Quick Reference to Adult and Older Adult Forensics
Kathleen M. Brown, PhD, APRN-BC, FAAN, is a practice assistant professor at the University of Pennsylvania School of Nursing as well as a practicing women’s health nurse practitioner (NP) for 23 years and a sexual assault nurse examiner for the Philadelphia County, Pennsylvania, Sexual Assault Response Team. Additionally, she is a postgraduate student of Dr. Robert Sadoff at the University of Pennsylvania School of Medicine in the Applications of Forensic Psychiatry curriculum. She has been a coinvestigator in four funded research studies: two for the National Institute of Justice and two for the National Institute of Nursing Research. Her dissertation research on leaving abusive relationships was funded by American Women’s Health, Obstetric and Neonatal Nursing (AWHONN).

Mary E. Muscari, PhD, CPNP, APRN-BC, CFNS, is an associate professor at the Decker School of Nursing, State University of New York (SUNY) at Binghamton (Binghamton University). Muscari has been a pediatric nurse practitioner (PNP) since 1980, when she earned her MSN/PNP from Columbia University. She earned a post-master’s certificate in psychiatric nursing and a PhD, both from Adelphi University; a post-master’s certificate in forensic nursing (2003) from Duquesne University; and has additional forensic education as a sexual assault nurse examiner, a legal nurse consultant, and a medicolegal death investigator. She attended the Sudden Unexpected Infant Death Investigation (SUIDI) Academy (2007) through the Centers for Disease Control and Prevention. Muscari has worked clinically as a PNP in a variety of environments, and has served on the Pennsylvania Sex Offender Assessment Board (2005–present) and as a private consultant on child health/mental health, parenting, and forensic issues.
Quick Reference to Adult and Older Adult Forensics
A Guide for Nurses and Other Health Care Professionals

KATHLEEN M. BROWN, PhD
MARY E. MUSCARI, PhD
This book is dedicated to
all health care professionals who work with victims and offenders;
to Ed for putting up with Kathy;
and to the Muscari Mob for putting up with Mary.

This book is also dedicated 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 hopefully assist health care
providers in working with victims and offenders.
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Alison S. Cole, MS
Clinical Psychology PhD Candidate
Laboratory of Consciousness & Cognition
Binghamton University Psychology Department
Clearview Hall
Binghamton, NY
Foreword

Forensics is a cutting-edge topic, especially for today’s health care providers who work with forensic clients regularly, sometimes without realizing it. Many health care clients have been victimized as children. Others are victimized by their intimate partner, their adult children, or strangers, and some are victimized by health care providers. Clients may also be the abusers: batterers, child abusers, elder abusers, or sexual predators, and many of these clients, such as female and older adult offenders, have special health care needs.

Health care professionals require information on forensics. Clients 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 intimate partner violence and elder abuse, they rarely learn how to conduct a forensic assessment, collect evidence, and testify as an expert witness. Concepts such as competency, human trafficking, stalking, sexual offending, and death investigation are rarely, if ever, mentioned in texts about adults and older adults.

This book provides health care providers with the tools they need to assess, manage, and prevent forensic problems within health care settings. The authors, Mary E. Muscari and Kathleen M. 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.
The authors have synthesized the key information on adult and older adult forensics and produced a “must read” text that needs to be on every person’s bookshelf. I strongly recommend it!

Ann Wolbert Burgess, DNSc., APRN, BC  
Professor of Psychiatric Nursing  
Boston College  
Chestnut Hill, MA
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, and the application of the forensic aspects of health care combined with the biopsychosocial education of the health care professional in the scientific investigation and treatment of trauma and/or death of victims and perpetrators of abuse, violence, criminal activity, and traumatic accidents.

Health care practitioners frequently—and sometimes unknowingly—work with victims or offenders of intimate partner violence, elder abuse, sexual assault, workplace violence, and unnatural deaths. 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.

Clients who are victims require treatment using unique skills for competent medicolegal evaluation. Unfortunately, few practitioners have the education or resources to care for this population, a factor that impairs recognition of these problems when clients present with vague complaints or other agendas. Practitioners also receive little education on forensic assessment, principles of evidence, competency, guardianship, and navigating the justice system.

