreased muscle tone (the amount of resistance to movement in a muscle). It is not the same as muscle weakness, although the two conditions can co-exist.

Children who have cerebral palsy with hypotonia have muscle tone that is abnormally low or floppy; the entire body is usually affected. Problems include poor head control, very poor trunk stability and control, absence of balance reactions and protective responses, and excessively-hyper mobile joints.

Common Symptoms and Features:

- Children with hypotonia have a floppy quality or "rag doll" appearance because their arms hang by their sides, and they have little or no head control.
- Other symptoms of hypotonia include problems with mobility and posture, breathing and speech difficulties, lethargy, ligament and joint laxity, and poor reflexes.
- Hypotonia does not affect intellect.
- Depending on the underlying condition, some children with hypotonia may take longer to develop social, language, and reasoning skills.

Causes:

Hypotonia may be caused by trauma, environmental factors, or by genetic, muscle, or central nervous system disorders. Sometimes, however, it is not be possible to determine the cause of hypotonia.

Strengths:

- Visual learners
- Strong receptive language
- Good long-term memory

Limitations:

- Motor planning and mobility challenges
- Difficulty with expressive language
- May take longer to develop social, language, and reasoning skills

INTELLECTUAL DISABILITIES (Formerly Mental Retardation)

Intellectual disability (ID) is a term used to describe a person with limitations in mental functioning and skills, such as communication, personal care, and social skills. As many as 1-3% of people in America have intellectual disabilities (The Arc, 2011). These limitations cause affected children to develop at slower rates than typical children. Many of the things they will learn in life may simply take them a little longer to learn, while some things they may never learn.

Common Symptoms and Features:

- Intelligence quotient (IQ) below 75
- Significant limitations in adaptive skill areas, such as social skills, leisure, functional academics, self-care, communication, home living, health and safety, and work
- Difficulty problem solving and thinking logically

Causes:

- Most often caused by genetic conditions, such as Phenylketonuria (PKU), Fragile X Syndrome, and Down Syndrome
- Issues during pregnancy (e.g. maternal infections), at birth (e.g. prematurity), and after birth (e.g. childhood diseases)
- Complications during the birth process (not enough oxygen to the brain)
- Health problems: certain diseases or malnutrition may cause intellectual disabilities

Strengths:

- Maintain capacity to learn and grow; many children will grow to live independently
- Most become productive and full participants of society
- Strong visual learners

Limitations:

- Learning is slowed and impaired
- May require varying degrees of adaptive support throughout lifetime

LEARNING DISABILITY (LD)

A learning disability is a neurological disorder in which a person's brain is "wired" differently. It is estimated that 20% of the American population has some type of learning disability, according to the U.S. Department of Education (2010). 8-10% of Americans under the age of 18 have a learning disability. Learning disabilities often run in families, and the most common types are difficulty with basic reading, language, or math skills. There is no cure for learning disabilities; it is a lifetime issue. Children with learning disabilities, however, are able to have success in school with proper educational supports and interventions.

Common Symptoms and Features:

- Delayed speech or pronunciation problems
- Trouble reading
- Easily distracted
- Difficulty interacting with other students
- Slow to develop fine motor skills
- Weak memory skills
- Trouble with open-ended questions
- Difficulty planning

Causes:

Mental health professionals do not know for certain what causes learning disabilities. There are some reasons that contribute to the condition. A current theory is learning disabilities stem from slight disturbances in brain structures and functions, and many times the disturbance begins before birth. Some factors that affect fetal brain development are genetic factors and mothers' use of tobacco, alcohol, or drugs during pregnancy. Other factors after birth that may contribute to learning disabilities are environmental in nature, such as lead poisoning.

Strengths:

- May be cognitively on task with other students
- Typically social; enjoy interacting with others
- Depending on the diagnosis, may do well with cross-age tutors (same-age peers) or buddies

Limitations:

- Possibly require more time to complete tasks
- Need more frequent reminders or cues to stay on task
- Challenges with reading, spelling, writing, and math
- Possible speech and language challenges

MICROCEPHALY

Microcephaly is a rare neurological condition in which the circumference of the head is smaller than average for the child's age and gender. A child may be born with the condition (congenital) or it may develop in the first few years of life. Treatment may involve physiotherapy, medication, and/or dietary management.

