Quick Reference to Child and Adolescent Forensics
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A Guide for Nurses and Other Health Care Professionals

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Pediatric Nurse Practitioners®
To Mike Barrett and the crew at Minooka Subaru
where this book was birthed and nurtured—in their waiting area—
all while we were experiencing the best customer service in the country.

And to Margaret Zuccarini, the editor who has been with this project since it was just an idea and whose expert guidance and support have made it a reality. Margaret enabled this book to become a guide that can, we hope, minimize some of these horrible forensic problems that happen to the most innocent of victims—our children, including those children who also have traveled onto the pathway of offending.
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Foreword

Forensics is a cutting-edge topic, especially for today’s pediatric health care providers. Far too often, children become victims or perpetrators of violence. Some children fall victim to bullies, sexual predators, and even their own parents, while other children become bullies, or commit violent acts such as animal cruelty, arson, and sexual offending. Many of these children become perpetrators after years of victimization.

Pediatric health care professionals need information on forensics. Children rarely present in health care settings with a chief complaint of victimization or offending. Instead they may manifest the signs of stress disorders or somatization, or present with no symptom at all, warranting advanced assessment skills on the part of health care providers. However, most providers lack these needed skills. While health care providers do learn the basics of child abuse, they rarely learn how to conduct a forensic assessment, collect evidence, and testify as an expert witness. Concepts such as filicide, abductions, sexual exploitation, delinquency, school violence, gangs, and death investigation are rarely, if ever, mentioned in pediatric texts.

This book provides pediatric health care providers with the tools they need to assess, manage, and prevent forensic pediatric problems within health care settings. The authors, Drs. Muscari and Brown, bring their years of experience to this book in a way that makes these challenging and often disturbing topics accessible to those providers on the front lines of violence recognition and management.
Drs. Muscari and Brown have synthesized the key information on forensic pediatrics and produced a “must read” text that needs to be on every pediatric health care provider’s bookshelf.

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Forensic means “pertaining to the law” or “that which is legal.” The word is derived from the Latin term for ensis, which means “open forum.” Forensic health is the application of the health care sciences to public or legal proceedings; the application of the forensic aspects of health care combined with the bio-psycho-social education of the health care professional in the scientific investigation and treatment of trauma and/or death of victims and perpetrators of abuse, violence, and criminal activity.

Health care practitioners frequently—and sometimes unknowingly—work with victims of child abuse, sexual assault, and unnatural deaths, as well as juvenile offenders. Emergency practitioners encounter the specialty of forensic science with increasing regularity, as many are now expected to know how to gather and preserve evidence from victims of gunshot or stab wounds and from those who have been victimized by sexual violence or other forms of abuse.

Violence is a health problem. The Centers for Disease Control and Prevention (CDC) note that physical abuse can cause anything from minor injuries to permanent disabilities to death. Emotional trauma could result in posttraumatic stress disorder (PTSD) and depression. Violence touches the lives of children with alarming frequency. A recent survey confirmed that most of our society’s children are exposed to violence in their daily lives. More than half were exposed to violence within the past year, either directly or indirectly, and nearly half were assaulted at least once in the past year. Juveniles of all ages are the victims of violent crime. Some of their offenders are family members, as is often the case for very young victims. Research has shown that child victimization and abuse are linked to problem behaviors that become evident later in life.

So an understanding of childhood victimization and its trends may lead to a better understanding of juvenile offending.
Children and adolescents become victims of neglect, physical abuse, sexual assault, prostitution, pornography, and abductions, and, many of these children complete the cycle of violence by becoming offenders, committing acts of bullying, cruelty, arson, rape, and even homicide. Health care professionals work with both victims and perpetrators, yet they have little education and resources for dealing with the everyday forensic issues of pediatric practice.

This guide helps fill the forensic void by providing current, concise, and easy-to-use information that assists pediatric practitioners with the prevention, identification, and management of pediatric victims and offenders. The book is designed to be integrated into advanced pediatric curriculums as a supplemental text, and to be utilized in primary, community, and acute care pediatric settings as an ongoing reference.