Violence is a health problem. Intimate partner violence, abuse between two people in an intimate relationship, can be very hazardous to health. 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. Victims are also more likely to smoke, abuse alcohol, use drugs, and engage in risky sexual behaviors. Victims of sexual assault may be terrified of the offender and fear for their lives.
Victims may also feel humiliation, shame, and self-blame. If the assault is perpetrated by an acquaintance, friend, or lover, violation of trust can be an issue for the victim. Because of their shame and fear about how people will react, many victims keep their assault a secret. Male victims are more likely to suffer from depression and to develop antisocial personality disorder. Adult survivors of child sexual abuse may experience major depression, adjustment disorder, alcohol or other substance abuse, personality disorders, multiple personality disorder, psychosexual dysfunctions, and somatic symptoms.

Violence touches the lives of elders with alarming frequency. An estimated 2.1 million older Americans are victims of physical, psychological, or other forms of abuse and neglect each year. Most victims of elder abuse are mentally competent and reside in the community. But those with mental or physical disabilities are especially vulnerable. Some elders are the victims of battery by their husband or wife. Isolation and abuse go hand-in-hand. Most abused older people are isolated from their friends, neighbors, and other family members. Often the abuser will not let anyone visit or talk to the victim, in order to maintain a sense of isolation and helplessness. Elders with dementia are sexually abused more often by persons known to them (family member, caregiver, or another nursing home resident) than a stranger, and they present with behavioral signs of distress instead of verbal disclosures. These elders are easily confused, verbally manipulated, and pressured into sex by the mere presence of the offender. The ages of known sex offenders against elders ranges from 13 to 90.

Elders are also perpetrators, and the past decade has seen a drastic increase in the number of incarcerated elderly, due to mandatory minimum sentencing, longer sentences, and tighter parole policies. Offenders older than age 50 are the fastest growing subgroup within the inmate population. The health challenges experienced by older offenders are no different from those experienced by nonincarcerated elders. However, older offenders’ situations are often complicated by their circumstances. As offenders age within the correctional system, changes that occur during their life spans create many challenges for prison authorities, health care personnel, and the offenders themselves.

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

The book begins with a general principles section that 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 issues of competence and guardianship, as well as violence in health care settings. 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 adults and older adults as victims. The section begins with the effects on victims and how these impact on provider care. Other chapters provide information on intimate partner victimization, physical abuse, financial abuse, sexual assault, emotional abuse, human trafficking, personal injury, stalking, and resources for victims.

Section three focuses on adults and older adults as offenders. One chapter differentiates the lifelong offender from the new offender, with some emphasis on dementia and crime. Other chapters focus on perpetrators of intimate partner violence and sexual assault, offenders in institutions, offenders in communities, and the relationship of drugs and alcohol to offending in the older adult. There is also a chapter on parenting while incarcerated that addresses the issue of grandparents raising their grandchildren, often because the parents are incarcerated or unable to parent due to substance abuse problems.

The final section concentrates on medicolegal death investigations. The section explains the health care provider’s role in elder death investigations and provides insight on topics that can better enable health care professionals to provide more detailed information to families undergoing these difficult times. There are chapters on suspicious deaths in long-term care facilities, autoerotic deaths, and homicide/suicide. This section ends with a chapter on working with grieving families who have lost a loved one to homicide.

Whenever possible, chapters are organized as follows:

- **Definition:** This section provides definitions of pertinent terms, as well as more in-depth information on the subject matter of the chapter. Example: Stalking generally describes a pattern of overtly criminal and/or apparently innocent behaviors whereby an
individual inflicts repeated, unwanted communications and intrusions upon another.

- **Prevalence:** This section provides statistics and relevant epidemiologic information. Example: Stalking is widespread, with nearly 1 in 12 women and 1 in 45 men stalked at least once in their lifetime. Most victims know their stalkers, and most stalkers (87%) are male.

- **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. Example: Stalking classifications or typologies vary. The National Center for Victims of Crime provides a typology that includes simple obsessional, love obsessional, and erotomaniac stalkers.

- **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: Most clients with psychotic disorders are not violent, but clients with acute psychosis who are paranoid and having command auditory hallucinations, or who have a history of being violent, being a victim of violence, or abusing alcohol or drugs are at high risk for violent behavior.

- **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: Clients do not typically present with complaints of substance abuse problems; however, they can present with “red flags.” Red flag symptoms include such issues as frequent absences from school or work, or history of frequent trauma or accidental injuries.

- **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 a 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.
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
ADULT AND OLDER ADULT FORENSICS

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.” Adult and older adult forensics are the application of health care sciences to public or legal proceedings; the application of the forensic aspects of health care combined with the biopsychosocial 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.