Common Symptoms and Features:

- Delayed motor and speech development
- Hyperactivity
- Loose, wrinkled scalp
- Intellectual disability
- Receding forehead
- Small head and large face
- Underweight and dwarfed body

Causes:

Microcephaly may be genetic in some cases and non-genetic in others. The condition may be caused by brain-damaging infections in infancy or by one of the following conditions:

- Congenital taxoplasmosis
- Congenital rubella
- Cornelia de Lange syndrome
- Cri du chat syndrome
- Down syndrome
- Rubinstein-Taybi syndrome
- Sekel's syndrome
- Trisomy 13
- Trisomy 18
- Uncontrolled maternal PKU

The exact cause of the disorder is unknown; and at present, there is no specific treatment for Microcephaly.

Strengths:

- Determined; able to overcome many difficulties
- Very social; enjoy being with others

Limitations:

- Delayed brain function
- Poor balance and motor planning

OBSESSIVE-COMPULSIVE DISORDER (OCD)

OCD is a neurological Anxiety Disorder that may have genetic origins and is caused by an imbalance of serotonin. Serotonin is a neurotransmitter (a chemical that acts as messenger in the brain) between the orbital cortex (the front of the brain) and the basal ganglia (deeper structures of the brain). When the serotonin levels are imbalanced, the messages that go from one part of the brain to the other are confused, resulting in repetitive "worry thoughts", sort of like a CD skipping! These repetitive "worry thoughts" are known as *obsessions*, and they drive the people experiencing them to act out time-consuming rituals known as *compulsions*.

The disorder usually begins in adolescence or young adulthood and is seen in as many as 2-3% of Americans. *Obsessions* are recurrent and persistent thoughts, impulses, or images that are unwanted and cause marked anxiety or distress. Frequently, they are unrealistic or irrational. *Compulsions* are repetitive behaviors or rituals (like hand washing, hoarding, keeping things in order, checking something over and over) or mental acts (like counting, repeating words silently, avoiding). In OCD, the obsessions or compulsions cause significant anxiety or distress, or they interfere with the child's normal routine, academic functioning, social activities, or relationships.

Common Symptoms and Features:

- Most people with OCD have both obsessions and compulsions, but some people experience just one or the other.
- The symptoms of OCD may wax and wane over time. Often, the symptoms get worse in times of stress.

Causes:

The exact causes of OCD are still unknown; however, researchers strongly suspect a biochemical imbalance is involved. Alterations in one or more of the brain's chemical systems that regulate repetitive behaviors may be related to the cause of OCD; these balances may be inherited. Psychological factors and stress may heighten symptoms.

Strengths:

- Often caring, sensitive, intelligent, creative, and imaginative
- Often perfectionists, analytical and deep thinking
- Not sad or lacking in pleasure

Limitations:

- Causes problems with attention and concentration
- Increased anxiety
- Possibly inflexible; difficulty with transition or change

OPPOSITIONAL DEFIANT DISORDER (ODD)

Children are often oppositional throughout childhood. There are many triggers that create oppositional attitudes, such as exhaustion, hunger, stress, or being upset. In turn children become argumentative, disobedient, and defiant. This is all a very normal part of childhood development, especially for two- to three-year-olds and young adolescents. When these behaviors become serious concerns and affect children's social, family, and academic lives, it may be more than normal childhood development. Children that are easily annoyed, repeatedly lose their tempers, become argumentative with adults, and blame others for their situations may have ODD. ODD is the most common psychiatrically-diagnosed behavioral disorder in children that typically continues into adulthood.

Common Symptoms and Features:

- Excessive arguing with persons in authority
- Easily annoyed
- Blaming others for mistakes or behaviors
- Intentional attempts to annoy or upset people
- Sometimes characterized by aggressive or violent behaviors
- Unkind and hateful talk when upset
- Prone to seek revenge

Causes:

The causes of ODD are unknown. It is believed, however, that biological and environmental factors may play a role. Studies have shown certain environments increase the development of ODD, for example, poor parenting, domestic violence, abuse, and substance abuse by caregivers. It has been documented that some children have developed ODD as a result of stress and frustration from life circumstances, such as death or divorce. Treatment may include education, psychotherapy, or cognitive-behavioral therapy.