The book begins with a general principles section that defines the term forensics (“that which pertains to legal”) and its implications in pediatric practice; describes the cycle, continuum, and cultural aspects of violence; and discusses the mechanisms of forensic assessment and documentation, evidence collection, the criminal and family justice systems, expert witness testimony, and working with the multidisciplinary team. It also describes the role of the pediatric provider in working with children who witness violence at home, in the community, and in the media, and gives practitioners an overview of the criminal and civil justice systems, child custody, and emancipation. Finally, it provides information on how professionals can manage their own mental health when working with these challenging issues.

The second section is devoted to children as victims. The child abuse chapters detail how to detect abusive parents as well as abused children and cover all aspects of intrafamiliar child abuse. Other chapters provide information on bullying, abductions, sexual molestation, pornography, and prostitution. Each chapter contains an overview of the problem, methods of victimization, the effects of victimization on children, recognition and problem management, and prevention techniques to provide to parents and children. The final chapters are devoted to instructing providers on working with abusive parents and to working with incarcerated parents and their children.

The third section focuses on children as offenders. The first chapter briefly explains delinquency and juvenile justice, as well as the pediatric provider’s role in the interdisciplinary team. The next chapter is devoted to the occurrence, recognition, and management of delinquency, and the following two chapters concentrate on the special issues of female and
child offenders. The next chapters deal with the description, assessment, management, and prevention of bullying, school violence, juvenile animal cruelty, arson, gang membership, juvenile sex offending, and dating violence. These issues were singled out because of the body of research that supports their relatively frequent incidence, specific management strategies, and preventative techniques (both primary and recidivism prevention).

The final section concentrates on unnatural pediatric deaths—sudden unexpected infant and child death, accidents, homicides, and suicides. The section explains the pediatric provider's role in child death review teams and in death investigations. There are also brief chapters on autoerotic fatalities, neonaticide/infanticide and filicide, which focus on prevention and early detection, and a chapter on working with grieving families who lost a child to homicide.

Whenever possible, chapters are organized as follows:

- **Definitions:** This section provides definitions of pertinent terms, as well as more in-depth information on the subject matter of the chapter. Example: *Parental kidnapping* describes the wrongful removal or retention of a child by a parent; however, since child kidnappings are frequently committed by other family members, the term *family abduction* is more accurate.

- **Prevalence:** This section provides statistics and relevant epidemiologic information. Example: A child is reported missing about every 40 seconds, and research shows that family abductions are the most prevalent child abduction type. More than 350,000 family abductions occur each year, accounting for about 1,000 per day.

- **Etiology:** This section addresses the cause or origin of the problem, as well as the factors that produce or predispose persons toward the problem, and/or issues found to correlate with the problem. Some chapters discuss typologies. Studies have revealed several reasons for parental abductions. Some are motivated by an effort to force reconciliation or to continue interaction with the left-behind parent. Others have a desire to blame, spite, or punish the other parent.

- **Assessment:** This section guides health care providers to assessment issues relevant to the specific problem. Health care providers can then incorporate this information into their daily assessments as needed.
- General Principles: This section provides information that helps guide assessments. Example: Relationships among the perpetrator, child, and health care provider may be long-term and complex. This involvement may hinder the health care provider from considering Münchausen Syndrome by Proxy (MSBP) as a differential diagnosis.

- History and Physical Assessment: This section provides suggestions for problem-specific subjective and objective data collection that can be incorporated into comprehensive, episodic, or interval assessments. Example: While the actual diagnosis of MSBP is for the perpetrator, the child remains a critical focus in making the diagnosis. There is no typical presentation. The literature notes more than 100 reported symptoms with the most common including lethargy, weight loss, fevers, abdominal pain, vomiting, diarrhea, seizures, apnea, infections, and bleeding.

- Diagnostic Testing/Screening Tools: When applicable, this section suggests testing that can help confirm specific diagnoses, or, in most cases, provides a brief overview and access information for screening tools appropriate for settings such as primary care and emergency departments. Common tools, such as those used to screen for alcohol abuse and domestic violence, are included in the chapter or appendix. This section also provides overview and access information on more advanced instruments, such as those used for assessing violence recidivism risk. These tools require specific educational backgrounds and training. However, it does benefit health care providers to have an understanding of these instruments since they relate to some of their clients.