According to the Centers for Disease Control and Prevention (CDC, 2009) violence is a serious public health problem that affects people in all stages of life: in 2006, more than 18,000 people were victims of homicide and more than 33,000 took their own lives. However, violent death numbers are only a fraction of the problem. Many more people survive violence with permanent physical and emotional damage, and communities erode due to reduced productivity, decreased property values, and disrupted social services.

Victims of violence are also more likely to smoke, abuse alcohol, use drugs, and engage in risky sexual behaviors. Victims of sexual assault may be terrified of the offender and fear for their lives. Victims may also feel humiliation, shame, and self-blame. If the assault is perpetrated by an
acquaintance, friend, or lover, violation of trust can be an issue for the victim. Because of their shame and fear about how people will react, many victims keep their assault a secret. Male victims are more likely to suffer from depression and to develop antisocial personality disorder. Adult survivors of child sexual abuse may experience major depression, adjustment disorder, alcohol or other substance abuse, personality disorders, multiple personality disorder, psychosexual dysfunctions, and somatic symptoms.

Violent offenders are usually from high-risk groups and have poor health histories, increasing their susceptibility to disease. But offender health problems are not contained within correctional facilities. Prisoner health problems are public health problems. Infectious diseases common in the incarcerated population include human immunodeficiency virus (HIV), tuberculosis, hepatitis, and sexually transmitted diseases. Mental health problems also abound in offenders. Persons with mental illness are more likely to be victims of a crime than to commit one; however, approximately half of all prisoners have mental health problems (James & Glaze, 2006).

Health care practitioners frequently—and sometimes unknowingly—work with victims of intrafamilial abuse, sexual assault, and unnatural deaths, as well as criminal 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.

VIOLENCE AS A HEALTH PROBLEM

Violence is a public health problem that affects all people, regardless of socioeconomic class, racial or ethnic background, educational level, or sexual preference. Some violent crime rates, including murder and sexual assault, have declined over the past decade; however, violence crime rates in the home, workplace, community, and schools have increased. Approximately 899,000 children were victimized by child abuse or neglect in 2005, and one to two million individuals age 65 and older were mistreated by those on whom they depended for their care and safety.
Intimate partner violence is responsible for 5.3 million victimizations among women, 2 million injuries, and 1,300 deaths per year, with an annual cost of $4.1 billion.

The cycle of violence refers to a sociological theory about violence that explains violence as a learned behavior passed down from one generation to the next. According to this theory, this learned behavior can explain all forms of violence. The person committing the violent act chooses violence as a response to a stimulus because violence is the behavior that has been modeled to the person. In other words, the person reacts to a situation with violence because this is the reaction the person has “learned” via family, peers, and community.

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 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 directly 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 (Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009).

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, putting children in “double jeopardy,” such as those exposed to both domestic and 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.

Dauvergne (2002) states that intimate partner violence and sexual assault are leading causes of injury-related death in women. Of solved crimes in 2001, 52% of all female homicide victims were killed by someone with whom they had an intimate relationship at one point in time,
either through marriage or dating, compared to 8% of male victims. The World Health Organization (WHO, 2009) notes that there are many forms of violence against women, including sexual, physical, or emotional abuse by an intimate partner; physical or sexual abuse by family members or others; sexual harassment and abuse by authority figures (such as teachers, police officers, or employers); and trafficking for forced labor or sex. Violence can result in long-term health consequences for women. Physical and sexual abuse is associated with injuries, as well as sexually transmitted infections such as HIV/AIDS, unintended pregnancies, gynecological problems, induced abortions, and adverse pregnancy outcomes, including miscarriage, low birth weight, and fetal death. Abuse can result in many physical health problems, including headaches, back pain, abdominal pain, fibromyalgia, gastrointestinal disorders, limited mobility, and poor overall health, and violence increases the risk of depression, posttraumatic stress disorder, sleep difficulties, eating disorders, and emotional distress (WHO, 2009).

Men's health can be significantly affected by violence. The World Health Organization (2002) states that males account for three-quarters of all victims of homicide, and that males also have higher rates of suicide. Male survivors of violence may also face non–life threatening injury, mental health problems, reproductive health problems, and sexually transmitted diseases. The Mayo Clinic (2009) notes that intimate partner violence against males may lead to depression and anxiety, as well as suicide. Male victims are also more likely to engage in substance abuse and unprotected sex that males who have not been abused. Men are also less likely than women to report intimate partner violence in a heterosexual relationship because of embarrassment or fear of ridicule, and similarly, a man being abused by another man may be reluctant to talk about the problem because of how it reflects on his masculinity.