Strengths:

- Structured learners; need to be kept busy
- Varied interests and hobbies

Limitations:

- Challenges with social skills
- Difficulty with change or transition
- Prone to classroom outbursts; choose what to ignore

PEDIATRIC BIPOLAR DISORDER (Also known as manic-depression)

Bipolar disorder is a serious, but treatable, mental illness. It is a disorder of the brain in which there are extreme changes in mood, thought processes, activity levels, and behavior. Until just recently, the medical community rarely made a diagnosis during childhood. Today, symptoms are often noted in infancy or early childhood. Early intervention and therapies offer the best hope in helping children with bipolar disorder gain stability.

Children with bipolar disorder typically have continual mood disturbances, which are a mix of mania and depression. The change or cycling betweens moods tends to create chronic irritability.

Common Symptoms and Features:

- Irritable mood
- Lack of interest or great sadness
- Either too much or not enough sleep
- Violent or destructive rages
- Defiant behaviors
- High degree of impulsivity or impaired judgment
- High level of anxiety
- Hallucinations or delusions

Causes:

There is clearly a strong genetic link, but there are also indications that environmental factors influence whether the disorder will occur in children.

Strengths:

- While the disorder affects people differently, individuals with bipolar disorder during the manic phase tend to be much more outgoing and daring than individuals without bipolar disorder.
- A series of authors have described mania or hypomania as related to higher accomplishment, elevated achievement motivation, and ambitious goal setting.
- One study indicated greater-than-average striving for goals, and sometimes obtaining them, corresponded with mania.

Limitations:

- Individuals with the illness have continual changes in energy, mood, thought, sleep, and activity.
- Sometimes have difficulty submitting to, or recognizing, authority.
- Often have issues with impulse control.

PERVASIVE DEVELOPMENTAL DISORDERS (PDD or PDD-NOS)

The five disorders under Pervasive Developmental Disorders (PDD) are:

- Autism Spectrum Disorder
- Asperger's Disorder
- Childhood Disintegrative Disorder (CDD)
- Rett's Disorder
- PDD – Not Otherwise Specified (PDD-NOS)

Autism is the most common of the Pervasive Developmental Disorders, affecting an estimated 1 in 110 births (Centers for Disease Control Prevention, 2007). Roughly translated, this means as many as 1.5 million Americans today are believed to have some form of autism, and this number is on the rise. Based on statistics from the U.S. Department of Education and other governmental agencies, autism is growing at a startling rate of 10%-17% per year. At this rate, the Autism Society of America (ASA) estimates the prevalence of autism could reach four million Americans in the next decade.

Common Symptoms and Features:

- Insistence on sameness; resistance to change; preference for being alone; aloof manner
- Difficulty expressing needs; using gestures or pointing instead of words
- Repeating words or phrases in place of normal, responsive language
- Laughing (and/or crying) for no apparent reason; showing distress for reasons not apparent to others
- Tantrums; non-responsive to verbal cues; acts as if deaf, although hearing tests in normal range
- Difficulty integrating with others; not wanting to cuddle or be cuddled; little or no eye contact
- Unresponsive to normal teaching methods; uneven gross/fine motor skills
- Sustained odd play; spinning objects; obsessive attachment to objects
- Apparent over-sensitivity or under-sensitivity to pain; no real fears of danger
- Noticeable physical over-activity or extreme under-activity

Causes:

There is no known single cause for autism, but it is generally accepted that it is caused by abnormalities in brain structure or function. Researchers are investigating a number of theories, including the link among heredity, genetics, and medical issues. In many families, there appears to be a pattern of autism or related disabilities. It also appears some children are born with a susceptibility to autism, though researchers have not yet identified a single "trigger" that causes autism to develop.

Strengths:

- Highly visual learners
- May be gifted in certain areas or subjects

Limitations:

- Deficits in social interaction
- Challenges understanding or interpreting emotions
- May have limited communication skills
- Sensory integration issues (difficulty processing external stimuli that can result in hypersensitivity to noise, sound, light, and/or odors)
- Repetitive behaviors

PICA

PICA is the pattern of eating non-food materials (dirt, paper, paint, crayons, small sticks, etc.). PICA is more common in young children than in adults, particularly those with a co-occurring developmental disability. PICA may also be seen in individual's who simply crave the sensation of certain textures in their mouths. An individual's eating patterns must fit the criteria for 1 month in order to receive a diagnosis of PICA.