- Intervention: This section provides information on therapeutic interventions and referrals.

- Prevention/Patient Teaching: This section is structured using the public health model of prevention. Patient teaching information is given when applicable.

- Primary Prevention is concerned with health promotion activities that prevent the actual occurrence of a specific illness or disease. Primary prevention attempts to serve those individuals
who are not yet part of the problem, and strives to build skills and resiliency so that the problem will not develop.

- **Secondary Prevention** promotes early detection or screening and treatment of disease and limitation of disability. By targeting individuals at high risk for the problem or who have displayed some form of antisocial or delinquent behavior, secondary prevention aims to keep these individuals from engaging in violent activity. Secondary prevention is also aimed at those who are at risk for becoming victims of violence to prevent the violence from occurring.

- **Tertiary Prevention** is directed toward recovery or rehabilitation of condition after the condition has been developed. Tertiary prevention is designed to serve those individuals who have already become violent or chronic offenders and emphasizes punishment and rehabilitation through the justice system. The objective is to help prevent future violent activity. Tertiary prevention for victims focuses on prevention of further damage from the victimization, as well as prevention of future victimization.

- **Resources:** This section provides readers with appropriate Web sites for further information.

- **References:** This section provides references used for that chapter.

To better allow health care providers to perform comprehensive assessments, Appendix D includes the following assessment questionnaires from the KySSSM (Keep your children/yourself Safe and Secure) Guide to Child and Adolescent Mental Health Screening, Early Intervention and Health Promotion:

- KySS Assessment Questions for Parents of Older Infants and Toddlers
- KySS Assessment Questions for Parents of Preschool Children
- KySS Assessment Questions for Parents of School-age Children and Teens
- KySS Assessment Questions for a Specific Emotional or Behavioral Problem
The information in this guide comes from health care and criminal justice literature, as well as credible professional organizations. Many of the issues in this book have yet to be well researched, and some topics do not lend themselves to the rigor of random controlled trials. Readers will find rich information for their practices, as well as ideas for future research.
We would like to acknowledge all the forensic health students whose classroom contributions help to stimulate ideas for this book, as well as those students who assisted in the literature review:

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General Principles

SECTION I
Forensic means “pertaining to the law” or “that which is legal.” The word is derived from the Latin term for ensis, which means open forum. Child and adolescent forensics is the application of pediatric health care sciences to public or legal proceedings; the application of the forensic aspects of health care combined with the bio-psycho-social education of the health care professional in the scientific investigation and treatment of trauma and/or death of victims and perpetrators of abuse, violence, and criminal activity.

Violence is a health problem. The Centers for Disease Control and Prevention (CDC) note that physical abuse can cause anything from minor injuries to permanent disabilities to death. Emotional trauma could result in posttraumatic stress disorder (PTSD) and depression. Violence touches the lives of children with alarming frequency. According to the U.S. Department of Health and Human Services, Administration on Children, Youth and Families (2009), in 2007, state and local child protective services (CPS) investigated 3.2 million reports of child abuse and neglect, classifying 794,000 (10.6 per 1,000) of these children as victims. Fifty-nine percent of the children were classified as victims of neglect, 4% as victims of emotional abuse, 8% as victims of sexual abuse, and 11% as victims of physical abuse. Approximately three-quarters of all the abused and neglected children had no history of prior victimization.
According to the Centers for Disease Control and Prevention (CDC, 2009), 5,958 young people ages 10 to 24 were murdered in 2006—an average of 16 each day. Homicide was the second leading cause of death for young people ages 10 to 24 years old. The CDC (2008) also noted that in a 2007 nationally representative sample of youth in Grades 9–12:

- 35.5% reported being in a physical fight in the 12 months preceding the survey; the prevalence was higher among males (44.4%) than females (26.5%).
- 18.0% reported carrying a weapon (gun, knife, or club) on one or more days in the 30 days preceding the survey.
- 5.2% carried a gun on one or more days in the 30 days preceding the survey.
- Males were more likely than females to carry a weapon (28.5% versus 7.5%) on one or more days in the 30 days preceding the survey.
- Males were also more likely than females to carry a gun on one or more days in the 30 days preceding the survey (9.0% versus 1.2%).