As the number of older adults increases, the number of elder abuse cases will increase as well, and the impact of elder abuse as a public health issue will grow. Elders who are victims of physical abuse or neglect have triple the mortality of those who were not abused. Mortality rates in physically abused elders are also significantly higher than for younger adults. Even with correction for severity of injury, elders are five to six times more likely to die of similar injuries than younger people. The Coalition to Eliminate the Abuse of Seniors (2005) points out that older adults have less physical strength and are less able to defend themselves from physical abuse. Additionally, older bones break more easily and take longer to heal. Abused elders may suffer from psychological distress or depression, worry, and anxiety that may be mistaken for dementia. They may also
feel shame, guilt, or embarrassment, especially when the abuser is a family member. Some older adult victims turn to alcohol or drugs, including the abuse of prescription medication, sometimes to the point of dependency.

**THE HEALTH CARE ROLE**

Health care providers can use the theory of violence as learned behavior to develop risk assessments based upon exposure to violence. If a client is determined to be a victim of violence, health care interventions would include counseling for psychological processing of the violent event with the goal of preventing the victim from reexperiencing violence or perpetrating violence. It is well known in the forensic community that the strongest correlate to victimization is past victimization, and that the best predictor of future violence is past violence. Victims and offenders require referrals to provide sufficient interventions to break the cycle of violence. The overall intervention for proponents of the cycle of violence theory is a strong public health initiative for reduction of violence in American culture. Cycle of violence theorists recommend interventions for young people who witness violence, are exposed to violence, and live in violent neighborhoods. Cycle of violence theorists recommend early detection and interventions to alter violent homes and neighborhoods.

Primary prevention methods include school and workplace programs designed to teach children or adults nonviolent strategies for managing conflict, as well as programs that provide support to young first-time mothers to prevent child abuse. Secondary prevention that requires early recognition of child abuse, intimate partner, and gang-related behaviors would facilitate referral into a system of support that will prevent further victimization and offending.

Tertiary prevention impacts on violence that has already occurred. Interventions are planned to decrease the probability that these clients will be revictimized or offend again. The juvenile justice system in the United States is based upon the theory that intensive rehabilitation will prevent juveniles from reoffending. Juveniles are treated by the justice system very differently from adults, based upon the theory that violence is learned and can therefore be unlearned through rehabilitation. Public health initiatives to stop drug dealing in neighborhoods are an overall effort to reduce violence in communities and stop the lessons drug dealing delivers about violence as a means to control territory.
RESOURCES

Bureau of Justice Statistics: http://www.ojp.usdoj.gov/bjs
Office for Victims of Crime: http://www.ojp.usdoj.gov/ovc

REFERENCES

DEFINITIONS

Twenty-five percent of the U.S. population identifies themselves as belonging to one of the federally defined minority groups, and almost 20% of the American population speaks a language other than English as their primary language. And the American population is becoming even more diverse. It is predicted that shortly after 2050, no single racial-ethnic group will hold a majority population position.

The increasing diversity of Western society adds an important dimension to forensic practice. The understanding of cultural differences can aid health care providers in managing the cycle of violence, and the utilization of culturally competent health care can facilitate recovery from trauma. An example would be interpreting the meaning of a man disallowing his wife to answer questions. Western cultural may lead the health care provider to interpret this as controlling behavior. However, this behavior may be acceptable in some cultures to the point where the woman is comfortable with it and not comfortable with answering the questions.

The Merriam-Webster Dictionary (http://www.merriam-webster.com) defines culture as the integrated pattern of human knowledge, beliefs, and behaviors that depend on transmission to succeeding generations, and the traditional beliefs, social manner, and material traits of a racial, religious,
or social group. Culture extends beyond ethnicity and religion to include elements such as gender identity (e.g., lesbian, gay, bisexual, transgender) and location (e.g., rural or urban), and it encompasses an array of values, beliefs, and customs.

- Values act as the foundation for culture. Values are acquired through socialization in early childhood and guide people’s goals, aspirations, and behaviors. For example, people value time differently. Some are present-oriented, accepting each day as it comes with little regard for the past and future; others are past-oriented, maintaining traditions and worshiping ancestors. Still others are future-oriented, with a high value for change.

- Beliefs include knowledge, opinions, and faith about the world. Witchcraft and the “evil eye” are two personalistic folk beliefs.