Common Symptoms and Features:

- Habitual or obsessive eating of non-food items (grass, art supplies, cloth, rubber pieces, etc.)
- Inability to control this behavior for at least a period of 1 month prior to diagnosis

Causes:

- In some cases, iron or zinc deficiency may trigger unusual cravings. However, not very much is known about the exact cause of PICA.
- PICA may co-occur with developmental disabilities.

Strengths:

- Strengths are consistent with the individual's personality. PICA does not bring out specific strengths on its own.

Limitations:

- May be distracted from activities by preoccupation with eating non-food items.
- May incur digestive issues (and subsequent irritability).

REACTIVE ATTACHMENT DISORDER (RAD)

RAD is a severe and uncommon psychiatric illness that affects young children. It is most often diagnosed by markedly-disturbed and developmentally-inappropriate social behaviors. It is characterized by extreme emotional attachments to, and boundary issues with, others. RAD is most often able to be diagnosed by age five, but parents or caregivers may notice attachment issues as early as a child's first birthday. RAD occurs most often in foster and adopted children but can appear in biological families due to situations such as divorce, separation, or illness.

Common Symptoms and Features:

- Failure to gain weight
- Detached and unresponsive behavior
- Difficulty being comforted when upset
- Defiant behaviors
- Inhibition or hesitancy in social interactions
- Inappropriate familiarity or closeness with strangers
- Sometimes exhibits self-injurious behaviors

Causes:

Most children with RAD have had disruption or interruption in early relationships. Many have been physically and/or emotionally abused or neglected. Some have experienced the traumatic loss of a parent or caregiver. Often, children have spent time in an institutional setting (i.e. hospital, residential care, or orphanage) and received inadequate care. Treatment requires parents/caregivers focus on creating and strengthening relationships with children that have RAD.

Strengths:

- Generally have above-average IQs
- With proper therapy, children learn to trust and feel safe

Limitations:

- Difficulties trusting adult relationships, including teachers
- Challenges with boundaries and personal space
- Strong need to control environments in order to feel safe

RETT SYNDROME

First described by Dr. Andreas Rett in 1966, Rett Syndrome (RS) is a neurological disorder almost exclusively affecting females. Infants follow typical patterns of development until 6 to 18 months of age, at which time symptoms of RS begin to appear. Loss of communication skills and purposeful use of hands are followed by the development of gait disturbances, autistic-like hand movements, and the slowing of head growth. Treatment focuses on relieving symptoms through the use of medication, physiotherapy, and behavior therapy.

Common Symptoms and Features:

- Autistic-like behaviors (i.e. repetitive hand movements, body rocking, prolonged toe walking)
- Avoidance of eye contact
- Breathing difficulties
- Difficulty expressing and understanding language
- Gait abnormalities (abnormal pattern of walking)
- Hypotonia (loss of muscle tone)
- Loss of purposeful use of hands
- Seizures
- Slowed brain and head growth

Causes:

RS is a genetic disease caused by a mutation of the MECP2 gene, which encodes the MeCP2 protein. Scientists believe the lack of a properly functioning MeCP2 protein may allow other genes to turn on or remain on at inappropriate stages in development, disturbing the precisely-regulated pattern of development. Presently, there is no cure for the disease.

Strengths:

- Can continue to learn and enjoy friends and family into middle age (shortened life expectancy)
- Can experience a full range of emotions

Limitations:

- Progressive loss of cognition, motor, behavior, and social skills over time
- Difficulty with transition and change
- Sensory integration issues (difficulty processing external stimuli that can result in hypersensitivity to noise, sound, light, and/or odors)

SENSORY INTEGRATION DISORDER or DYSFUNCTION (SID)

SID is a neurological disorder that results from the brain's inability to integrate information from the five classical senses (vision, taste, smell, touch, and olfaction), the sense of movement (vestibular), and the sense of body in space (proprioception). Sensory integration is the ability to take information obtained through the senses and combine it with prior information, memories, and knowledge to drive meaning for the processing of stimuli. SID is also called sensory processing disorder.

Common Symptoms and Features:

- Overly-sensitive, or under-sensitive, to touch, movement, and sights
- Easily distracted
- High degree of impulsivity
- May cover ears in new or loud environments
- Delays in speech, languages, or motor skills
- Physical clumsiness or lack of coordination
- Activity level that is unusually high or low
- Avoid stimuli normally tolerated by children of the same age
- Inability to comfort self or unwind

Causes:

Sensory Integration Disorder usually appears in young children. SID is a neurological disorder in which one of three things happen: the brain does not receive messages because of disconnects in the neuron cells, inconsistent messages are received, or sensory messages are received consistently but do not connect correctly with other sensory messages. Research has shown that potentially 70% of those labeled with learning disabilities in the school system have sensory integration disorders.

