Infant Victimization in a Nationally Representative Sample

WHAT'S KNOWN ON THIS SUBJECT: Child maltreatment by caregivers is recognized as a particular risk for infants and young children who make up the largest age group among reports to child protection agencies.

WHAT THIS STUDY ADDS: This study highlights several additional victimization risks beyond maltreatment, including a high rate of infant victimization at the hands of siblings. This type of victimization appears to be associated wtih considerable levels of emotional and behavioral symptoms.

abstract

OBJECTIVE: The objectives of this research were to (1) obtain estimates of child maltreatment and other forms of personal, witnessing of, and indirect victimization among children aged 0 to 1 year in the United States and (2) examine associations between infant victimization exposure and the infant's level of emotional and behavioral symptoms.

METHODS: The study is based on a cross-sectional national telephone survey that included caregivers of a sample of 503 children under 2 years of age.

RESULTS: Nearly one-third of the sample of infants (31.6%) had experienced some form of personal, witnessing, or indirect form of victimization. The rate of infant maltreatment by caregivers (2.1%) was significantly lower than among older preschool-aged children. However, the rate of infant assault by siblings was considerable at 15.4%. The greatest risk of assault occurred in households with young siblings; nearly 35% of the infants with a sibling aged 2 to 3 years were assaulted in the year before the interview. Witnessing family violence was also relatively common among the infants (9.5%). Victimization was associated with emotional and behavioral problems; sibling assault and witnessing family violence had the highest correlations with infant symptom scores.

CONCLUSION: The results of this study highlight the need for attention to infant victimization that considers a wider array of victimization sources and a broader scope of prevention efforts than has been typical in the child-maltreatment field. *Pediatrics* 2010;126:44–52

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KEY WORDS

infants, maltreatment, sibling assault, emotional and behavioral symptoms, victimization

ABBREVIATIONS

RDD—random-digit dialing
RR—risk ratio

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The maltreatment of infants receives a great deal of clinical attention, in part because so many such children come to professional attention. Among cases of maltreatment reported to authorities, children under the age of 1 year constitute the largest single age group[1,2] and predominate among victims of child-maltreatment homicide.[3,4]

Most existing studies on infant maltreatment have included only cases identified to medical and child protective authorities. Fewer authors have focused on the broader spectrum of maltreatment in very young children[5] that may be revealed in community-based populations. One such study revealed the incidence of harsh discipline of infants, such as shaking, to be alarmingly high (2.6%),[6] which suggests a potential precursor to injurious maltreatment. Thus, addressing infant maltreatment in the general population, regardless of whether it leads to injury and identification by authorities, is crucial because it may represent an important marker for ongoing abuse and other high-risk developmental trajectories.

In addition, little or no research to date has examined the incidence of infant exposure to other forms of victimization beyond caregiver maltreatment. It is widely assumed that caregivers are the most likely perpetrators of victimization against infants, but assaults by other juveniles are also potential sources of risk. Indeed, young children often experience a great deal of abuse at the hands of siblings and other children, some of which can be very serious.[7] Infants also constitute a target population for family abduction[8] and are among children most exposed to domestic violence.[9] The assessment of a wider array of potential victimizations can provide greater insight into the broader contexts of risk that characterize vulnerability in this youngest age group. To date, no community epidemiologic studies, to our knowledge, have had a large enough sample and a broad enough scope to explore the diverse forms of victimization types encountered among the general population of infants.

The primary objectives of this research were to (1) estimate the 1-year incidence of different forms of victimization in a sample of 0- to 1-year-old children, obtained from a recent national probability survey of children and youth, (2) identify perpetrator, child, and family characteristics associated with infant victimization, and (3) examine the association between victimization exposure and infant emotional and behavioral symptomatology.

METHODS

Participants

The National Survey of Children's Exposure to Violence (NatSCEV) was designed to obtain incidence and prevalence estimates of a wide range of childhood victimizations. Conducted between January 2008 and May 2008, the survey addressed the experiences of a nationally representative sample of 4549 children aged 0 to 17 living in the contiguous United States. Our research focused on the subsample of 503 children under 2 years of age.