- Customs are learned behaviors that are easily assessed through questioning and observation. Problems can develop if professionals do not validate the meaning of observed behaviors. For example, most health care providers consider lack of eye contact abnormal behavior; however, some cultures consider eye contact a sign of disrespect or even hostility.

Race is a social and political construct rather than a biological one. Ethnicity is a term used to describe a common heritage, history, and worldview. The U.S. Census Bureau combines race and ethnicity into the following categories: American Indian, Alaskan Native, Asian, Black or African American, Hispanic or Latino, Native Hawaiian or Pacific Islander, and White. The purpose of this categorization is to help the government understand the needs of its citizens, including mental health care. However, this classification can be confusing and inadequate. There are more than 40 Asian and Pacific Island Countries, and over 560 Native American and Alaskan Native tribes. African Americans whose ancestors lived in the United States centuries ago have different cultural norms than those from Africa or the Caribbean today. Latinos may be from different racial groups, and the White group includes a very diverse population of Americans of European descent, as well as people from the Middle East. Biracial persons have no unique category.

Culture also includes immigration status, an issue critical in forensics since foreign-born women are over-represented among intimate partner female homicide victims when compared to the general population.
Permanent residents or immigrants are persons who come to the United States to remain permanently or for an indefinite period of time. The United States is their primary place of residence, and their permanent resident status is shown by possession of an identification card (green card).

Refugees are those persons living outside of their country of nationality and who are unable or unwilling to return because of persecution or fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.

Refugees make an application to U.S. authorities outside the United States and are approved for such status before coming to the United States. They are eligible to apply for permanent resident status after one year of continuous stay in the United States.

Asylees must meet the definition for a refugee but differ because they make an application for asylum (protection) after arriving in the United States.

Naturalization is the process of becoming a U.S. citizen. Lawful permanent residents may apply for U.S. citizenship by filing an application with the U.S. Citizenship and Immigration Services. It usually takes six months to two years to become naturalized.

Undocumented immigrants are those who entered the country without valid documents, as well as those who entered with valid visas but overstayed their visas’ expiration or otherwise violated the terms of their admission.

**CULTURE AND FORENSICS**

Certain cultural beliefs and customs have implications in the legal system, and health care professionals can assist law enforcement by performing detailed assessments to ascertain whether beliefs and behaviors are related to culture, mental health issues, or other factors. This may be important in cases where family violence is suspected or other violence has taken place.

**Culture-Bound Syndromes**

Culture-bound syndromes (culture-related syndromes) are folk illnesses with prominent alterations of behavior and experience. They usually do not conform to conventional diagnostic syndromes; however, they have
cultural validity in the societies in which they occur. Some culture-bound syndromes involve somatic symptoms (pain or disturbed function of a body part), while others are purely behavioral. The ones noted here are those that may have legal implications:

- **Amok or mata elap** (Malaysia) is probably the most known in this category and is a dissociative episode characterized by an outburst of violent, aggressive, or homicidal behavior directed at people and objects. The episode is usually triggered by a perceived insult or slight and seems to be prevalent among males. Persons who “run amok” usually experience persecutory ideas, automatism, and amnesia during the episode, and a return to premorbid state following the episode. A similar behavior pattern is found in Laos, the Philippines, Polynesia (**cafard** or **cathard**); New Guinea and Puerto Rico (**mal de pelea**); and among the Navajos (**iich’aa**).

- **Ataquque de nervios** (Latinos from the Caribbean, and other Latino groups) manifests in symptoms of uncontrollable shouting, crying, trembling, and verbal or physical aggression. The individual may also experience dissociative experiences, seizure-like or fainting episodes, and suicidal gestures. These symptoms frequently occur after a stressful event relating to the family, such as separation, divorce, or an accident.

- **Boufée deliriante** (West Africa and Haiti) is a sudden outburst of agitated and aggressive behavior, marked confusion, and psychomotor excitement. **Boufée deliriante** may sometimes be accompanied by visual and auditory hallucinations or paranoid ideation.

- **Hi-Wa itck** (Mohave American Indians) is associated with the unwanted separation from a loved one, resulting in insomnia, depression, loss of appetite, and sometimes suicide.

- **Latah** (Malaysia and Indonesia) is characterized by hypersensitivity to sudden fright, often with echopraxia, echolalia, command obedience, and dissociative or trancelike behavior. The Malaysian syndrome is more common in middle-aged women. Similar syndromes are found in Siberian groups (**anurakh, irkunii, ikota, olan, myriachit, and menkeiti**); Thailand (**bah-tschi, bah-tsi, and baah-ji**); Japan (**imu**); and Philippines (**mali-mali** and **silok**).