Strengths:

- With appropriate environments, children with SID can have great success
- SID can be managed with therapies, tactics, and modifications in the classroom
- Can be strong learners if sensory needs are addressed

Limitations:

- Sensory dysfunction may interfere with learning or classroom engagements
- Children may be easily overwhelmed by classroom activities and create quiet or retreat spaces that may or may not be understood or tolerated by others.

SMITH-MAGENIS SYNDROME (SMS)

Smith-Magenis Syndrome (SMS) is a distinct and clinically-recognizable genetic disorder characterized by a specific pattern of physical, behavioral, and developmental features. SMS is considered a rare disorder and is estimated to occur in 1 in 15,000 - 25,000 live births.

Common Symptoms and Features (not every individual has every characteristic):

- Distinct facial features: short, wide head; mid-face is below normal size; prominent forehead; broad nasal bridge; protruding jaw; and ear abnormalities
- Short fingers and toes
- Short stature
- Hoarse, deep voice
- Speech delay
- Learning disability
- Intellectual disability (varying degrees, but have IQs typically in the 50 to 60 range)
- Low muscle tone and/or feeding problems in infancy
- Eye/Vision problems
- Sleep disturbances
- Insensitivity to pain
- Attention-seeking outbursts
- Behavioral problems: hyperactivity, head banging, hand/nail biting, skin picking, pulling off fingernails and/or toenails, explosive outbursts, tantrums, destructive and aggressive behavior, excitability, arm hugging/hand squeezing when excited

Causes:

SMS is the result of a deletion of chromosome 17 that happens for unknown reasons; it is not a hereditary disorder.

Strengths:

- Engaging and endearing personalities
- Respond positively to consistency, structure, and routines
- Very responsive to affection, praise, and other positive emotions
- Enjoy interactions with adults

Limitations:

- Possible behavioral concerns
- Intellectual challenges

TOURETTE SYNDROME

First described in 1885 by Dr. George de la Tourette, Tourette Syndrome (TS) is a genetic neurological disorder characterized by uncontrollable vocal sounds and repeated involuntary movements called tics. Although tics can sometimes be suppressed for a brief time, tension eventually mounts to the point where it must be expressed. Tics worsen in stressful situations and improve when the individual is relaxed or absorbed in an activity. TS may be treated with medication or with relaxation techniques and biofeedback to reduce stress.

Common Symptoms and Features:

- Facial tics:
  - Eye blinking
  - Grimacing
  - Nose twitching
- Motor tics:
  - Body twisting or bending
  - Excessive touching of others
  - Foot stamping
  - Head jerking
  - Neck stretching
  - Repeating actions obsessively
- Vocal tics:
  - Continuous throat clearing, coughing, sniffing, grunting, yelping, barking, or shouting
  - Coprolalia (involuntarily shouting obscenities)
  - Echolalia (repeating the verbalizations of a previous speaker)

Causes:

TS is generally believed to be a genetic condition, although the chromosomal location of the TS gene and the genetic marker for TS have not yet been found. Studies suggest an abnormality in the genes affects the brain's metabolism of neurotransmitters. At present, there is no cure for TS.

Strengths:

- Does not impair intelligence
- Frequency of tics decreases with age

Limitations:

- May be accompanied by a learning disability
- May interfere with academic performance or social adjustment

TRAUMATIC BRAIN INJURY (TBI)

Traumatic brain injury (TBI) is an injury to the brain caused by the head being hit by something or shaken violently. This injury can change how the person acts, moves, and thinks. A traumatic brain injury can also change how a student learns and acts in school. The term TBI is used for head injuries that can cause changes in one or more areas, such as thinking and reasoning, understanding words, memory, paying attention, solving problems, thinking abstractly, talking, behaving, walking and other physical activities, seeing, and/or hearing.

Common Symptoms and Features:

- Memory loss or recall deficits
- Neurological impairment
- Some old skills and knowledge gained prior to the onset of TBI still remain after the injury
- Unpredictable emotions that may not match situations
- Disorientation with times, places, and people
- Impulse control deficits

Causes:

- TBI occurs when an outside force injures the brain, including falls, vehicle accidents, and violence.
- Brain trauma can be caused by a direct impact or by acceleration alone.