The interviews with parents and youth were conducted over the telephone by the employees of an experienced survey research firm. Telephone interviewing is a cost-effective methodology[10,11] that has been demonstrated to be comparable to in-person interviews in data quality, even for reports of victimization, psychopathology, and other sensitive topics.[12–17] In fact, some evidence suggests that telephone interviews are perceived by respondents as more anonymous, less intimidating, and more private than in-person modes[12,18] and, as a result, may encourage greater disclosure of victimization events.[12]

The primary foundation of the design was a nationwide sampling frame of residential telephone numbers from which a sample of telephone households was drawn by random-digit dialing (RDD). This nationally representative cross-section yielded 3053 of the 4549 completed interviews. To ensure a sizeable proportion of minorities and low-income respondents for accurate subgroup analyses, there also was an over-sampling of US telephone exchanges that had a population of 70% or more of black, Hispanic, or low-income households. RDD used with this second "oversample" yielded 1496 of the completed interviews. Sample weights were applied to adjust for differential probability of selection dues to (1) study design, (2) demographic variations in nonresponse, and (3) variations in within-household eligibility.

Procedure

A short interview was conducted with an adult caregiver (usually a parent) in each household to obtain family demographic information. One child was randomly selected from all eligible children who lived in a household by selecting the child with the most recent birthday. If the selected child was under the age of 10, the interview was conducted with the caregiver who was "most familiar with the child's daily routine and experiences."

Respondents were promised complete confidentiality and were paid $20 for their participation. The interviews averaged 45 minutes in length and were conducted in both English and Spanish. Respondents who disclosed a situation of serious threat or ongoing victimization were contacted again by a clinical member of the research team, trained in telephone crisis counseling, whose responsibility was to stay in

contact with the respondent until the situation was resolved. All procedures were authorized by the institutional review board of the University of New Hampshire.

The cooperation rate for the RDD cross-section portion of this survey was 71%, and the response rate was 54%. The cooperation and response rates associated with the smaller oversample were somewhat lower, at 63% and 43%, respectively. These are good rates by current survey research standards,[19,20] given the steady decline in response rates that have occurred during the last 3 decades[21] and the particular marked decrease in recent years.[19,22,23] Although the potential for response bias remains a consideration, several recent studies have revealed no meaningful association between response rates and response bias.[24–27] This survey also did not sample cell-phone–only households. Because these households are most likely to consist of young adults (aged 18–25 years),[28] some portion will likely include parents of infants. Although we have no particular reason to suspect greater victimization risk in cell-phone–only households, to the extent that such differences exist, infant victimization might be underestimated in this community-based sample.

TABLE 1 Infant Victimization Rates According to Individual and Aggregate Types (Previous Year)

Victimization Type	Rate, %	95% Confidence Interval
Personal victimization		
PV1. Assault with weapon	1.5	0.4–2.6
PV2. Assault without a weapon	2.0	0.7–3.3
PV3. Attempted assault	0.9	0.1–1.7
PV4. Kidnapping	0.1	−0.2–0.4
PV5. Physical abuse	0.6	−0.1–1.3
PV6. Neglect	0.6	−0.1–1.3
PV7. Custodial interference	1.0	0.1–1.9
PV8. Peer/sibling assault	16.7	13.4–20.0
PV9. Sexual assault by a known adult	0.0	
PV10. Sexual assault by another adult	0.0	
PV11. Sexual assault by juvenile	0.0	
PV12. Rape (completed or attempted)	0.0	
Witnessing family violence		
FV1. Witness partner assault	2.6	1.2–4.0
FV2. Witness physical abuse of sibling	0.7	0.0–1.4
FV3. Witness parent threatening parent	1.8	0.6–3.0
FV4. Witness parent throwing object	4.1	2.3–5.9
FV5. Witness parent push parent	3.8	2.0–5.6
FV6. Witness parent hit parent	1.6	0.5–2.7
FV7. Witness parent beat parent	0.6	0.1–1.3
FV8. Witness assault by another adult in the household	2.1	0.8–3.4
Other witnessing and indirect victimization		
WI1. Witness assault with weapon	1.2	0.2–2.2
WI2. Witness assault without a weapon	4.4	2.6–6.2
WI3. Household theft	7.3	5.0–9.6
WI4. Someone close murdered	2.2	0.9–3.5
WI5. Witnessed murder	0.4	−0.2–1.0
WI6. Witnessed shooting/riots	1.9	0.7–3.1
WI7. In the middle of a war	0.4	−0.2–1.0
Summary of victimizations		
Any infant victimization (PV1–WI7)	31.6	27.4–35.8
Any personal infant victimization (PV1–PV12)	19.3	15.8–22.8
Any assault (PV1–PV3, PV5, PV6, PV8)	17.9	14.5–21.3
Any juvenile sibling assault (any assault with sibling as perpetrator)	15.4	12.2–18.6
Any maltreatment (PV5, PV6, PV7)	2.2	0.9–3.5
Any witnessing of family violence (FV1–FV8, WI1,[a] and WI2[a])	9.5	5.7–10.5
Any witnessing of family assault (FV 1, FV2, FV5–FV8)[a]	7.6	4.1–8.5
Any witnessing of partner assault (FV1, FV5, FV6, FV7)	4.6	2.7–6.5

[a] If the perpetrator and victim are with family.