- **Locura** (Latin America) is a severe form of chronic psychosis that is attributed to an inherited vulnerability, the effect of multiple life difficulties, or a combination of the two. Manifestations include incoherence, agitation, auditory and visual hallucinations, inability to follow social interaction rules, unpredictability, and possible violence.
Pibloktoq or Arctic hysteria (Greenland Eskimos) is an abrupt dissociative episode accompanied by extreme excitement lasting up to 30 minutes and frequently followed by seizures and coma lasting up to 12 hours. The affected individual may be withdrawn or slightly irritable for a period of hours or days before the attack and typically reports complete amnesia for the attack. During the attack, the individual may shout obscenities, eat feces, flee from protective shelters, tear off his or her clothing, break furniture, or perform other irrational or dangerous acts.

Qi-gong psychotic reaction (China) is an acute, time-limited episode characterized by dissociative, paranoid, or other symptoms that occur after participating in the Chinese folk health-enhancing practice of qi-gong. Individuals who become overly involved in the practice are especially vulnerable.

Shenkui (China) is characterized by marked anxiety or panic symptoms with accompanying somatic complaints without obvious physical cause. Symptoms include dizziness, backache, fatigability, general weakness, insomnia, frequent dreams, and complaints of sexual dysfunction (such as premature ejaculation and impotence). Symptoms are attributed to excessive semen loss from frequent intercourse, masturbation, nocturnal emission, or passing of “white turbid urine” believed to contain semen. Similar symptoms are found in India (dhat and jiryan); and Sri Lanka (sukra prameha).

Tabanka (Trinidad) is characterized by depression associated with a high rate of suicide and is usually seen in men who have been abandoned by their wives.

Zar (North Africa and the Middle East) is an experience of spirit possession with symptoms that include dissociative episodes with laughing, shouting, hitting the head against a wall, singing, or weeping. Individuals may show apathy and withdrawal, refusing to eat or carry out daily tasks, or may develop a long-term relationship with the possessing spirit.

Cultural Customs Related to Female Reproduction

Female Genital Mutilation (May Mimic Intimate Partner Violence)

Female genital mutilation (FGM) refers to procedures that intentionally alter or injure female genital organs for nonmedical reasons. FGM is
usually performed when a girl is between 4 and 8 years old. It is practiced in about 28 African countries, Asia, the Middle East, and increasingly in Europe, Australia, Canada, and the United States. The World Health Organization (WHO), which promotes the elimination of FGM, has estimated that between 100 and 140 million women have undergone FGM, and that two million more undergo some form of FGM every year.

The WHO has identified four types of FGM.

- **Type I** is a clitoridectomy, which is the only type that can accurately be referred to as female circumcision and involves the removal of the prepuce and all or parts of the clitoris. This procedure typically does not result in long-term complications.

- **Type II** involves removal of the clitoris and inner labia, possibly resulting in pain during intercourse and other long-term problems.

- **Type III** is an extreme form of circumcision that involves removal of the clitoris, at least two-thirds of the labia majora, and the entire labia minora. Incisions are made in the labia majora to create raw surfaces, which are then stitched or held together (sometimes by tying the woman’s legs together), until a hood of skin grows to cover the urethra and vagina. Afterward, a tiny hole is made to allow for menstrual flow and urination.

- **Type IV** involves piercing or incising the clitoris and/or labia, and cauterization by burning of the clitoris and surrounding tissue.

Health care providers are likely to encounter women who have had FGM in their clinical practice, possibly for one of the adverse effects, which include: cysts, abscesses, and scar tissue; sexual dysfunction; dysmenorrhea; chronic pelvic infections; damage to the urethra; incontinence; chronic pelvic and back pain; chronic urinary tract infections; and difficulties with childbirth. It is important that health care providers not assume that all these women want this condition reversed. Women who have undergone FGM have been taught to believe that this rite of passage is normal. Their culture may believe that reversal of circumcision makes a woman unsuitable for marriage, liable for divorce, and virtually an outcast in their communities. Instead, providers should ask how this alteration has affected the woman’s life, urination, and menstruation. Health care professionals can also refer these women to a counselor from the same cultural background to discuss deinfibulation or other possible treatments, if needed.
Practices Around Menstruation

Beliefs about the cause and purpose of menstruation vary among cultures. For example, Navajo culture views menarche as a symbol for passage into adulthood, whereas both Iranian and Orthodox Jewish cultures view menstruation as a period of uncleanness. Extremely Orthodox Jewish women separate themselves from all men during menses, and no man is allowed to touch or even sit where a menstruating woman has sat. Women are considered to be in a state of impurity for at least 12 days (5 days from the onset of the menstrual cycle and 7 clean days following it). They then must attend a mikvah (ritual bath) before engaging in sexual intercourse with their husbands.