Strengths:

- Strong visual learners
- May be on task cognitively, but may require extra time for processing or completion of tasks

Limitations:

- May have physical limitations
- Difficulties with processing or critical thinking
- Distractibility
- Social, behavioral, or emotional problems

TYPE ONE (1) DIABETES

Type 1 Diabetes is a chronic (lifelong) illness in which there are high levels or sugar in the blood, and an individual's pancreas is not able to produce enough insulin to regulate his/her sugar levels on its own. Insulin moves blood sugar into the body's cells, where it is stored as energy. Without enough insulin, glucose (blood sugar) builds up in the bloodstream instead of going into the cells – the body cannot then use it for energy, and the overload leads to diabetic symptoms. Type 1 Diabetes may occur at any age, but is most often diagnoses in children, teens, and young adults.

Common Symptoms and Features (that occur during hyperglycemia, or high blood sugar):

- Feeling very thirsty or hungry all of the time
- Feeling tired of fatigued
- Blurry eyesight
- Tingling or loss of sensation in the individual's feet
- Urinating more often than usual
- Losing weight without trying
- Fruity breath odor
- Stomach pain, nausea/vomiting, inability to keep down fluids
- Dry skin/mouth
- Deep, rapid breathing

Causes:

- The exact cause of Type 1 Diabetes is unknown, but is most likely autoimmune. Infections or other triggers may cause an individual's body to mistakenly attack the pancreatic cells that produce insulin. Type 1 Diabetes, or the tendency towards it, can be passed down through families.

Strengths:

- Cognitively in the typical range
- Management of this illness is possible with the proper steps and training; may lead typical lives with the proper diet, exercise, and attention to medication.

Limitations:

- Must take special care with diets and meal planning
- Frequent insulin adjustments may be needed, based on an individual's daily lifestyle
- Higher possibility of nerve damage, especially to an individual's feet.

WILLIAMS SYNDROME

Williams Syndrome is a rare condition (1 in 8,000-10,000 births) caused by 25 missing genes. This condition randomly occurs, and is present equally in both males and females. An individual with Williams Syndrome has a 50% chance of passing the condition on to his or her own children. One of the missing genes is the gene that produces protein to allow blood vessels, and other body tissues, to stretch (elastin). Having only 1 copy of this gene is likely what causes the narrowing of blood vessels seen in Williams Syndrome.

Common Symptoms and Features (that occur during hyperglycemia, or high blood sugar):

- Feeding issues, including reflux, colic, vomiting, and oral defensiveness
- ADD/ADHD
- Developmental disabilities
- Delayed speech (later turns into strong speaking ability and strong auditory learning ability)
- Learning disabilities
- Mild to moderate intellectual disabilities (in 75% of diagnosed individuals)
- Cardiac issues

Causes:

- Williams Syndrome is a randomly-occurring condition caused by missing copies of 25 different genes.

Strengths:

- Strong musical interests
- Strong speaking ability and vocabulary, once language is developed
- Very open, friendly, and social

Limitations:

- No “stranger danger” concept
- Difficulties with spatial reasoning
- Abstract reasoning difficulties

SOURCE INFORMATION

Information about the disabilities and disorders highlighted in this handbook was pulled from the following Internet sites:

ASPERGER SYNDROME

- Asperger Syndrome Education Network, Inc. "What is Asperger Syndrome?" www.aspennj.org
- Center for the Study of Autism. "Asperger's Syndrome." www.autism.com/autism/behavior/asperger.htm
- National Institute of Neurological Disorder and Stroke. "Asperger Syndrome." http://www.ninds.nih.gov/disorders/asperger/asperger.htm
- Online Asperger Syndrome Information and Support. "What is Asperger Syndrome?" www.udel.edu/bkirby/asperger/geneva3.html

ATTENTION DEFICIT DISORDER

- Children and Adults with Attention-Deficit/Hyperactivity Disorder. "The Disability Named ADD." www.chadd.org
- Medscape. "Attention Deficit Hyperactivity Disorder." www.medscape.com
- National Institute of Neurological Disorders and Stroke. "Attention Deficit Disorder." www.ninds.nih.gov

AUTISM

- The Harvard Mental Health Letter. "Autism-Part I." www.feat.org/Default.aspx
- National Institute of Neurological Disorders and Stroke. "Autism." www.ninds.nih.gov