Measurement

This survey used an enhanced version of the Juvenile Victimization Questionnaire, an inventory of childhood victimization.[29–31] A total of 27 items were administered to the caregivers of infants, representing only those victimizations that were potentially relevant to the experiences of very young children. These covered 5 general areas of interest: conventional crimes; maltreatment; victimization by peer and siblings; sexual victimization; and witnessing and indirect victimization, including witnessing family violence.[32] Specific screener wording for all individual items is presented in the Appendix. Follow-up questions for each screener item (not shown) gathered additional information about each victimization, including perpetrator characteristics, the use of a weapon, and whether injury resulted. Respondents also were asked whether the event had occurred within the previous year; for the current research, only previous-year victimizations were counted. Individual items also were aggregated into summary victimizations for additional analysis (see Table 1). It is important to note that Juvenile Victimization Questionnaire items and categories were developed to be relevant across the full developmental spectrum of childhood. We acknowledge that some terminology, such as peer or sibling assault, have crime-related connotations that do not necessarily apply to very young children.

Emotional and behavioral symptoms were assessed by using the 13 items from the Infant Traumatic Stress Questionnaire and 6 additional items from the Brief Infant Toddler Social and

Emotional Assessment, which assessed additional dimensions of emotional functioning (ie, depression/withdrawal, emotion regulation, negative emotionality, and separation distress). Caregivers were asked how often their child demonstrated each of 19 behaviors in the previous month. Response options were on a 3-point scale from 1 (never) to 3 (often). The Infant Traumatic Stress Questionnaire has demonstrated good internal validity,[33] and in its full form the Brief Infant Toddler Social and Emotional Assessment has demonstrated adequate validity and reliability.[34] A factor analysis of the 19 symptoms revealed 1 dimension. This combined measure has an α coefficient of .75.

Demographic information was obtained, including the child's gender, age (in years), race/ethnicity (coded into 4 groups: white non-Hispanic, Black non-Hispanic, Hispanic any race, and other race), socioeconomic status (a composite of family income and parent education), and family structure (categorized into 4 groups: children living with 2 biological or adoptive parents, 1 biological parent plus partner, single biological parent, and other caregiver).

RESULTS

Table 1 lists the percentage of the sample exposed to individual forms of victimization, as well as aggregate categories. Almost one-third of this sample of infants (31.6%) had experienced some form of personal, witnessing, or indirect form of victimization. However, it is noteworthy that only a small proportion of the sample reported infant maltreatment by caregivers, with rates ranging from 0.6% for physical abuse and neglect to 1% for custodial interference. Slightly more than 2% of this sample of infants experienced any form of maltreatment in the previous year. The rates of peer/sibling assault are much higher at nearly 17%. The large majority of these exposures (15.4%) represented assaults at the hands of siblings. No infants in this sample were exposed to any form of sexual abuse. Among the 19.3% of infants who were exposed to some form of personal victimization, 4.3% sustained some physical injury such as a bruise, cut, or broken bone (data not shown).

In assessment of indirect and witnessing victimizations, 9.5% of the sample witnessed some form of family violence. More than 7% of the sample (7.6%) witnessed some form of family assault, and nearly 5% witnessed interparental assault. Other witnessing and indirect victimizations such as witnessing an assult (no weapon) (4.4%) and household theft (7.3%) were also relatively common forms of exposure. Almost 15% of the sample experienced some form of witnessing or indirect victimization beyond family violence. Approximately 83% of all victimizations among infants occurred within the home; approximately 3% occurred in a day care setting (data not shown).