Practices Related to Illness Treatment
(May Mimic Child or Elder Abuse)

Coining, or CaoGio (Southeast Asia) is one of the most commonly practiced cultural folk remedies. Coining is rubbing or scratching with a coin on the skin of the back, neck, upper chest, and arms. Before or during rubbing, Tiger Balm (a mentholated ointment), Ben-Gay, an herbal liquid medicine or water is applied on the skin. The skin is then rubbed in a downward, linear fashion with the edge of the copper coin or a silver spoon until dark lines appear. These marks can persist for several days and have the appearance of being struck with a stick or whip.

Cupping (Hmong, Vietnamese, ethnic Chinese) or bahnkes (Russians, Koreans, and others) is performed on the chest, back, abdomen, and/or back of legs for pain, and the forehead and temples for headaches. A glass is held upside down, and a lit match, candle, or lighter is held under it in order to burn off the oxygen, creating a vacuum. The cup is quickly placed on the skin and the vacuum effect pulls the skin up, creating a mark that looks like a bruise and that may last for several days.

Stick burns and moxibustion, also called poua, are remedies used in certain cultures to relieve a variety of illness symptoms. These remedies are related to acupuncture; however, they cause a circular, cigarette-tip-size burn. The procedure calls for an incense-like stick to be lit and placed on the palms of the hands, soles of the feet, and genital area. Moxa herbs, usually mugwort (Artemisia vulgaris), or yarn are rolled into a peasized ball, placed on the skin, lit, and allowed to burn to the point of pain.

Pinching, or bat gio (Southeast Asia) is used to treat pain and a variety of conditions. For example, the area between the eyebrows, upper
nose, and temples is pinched to relieve headaches. Tiger balm may be massaged into the area before pinching. The pressure from the pinching leaves a reddened area that may give the appearance of having been struck.

Air suctioning (Southeast Asia) is used to relieve headaches. The cut end of a bull or goat horn is placed on the patient's forehead and/or temples, and the practitioner sucks the air out of the other end. The horn sticks to the application site and is then plugged with wax and left on the forehead for 10 to 15 minutes. Blood drawn to the surface of the skin leaves a round, bruiselike mark after the horn is removed. The marks may persist for several days.

Fallen fontanel or caida de la mollera (Latino populations), a challenging and potentially fatal pediatric folk illness, may develop from any severe illness (such as gastroenteritis) resulting in a 10% body weight loss in an infant. Children with caida are believed to be neglected, creating a high degree of maternal guilt. The cause is believed to be mechanical, such as the soft palate pulling down the fontanel when the feeding nipple is suddenly pulled out of the infant's mouth. Folk remedies include: pressing upward on the soft palate with thumbs or fingers, sucking the anterior fontanel, holding the baby upside down over water with or without shaking or hitting the feet. Poultices may be applied to the fontanel with raw egg, oil, or liniment and the hair is pulled up (so that the roots will raise the skin back up).

**Culture and Intimate Partner Violence**

Intimate partner violence (IPV) seems to be more prevalent and more lethal among immigrant women than among U.S. citizens. The Office for Victims of Crime notes that there are several factors that may make this type of victimization more likely, as well increase the difficulty immigrant victims face in seeking safety and using the justice system effectively:

- Cultural barriers: Cultural beliefs and practices may make it difficult for a victim to leave an abusive relationship and may even reinforce the idea that violence against a spouse is acceptable.
- Fear of deportation: Immigrants may fear being deported and losing custody of their children. Perpetrators of domestic violence and other crimes may use the fear of deportation to thwart the victim from reporting the crime. Lack of proper legal documentation (social security number, green card, or employment authorization)
to work or live in the United States can contribute to immigrants staying with abusive partners and not seeking outside help.

- Language barriers: Lack of or limited English proficiency keeps victimized immigrants from seeking protection with the police, the court system, social service agencies, and shelters.
- Misinformation about the legal system: Many immigrants come from countries where women cannot receive justice. Immigrant victims may be wary of seeking assistance from official institutions based on real or imagined experiences.
- Fear of the police: Immigrants may come from countries where police repress citizens, respond only to bribes, or believe women should be subordinate to men.
- Economic barriers: An abusive spouse may be a woman’s only means of support, and her immigrant status may make it impossible for her to legally obtain work or find child care.