CEREBRAL PALSY

- HealthCentral. "Cerebral Palsy." www.healthcentral.com
- HealthCentral. "Cerebral Palsy Caused by Infection?" www.healthcentral.com
- National Institute of Neurological Disorders and Stroke. "Cerebral Palsy." www.ninds.nih.gov

CYSTIC FIBROSIS

- Cystic Fibrosis.com. "Cystic Fibrosis.com" www.cysticfibrosis.com
- Cystic Fibrosis Research Inc. "Facts About Cystic Fibrosis." www.cfri.org
- HealthCentral. "Cystic Fibrosis." www.healthcentral.com
- Healthtouch and the National Heart, Lung, and Blood Institute. "Cystic Fibrosis." www.healthtouch.com

DOWN SYNDROME

- National Down Syndrome Society. "About Down Syndrome." www.ndss.org
- National Information Center for Children and Youth with Disabilities. "General Information about Down Syndrome." www.nichcy.org

EMOTIONAL DISTURBANCE

- National Dissemination Center for Children with Disabilities. "Emotional Disturbance, Fact Sheet 5." www.nichcy.org/pubs/factshe/fs5txt.htm
- Center for Effective Collaboration and Practice. cecp.air.org/resources/20th/eligchar.asp

EPILEPSY OR SEIZURE DISORDER

- Epilepsy Foundation. www.epilepsyfoundation.org/about/

FETAL ALCOHOL SYNDROME

- U.S. National Library of Medicine. "Fetal Alcohol Syndrome." www.nlm.nih.gov/medlineplus/ency/article/000911.htm
- Adopting Resources. "Fetal Alcohol Syndrome." http://www.adopting.org/uni/search.php
- ADA, Division of Alcohol and Drug Abuse. "As A Matter of Fact…Fetal Alcohol Syndrome." www.well.com/user/woa/fsfas.htm

FRAGILE X SYNDROME

- Healthtouch and American Speech-Language-Hearing Association. "Fragile X Syndrome & Speech Problems." www.healthtouch.com
- National Institute of Child Health & Human Development. "Facts About Fragile X Syndrome." www.nichd.nih.gov/

HEMOPHILIA

- National Heart Lung and Blood Institute. "What is Hemophilia?" www.nhlbi.nih.gov/health/dci/Diseases/hemophilia/hemophilia_what.html
- Mayo Clinic. "Hemophilia." mayoclinic.com/health/hemophilia/DS00218

HYPOTONIA

- National Institute of Neurological Disorders and Stroke. "Hypotonia." www.ninds.nih.gov/disorders/hypotonia/hypotonia.htm
- Children's Hospital. "Hypotonia (Muscle Weakness)." www.childrenshospital.org/az/Site1106/mainpageS1106P0.html

INTELLECTUAL DISABILITIES (FORMERLY MENTAL RETARDATION)

- National Dissemination Center for Children with Disabilities. www.nichcy.org/Disabilities/Specific/Pages/IntellectualDisability.aspx
- The Arc. "Introduction to Mental Retardation." www.thearc.org
- National Information Center for Children and Youth with Disabilities. "General Information about Mental Retardation." www.nichcy.org

LEARNING DISABILITIES

- LD OnLine. www.ldonline.org/
- Great Schools. www.schwablearning.org, www.greatschools.net/content/specialNeeds.page

MICROCEPHALY

- National Institute of Neurological Disorders and Stroke. "Microcephaly." www.ninds.nih.gov

OBSESSIVE-COMPULSIVE DISORDER

- Obsessive-Compulsive Foundation. "Questions and Answers about Obsessive-Compulsive Disorders." www.ocfoundation.org
- National Institute of Mental Health. "Obsessive-Compulsive Disorders." www.nimh.nih.gov/healthinformation/ocdmenu.cfm
- U.S. National Library of Medicine. "Obsessive-Compulsive Disorders." www.nlm.nih.gov/medlineplus/obsessivecompulsivedisorder.html
- American Academy of Family Physicians. "Obsessive-Compulsive Disorder: What it is and how to treat it." www.familydoctor.org/online/famdocen/home/common/mentalhealth/anxiety/133.html