Health care practitioners frequently—and sometimes unknowingly—work with victims of child abuse, sexual assault, and unnatural deaths, as well as juvenile offenders. Emergency practitioners encounter the specialty of forensic science with increasing regularity, as many are now expected to know how to gather and preserve evidence from victims of gunshot or stab wounds and from those who have been victimized by sexual violence or other forms of abuse. Primary care and other providers often see clients who present with vague symptoms that may indicate the hidden agenda of abuse. Therefore it is critical that forensic issues become a component in the education of health care providers.

**THE EFFECTS OF VIOLENCE EXPOSURE ON CHILDREN**

Children in the United States are more likely to be exposed to violence than are adults, and millions of children and adolescents in the United States are exposed to violence in their homes, schools, and communities as both victims and witnesses. The recent Comprehensive National Survey (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009) on children’s exposure to violence confirms that most of the children in the United States are exposed to violence on a daily basis. More than 60% of the children surveyed were exposed to violence within the past year, either di-
rectly or indirectly; and 46.3% were assaulted at least once in the past year. A little more than 25% witnessed a violent act and 9.8% saw one family member assault another.

Violence exposure can have significant effects on children as they develop and as they form their own intimate relationships throughout childhood and adulthood. Some children experience chronic community violence and are exposed to guns, knives, drugs, and random violence in their neighborhoods; some are exposed to witnessing violence against their mother perpetrated by their father or her paramour on a regular basis; some children are exposed to a plethora of violent acts on the screens of televisions, computers, video games, and other media. Many children are exposed to all of these. Risk factors are cumulative, and thus the risk of negative outcomes multiplies for children who are in “double jeopardy,” such as those who are exposed to domestic and/or community violence. Children who are direct victims of assault and who witness repeated violence are more likely to have significant negative outcomes than children who are exposed to a single instance.

**VIOLENCE IN THE HOME**

Parents may think that their children are shielded from exposure to intimate partner violence; however, research findings indicate otherwise. Kennedy and colleagues (2009) noted that children frequently observe or hear the abuse as well as its aftermath (e.g., crying or injuries). In a sizable percentage of cases, the children are actually physically involved in their parent’s partner violence and may be injured themselves.

Children who are exposed to intimate partner violence also are at risk of exposure to traumatic events, the risk of neglect, the risk of being abused, and the risk of losing one or both of their parents. These traumas can lead to negative outcomes for children and may affect their well-being, safety, and stability. Childhood problems associated with exposure to domestic violence fall into three primary categories:

*Psychological:* Fear, anxiety, low self-esteem, withdrawal, and depression; problematic relationships; higher levels of aggression, anger, hostility, oppositional behavior, and disobedience.

*Cognitive:* Lower cognitive functioning, poor school performance, lack of conflict resolution skills, limited problem-solving skills, proviolence attitudes, and belief in rigid gender stereotypes and male dominance.
**Long-term:** Higher levels of depression and trauma symptoms, increased tolerance for and use of violence in relationships during adulthood.

Reaction and risk exist on a continuum. Some children demonstrate resiliency, while others show signs of maladaptive adjustment. Protective factors can help protect children from the adverse effects of exposure to domestic violence. These include social competence, intelligence, high self-esteem, outgoing temperament, strong sibling and peer relationships, and a supportive relationship with an adult.

**VIOLENCE IN THE COMMUNITY**

Children’s witnessing violence in urban communities is prevalent in the United States. Cooley-Quille, Boyd, Frantz, and Walsh (2001) found that inner-city youth with high levels of community violence exposure reported more fears, anxiety, internalizing behavior, and negative life experiences than those with low exposure.

The majority of these children report witnessing relatively less severe forms of violence such as seeing someone arrested or assaulted. There have been fewer studies relating to the effect of children’s exposure to community violence within suburban or rural communities.

Community violence, with its associated mental health problems, may impact a child’s ability to function effectively at school. Research demonstrates that increased levels of community violence are associated with decreased academic performance, as measured by grades, standardized test scores, and attendance. Psychological distress secondary to community violence exposure may be one explanation for these findings. However, few studies have examined mental health symptoms as a mechanism through which community violence exposure impacts functioning at school.