The Violence Against Women Act (VAWA) of 1994 addresses the needs of immigrant women who are victimized by their spouses. This law created two ways for women who are married to U.S. citizens or lawful permanent residents to get their residency without having to rely on their abusive spouse: (a) Self-petitions allow a victim of IPV to file for and obtain permanent resident status without the knowledge, cooperation, or participation of the perpetrator. These petitions are applicable to victims of IPV who would have lawful immigration status through their spouses. These women should first consult a shelter worker, immigration attorney, or domestic violence or immigration agency for assistance. (b) Undocumented immigrant victims of IPV may be able to obtain U.S. residency through VAWA cancellation of deportation, if they are currently in or can be placed into deportation proceedings. Victims who qualify for cancellation may have their deportation waived by the court and may be granted residency. These women should consult an immigration attorney before proceeding.

**Culture and Human Trafficking**

The United Nations defines human trafficking as

The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a
position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. (United Nations, n.d.)

Many victims have language barriers and are isolated and unable to communicate with service providers, law enforcement, and others who might help them. They are often subjected to debt-bondage, usually in the context of paying off transportation fees into the destination countries, and are often threatened with injury or death or threats to the safety of their family back home. Please see chapter 20 for more on human trafficking.

**Immigration Consultant Fraud**

Scam artists prey upon immigrants seeking assistance in obtaining legal residence, work authorization, or citizenship. Many claim that they are attorneys or that they have close connections to the Immigration and Naturalization Service (INS). Others use titles such as notary public to deceive people into believing that they are lawyers. Typical scams include: charging excessive fees for immigration services and then failing to file any documents; filing false asylum claims; and charging fees to prepare applications for nonexistent immigration programs or for legitimate programs for which the client does not qualify.

**CULTURAL COMPETENCY**

Cultural competence goes beyond cultural sensitivity. It implies moving beyond awareness about different cultures to in-depth knowledge, and from sensitivity to issues to commitment to change situations of oppression. Culturally competent providers move beyond awareness about different cultures to an in-depth knowledge of them.

To provide culturally competent care, health care providers should:

- Develop knowledge about the norms of the ethnic and cultural groups they are likely to encounter in everyday practice
- Have the ability to perform a cultural assessment
- Make a commitment to spend time with diverse groups outside the health care setting
Understand the political and social issues that affect these groups
Understand how various groups react to stress

To provide culturally competent care:

- Become aware of your own professional and personal values about cultural practices. Ethnocentrism is common in all cultural and social groups, but health care professionals must transcend this bias. Health care professionals do not need to abandon personal values, beliefs, and cultural practices; however, they do need to understand how their personal perspectives may impact on their responses and assessments of diverse patients.

- Identify cultural nuances when assessing behaviors considered abnormal by Western society, such as lack of eye contact or an unresponsive or flat affect. These signs are often associated with mental illness or deceptiveness, yet in some cultures these are normal behaviors. Be sure to compare the patient’s behavior with normative standards of his or her cultural group, not only with the Westernized diagnostic system.

- Try to understand patients and their situations within the context of their cultural group. Ask questions about beliefs, perceptions about the cause of a problem, and how this type of problem is usually addressed in their culture. Ask about religious and spiritual beliefs and experiences.

- Realize that not all members of a particular cultural group are the same. Information about cultural trends should not overshadow the understanding of the individual person. Avoid stereotyping.

- Empathy can bridge cultural differences. Convey a caring attitude toward patients, and show interest in cultural differences and acknowledge these with the patient.

The U.S. Department of Justice’s Office of Victims of Crime presents five core tenets to providing high-quality multicultural victim assistance services:

- Develop the cultural awareness and competency
- Acknowledge the different and valid cultural customs of recovery from traumatic events
- Support cultural pathways to mental health and incorporate these into victim services and referrals
Rely on multiethnic and multilingual teamwork to implement and monitor effective victim services
Develop a cross-cultural perspective

RESOURCES

National Center for Cultural Competence: http://www.11.georgetown.edu/research/guc
Program for Multicultural Health: http://www.med.umich.edu/Multicultural/ccp/index.htm
Think Cultural Health (U.S. Department of Health & Human Services): http://www.thinkculturalhealth.org/

REFERENCES