OPPOSITIONAL DEFIANT DISORDER

- American Academy of Child and Adolescent Psychiatry. www.aacap.org

PEDIATRIC BIPOLAR DISORDER

- Child and Adolescent Bipolar Foundation. www.bpkids.org
- National Institute of Mental Health. www.nimh.nih.gov/health/publications
- Wikipedia. en.wikipedia.org/wiki/Bipolar_disorder#Cognitive_functioning

PERVASIVE DEVELOPMENTAL DISORDER

- National Institute of Mental Health. "Autism Spectrum Disorders (Pervasive Developmental Disorders)." www.nimh.nih.gov/publicat/autism.cfm
- National Institute of Neurological Disorders and Stroke. "Pervasive Developmental Disorders Information Page." www.ninds.nih.gov/disorders/pdd/pdd.htm
- National Institute of Neurological Disorders and Stroke. "Autism Information Page." www.ninds.nih.gov/disorders/autism/autism.htm
- Autism Society of America. "What is Autism?" www.autism-society.org/site/PageServer?pagename=about_whatis
- Charlotte Crane, M.Ed., Board Certified Behavior Analyst, Autism Resource Specialist for Loudoun County Public Schools (Practical Applications – strategies)

REACTIVE ATTACHMENT DISORDER

- Attachment Disorder Site. www.attachmentdisorder.net
- Wikipedia. en.wikipedia.org/wiki/Attachment_disorder

RETT SYNDROME

- HealthCentral. "Rett's Disorder." www.healthcentral.com
- Healthtouch and the National Institute of Neurological Disorders and Stroke. "Rett Syndrome." www.healthtouch.com
- International Rett Syndrome Association. "The Genetics of Rett Syndrome." www.rettsyndrome.org

RUSSELL-SILVER SYNDROME

- U.S. National Library of Medicine. "Russell-Silver Syndrome." www.nlm.nih.gov/medlineplus/ency/article/001209.htm
- Wikipedia. en.wikipedia.org/wiki/Russell-Silver_Syndrome

SENSORY INTEGRATION DISORDER

- Health A to Z. www.healthatoz.com
- Scholastic. www.scholastic.com

SMITH-MAGENIS SYNDROME

- PRISMS, Inc. "What is Smith-Magenis Syndrome?" www.smithmagenis.org/WhatisSMS/characteristics.htm
- The Resource Foundation for Children with Challenges. "Disorder Zone Archives: Smith-Magenis Syndrome." www.specialchild.com/archives/dz-027.html

TOURETTE SYNDROME

- National Institute of Neurological Disorders and Stroke. "Tourette Syndrome." www.ninds.nih.gov

TRAUMATIC BRAIN INJURY

- Brain Injury Association. www.biausa.org/
- National Dissemination Center for Children with Disabilities. "Traumatic Brain Injury." www.nichcy.org/Pages/Home.aspx
- National Institute of Neurological Disorders and Stroke. "Traumatic Brain Injury Information Page." www.ninds.nih.gov/disorders/tbi/tbi.htm
- Wikipedia. en.wikipedia.org/wiki/Traumatic_brain_injury

ADDITIONAL INTERNET SITES

GENERAL HEALTH INFORMATION:

- Dr.Koop.com. www.drkoop.com
- HealthCentral. www.healthcentral.com
- Medscape. www.medscape.com (You must register for this free site.)
- National Institutes of Health, Health Information Index 2000. health.nih.gov/
- National Institute of Neurological Disorders and Stroke. www.ninds.nih.gov/
- OnHealth. www.onhealth.com

DISABILITY:

- The Arc (National Organization of and for People with mental retardation and related disabilities). www.thearc.org/
- Autism Society of America. www.autism-society.org
- Children and Adults with Attention Deficit/Hyperactivity Disorder. www.chadd.org
- Cystic Fibrosis Foundation. www.cff.org
- Family Village. www.familyvillage.wisc.edu
- International Rett Syndrome. www.rettsyndrome.org
- National Down Syndrome Society. www.ndss.org
- Online Asperger Syndrome Information and Support (OASIS). www.udel.edu/bkirby/asperger/frame1.html

CHRISTIAN SITES ON DISABILITY:

- Access Ministry. www.mbctysons.org/access
- Christian Church Foundation for the Handicapped. www.ccfh.org
- Joni & Friends (JAF) Ministries. www.joniandfriends.org
- Ron Heagy's Life is an Attitude. www.ronheagy.com/page/page/933283.htm, rollonron.com/#