**VIOLENCE IN THE MEDIA**

Media violence (television, cinema, Internet) touches virtually every child. The average child spends about 5.5 hours every day watching electronic media. Children will see 200,000 acts of violence before graduation, including thousands of murders. Preschoolers witness almost 10,000 violent episodes every year just by watching 2 hours of cartoons each day.
According to the American Psychiatric Association, the typical American child watches 28 hours of television a week, and by the age of 18 will have seen 16,000 simulated murders and 200,000 acts of violence. Commercial television for children is 50 to 60 times more violent than prime-time programs for adults, and some cartoons average more than 80 violent acts per hour. With the advent of videocassette sales and rentals of movies, pay-per-view TV, cable TV, video games, and online interactive computer games, many more children and adolescents are exposed to media with violent content than ever before.

Variances in population sampling, measuring criteria, and even the types of media have resulted in different outcomes in studies that addressed the relationship between violent media and human violence. Much of the literature on media violence was written in the post-Columbine era, and suggested both immediate and long-term effects on children. More recently, Ferguson and Kilburn (2009) conducted a meta-analytic review of studies that examine the impact of violent media on aggressive behavior to determine whether this effect could be explained through methodological problems inherent in this research field. The results from their analysis did not support the conclusion that media violence leads to aggressive behavior, and they noted that it cannot be concluded at this time that media violence presents a significant public health risk. Thus, the effects of media violence remain under debate.

DEVELOPMENTAL REACTIONS TO VIOLENCE EXPOSURE

Early Childhood

Young children who witness domestic or community violence show increased irritability, immature behavior, developmental regression, increased fears, temper tantrums, clinging, and difficulty separating from parents. They may even exhibit symptoms of posttraumatic stress disorder (PTSD). When exposed to violence, children as young as 2 can experience sleep disturbances, withdrawn or aggressive behaviors, developmental regression, and disruptions in the parent-child relationship.

Exposure to domestic violence has a negative impact on neurocognitive development, leading to lower intelligence scores in young children. There is also an overlap between domestic violence and child abuse. In families where one form of violence exists, it is likely that the other forms
will also exit, and young children are at higher risk for child abuse than older children. Community violence exposure is associated with negative outcomes for children, including reduced behavioral and social competence.

**Middle Childhood**

Like preschoolers, school-aged children exposed to violence are more likely to have sleep disturbances, and less likely to explore and play freely or to show motivation in mastering their environment. They often have difficulty with attention and concentration because they are distracted by intrusive thoughts. School-aged children are likely to understand more about the intentionality of the violence and worry about what they could have done to prevent or stop it. School-aged children with extreme exposure to chronic community violence may also exhibit symptoms of post-traumatic stress disorder.

School-aged children who are exposed to family violence are affected similarly to those exposed to community violence. They often experience a greater frequency of internalizing (withdrawal, anxiety) and externalizing (aggressiveness, delinquency) behavior problems in comparison to children from nonviolent families. Overall functioning, attitudes, social competence, and school performance are often affected negatively.

School-aged children watch more television and thus may be more exposed to television violence than other children. Studies of school-aged children exposed to media violence have also identified adverse effects over time. Exposure to media violence may increase negative behaviors because of the potential for social learning and modeling of inappropriate behaviors by youths. Fictionalized violence is likely to have negative impacts on children and increase their propensity for violence when the violence is dramatically portrayed and glamorized. However, real-life events shown in a sensationalized manner may overwhelm or numb the senses.

**Adolescence**

There is a considerable body of research that suggests adolescents exposed to violence, especially ongoing chronic community violence, tend to show high levels of aggression and acting out, accompanied by anxiety, behavioral problems, school problems, truancy, and revenge seeking. Ado-
Adolescents may have more severe effects of violence exposure than younger children because they are exposed to more violence overall.

Adolescents who witness community violence can overcome the experience; however, many are affected. Some report giving up hope because they expect that they may not live through adolescence or early adulthood. These chronically traumatized youths often appear numb to feelings and pain, and show restricted emotional development. Some of these youths may attach themselves to gangs as substitute family and incorporate violence as a method of dealing with disputes or frustration.

Media violence comes in multiple forms for adolescents, including television, movies, the Internet, music lyrics, music videos, and electronic games. Playing electronic games has become one of the most popular leisure activities of children and adolescents in the United States and Europe. Boys and girls play regularly, but boys outnumber girls in terms of frequency and duration of game-playing sessions, especially for games with violent content. Electronic games are played throughout the lifespan, but early adolescence is the peak time for exposure in most Western cultures, and adolescents show a particular interest in violent games. Trait aggression increases during adolescence, and violent media fits into this developmental theme. Adolescents also show an increased need for novelty, risk-taking behavior, and a heightened level of physiological arousal. Action-oriented games, especially those with violence, satisfy those needs. At the same time, they provide a safe environment because all the risks happen in a virtual reality and do not lead to physical harm.

**ASSESSMENT**

Assess all families for the presence of domestic violence. Several health care organizations have issued position statements regarding routine screening of patients and their families for domestic violence, including the American Academy of Pediatrics (AAP), which classified the abuse of women as a pediatric problem. Children also should be questioned regarding their knowledge of the domestic violence, since they often are much more aware of the violence than adults may think. Monitor children for signs of PTSD and for child abuse as noted elsewhere in this book.

Comprehensive assessment of domestic and other violence exposure can inform decision making regarding the types of interventions needed for children living with violence. Factors that influence the impact of violence exposure on children include the nature and frequency of the...
violence, elapsed time since exposure, the age and gender of the child, the child’s coping skills, and whether the child has been abused.

**Age-Specific Indicators of Reactions to Domestic Violence**

Observe for the following age-specific indicators of reactions to domestic violence, as suggested by the Alabama Coalition Against Domestic Violence (ACADV, n.d.):

**Infants**

- Basic need for attachment is disrupted
- Routines around feeding/sleeping are disturbed
- Injuries while “caught in the crossfire”
- Irritability or inconsolable crying
- Frequent illness
- Difficulty sleeping
- Diarrhea
- Developmental delays
- Lack of responsiveness

**Preschool Child**

- Somatic or psychosomatic complaints
- Regression
- Irritability
- Fearful of being alone
- Extreme separation anxiety
- Developmental delays
- Sympathetic toward mother
Chapter 1  The Effects of Violence Exposure on Children

School-Aged Child

- Vacillate between being eager to please and being hostile
- Verbal about home life
- Developmental delays
- Externalized behavior problems
- Inadequate social skill development
- Gender role modeling creates conflict/confusion

Preadolescent Child

- Behavior problems become more serious
- Increased internalized behavior difficulties: depression, isolation, withdrawal
- Emotional difficulties: shame, fear, confusion, rage
- Poor social skills
- Developmental delays
- Protection of mother, sees her as “weak”
- Guarded/secretive about family

Adolescent

- Internalized and externalized behavior problems can become extreme and dangerous: drug/alcohol, truancy, gangs, sexual acting out, pregnancy, runaway, suicidal
- Dating relationships may reflect violence learned or witnessed in the home.

INTERVENTIONS

If child abuse is suspected, report to child protective services according to state laws. Not all children exposed to domestic violence will need therapy. However, all children should be referred to a therapist with
expertise in working with children who have witnessed domestic violence so that they may receive a comprehensive evaluation. Children may also warrant treatment for PTSD, which is discussed in Chapter 14, “Psychological Effects of Victimization.”

Provide the domestic violence victim, typically the mother, with local domestic violence crisis numbers and counseling resources. Listen to what the victim has to say and do not judge if the person is unable to leave the relationship or accept counseling. Discuss the possibility of a protective order and help the family to develop a safety plan.

Orders of Protection

Domestic violence cases may warrant that the adult victim obtain an order of protection. An order of protection is a legally binding court order that restrains an individual who has committed an act of violence against a person from further acts against that person. Protective orders vary state by state and are called by various names (restraining orders, Protection From Abuse orders [PFAs], etc.). Most are used to protect against family/intimate partner violence; some jurisdictions use them for strangers.

There are different types of protective orders, demonstrated by the three stages of Protection From Abuse (PFA) orders issued in Pennsylvania:

- Emergency Orders issued by District Justice when Court of Common Pleas is closed. It is in effect until the next business day at the Court of Common Pleas.
- Temporary Order issued on a daily basis by Court of Common Pleas in Media and is in effect until the hearing for a Permanent PFA is held.
- Permanent Order issued for up to 18 months at a hearing before Court of Common Pleas. The hearing date is scheduled when the temporary PFA is received.

Health care providers can contact the police, district attorney’s office, or victim advocate center to learn how victims may obtain protective orders in their areas. However, it is best they do this before a situation occurs and keep the information readily available for emergent purposes.

The protection order can prohibit the abuser from committing acts of violence; exclude the abuser from the residence shared by the petitioner and abuser; prohibit the abuser from harassing or contacting the
petitioner by mail, telephone, or in person; award temporary custody of minor children; establish temporary visitation and restrain the abuser from interfering with custody; prohibit the abuser from removing the children from the jurisdiction of the court; and order the abuser to participate in treatment or counseling. Some states, including New York, include pets in the protective orders. Although seemingly powerful, protective orders are nothing more than pieces of paper—they are not bullet proof. They seem to work best on those offenders who have something to lose if they disobey them, and in some cases, may aggravate the situation. Therefore, victims still need to take precautions to keep themselves safe.

VICTIM'S COMPENSATION

Crime victim compensation programs offer crucial financial assistance to victims of violence. According to the National Association of Crime Victim Compensation Boards, recovering from violence is difficult enough without having to worry about the costs of medical care and counseling. Every state has a crime victim compensation program that can provide substantial financial assistance to crime victims and their families. While money cannot erase the trauma and grief victims suffer, it can be crucial in the recovery process. By paying for care that restores victims’ physical and mental health, compensation programs are helping victims regain their lives.

Compensation needs are more common in adult victimization; however, there are many cases where child victims qualify. Conviction of the offender is not required, and victims of crime under state, federal, military, and tribal jurisdiction are eligible to apply for compensation. Eligible crime victims include those who have been physically injured and/or who suffer emotional injury as a result of violence or attempted violence, even though no physical injury resulted. Some states also include family members of deceased victims and other individuals who pay for expenses resulting from a victim’s injury or death.

According to the National Association of Crime Victim Compensation Boards, each state’s eligibility requirements vary slightly, but victims are generally required to report the crime promptly to law enforcement, usually within 72 hours; file a timely application with the compensation program in the state where the crime occurred, and provide any information requested; cooperate in the investigation and prosecution of the crime; and be innocent of any criminal activity or misconduct leading to
the victim’s injury or death. Many states require that the application be filed within 1 year from the date of the crime, but some states have shorter or longer periods. Applications can be obtained from the state compensation program, police, prosecutors, or victim service agencies. Most state programs have brochures describing their benefits, requirements, and procedures. Health care providers can refer victims to victim service programs for assistance in completing the application. The application should be submitted to the compensation program as soon as possible, where it will be reviewed to determine eligibility and to decide what costs can be paid. The program will notify the applicant of its decision.

Depending on the state, expenses may be covered if they are not paid for by insurance or by another public benefit program, and if they result directly from the crime. These include medical and hospital care, and dental work to repair injury to teeth; mental health counseling; lost earnings due to crime-related injuries; loss of support for dependents of a deceased victim; and funeral and burial expenses. Expenses that are not covered usually include property loss, theft and damage (unless damage is to eyeglasses, hearing aids, or other medically necessary devices), and expenses paid by other sources, such as any type of public or private health insurance, automobile insurance, disability insurance, or workers compensation. A few states may pay limited amounts for the loss of essential personal property during a violent crime and for cleaning up the crime scene.

PREVENTION

Health care providers can prevent the circle of violence by assuring that violence-exposed children get the treatment they need. They can also discuss safe dating practices with preteen and teenage clients, instruct families on health media usage, and work with their communities to improve safety and decrease violence.

RESOURCES

Appendix C: Crime Victim Compensation Programs
Helping Young Children Affected by Domestic Violence: The Role of Pediatric Health Settings: www.uiowa.edu/~socialwk/pape_L.pdf
National Association of Crime Victim Compensation Boards: www.nacvcb.org
REFERENCES