In follow-up analyses, we compared rates of victimization among infants with those of other preschool-aged children. We noted significantly lower rates of several forms of personal victimization among infants relative to older preschool-aged children. For example, the rate of physical abuse by caregivers was 0.6% among infants but 1.3% and 4.6% among 2- to 3-year-olds and 4- to 5-year-olds, respectively ($P < .001$). Similarly, assault without a weapon had a rate of 2.1% among infants, 6.9% among 2- to 3-year-olds, and 13.5% among 4- to 5-year-old children. In contrast, most types of witnessing family violence and other witnessing/indirect forms of victimization did not significantly differ across age groups. Additional age comparisons of victimization rates, including comparisons with older children, were reported elsewhere.[35]

Given the relatively high rates of exposure to sibling-perpetrated violence, we sought to better specify the nature of this risk. Because not all infants have siblings, we first recalculated the rates of sibling assault among the subsample of infants who had at least 1 sibling in the household to gain a more accurate picture of this source of victimization risk. Nearly 21% of infants with 1 or more siblings were exposed to sibling assault. Although our data did not allow the identification of the sibling-perpetrator's age, we were able to stratify risk according to the presence of different-aged siblings in the household. As shown in Table 2, the greatest risk of sibling assault occurred in households with siblings only slightly older than the target respondent. Nearly 35% of the infants with a sibling aged 2 to 3 were as-

TABLE 2 Infant Exposure to Juvenile Sibling Assault

	n (%)	RR[a]
Any 2- to 3-y-old sibling in household		
Percent assaulted by juvenile sibling	34.8	5.09[b]
Any 4- to 5-y-old sibling in household		
Percent assaulted by juvenile sibling	22.4	1.88[c]
Any 6- to 9-y-old sibling in household		
Percent assaulted by juvenile sibling	20.0	1.72[c]
Any sibling ≥10 y old in household		
Percent assaulted by juvenile sibling	10.6	0.72 (not significant)

[a] Based on logistic regression controlling for other age categories of siblings in household. Relative RRs were approximated from ORs to adjust for outcome incidence.[43]
[b] $P < .001$.
[c] $P < .05$.

saulted in the year before the interview; the relative risk of a sibling assault was more than 5 times greater among these infants than among infants for whom there was not a 2- to 3-year-old in the household. Risk became lower as the age of siblings increased but remained significantly greater for infants with 4- to 5-year-old siblings (risk ratio [RR]: 1.88; $P < .05$) and those with 6- to 9-year-old siblings (RR: 1.72; $P < .05$). There were no significant differences in exposure according to the gender of the sibling-perpetrator; brothers and sisters were equally likely to be perpetrators.

Demographic variations in exposure to different categories of victimization also were evident. With respect to maltreatment, findings should be regarded with caution because analyses involved only a small number of cases ($n = 11$). For black infants and those in single-parent families, there were significantly higher rates of maltreatment than for those in other race/ethnic groups and family structures, with relative RRs of 6.6 and 8.2, respectively ($P < .001$). In contrast, for white children there were significantly higher rates of sibling assault relative to other race/ethnic groups (RR: 1.8; $P < .01$). Infants from single-parent families were at significantly greater risk of witnessing family violence (RR: 2.1; $P < .05$), including witnessing family assault (RR: 3.2; $P < 001$), than were infants in other family structures. No other demographic differences were significant.

Additional analyses revealed significant associations between exposure to maltreatment and several other risk factors ($P < .001$). Again, these finding should be considered only suggestive given the small number of cases involved. Infants who (1) lived in more than 1 household in the previous year, (2) had other (nonparent) adults who regularly spent the night in the household, or (3) experienced residential moves in the previous year were more likely to have been exposed to some form of maltreatment. Finally, for infants whose biological mother had ever been diagnosed with a psychiatric disorder there was a higher rate of maltreatment. None of these factors were significantly related to other forms of victimization.

Exposure to any victimization in the previous year also was significantly and substantially associated with infant emotional and behavioral symptom scores ($r = 0.32$; $P < .001$). This association remained significant even when we controlled for all sociodemographic factors ($\beta = 0.30$; $P < .001$). Among specific aggregate types, the strongest associations were with respect to juvenile sibling assault ($r = 0.21$; $P < .001$) and witnessing family violence ($r = 0.25$; $P < .001$). Individual symptoms that were most strongly related to any victimization exposure included "acted in ways that made you want to punish him/her" ($r = 0.29$; $P < .001$), "had trouble adjusting to changes" ($r = 0.22$; $P < .001$), "had trouble calming down when upset" ($r = 0.19$; $P < .001$), and "cried or had a tantrum until he/she was exhausted" ($r = 0.17$; $P < .001$). The symptom patterns were similar for individual types of victimization with a few interesting exceptions. Juvenile sibling assault was also quite strongly related to "had trouble going to sleep" ($r = 0.20$; $P < .001$), and witnessing family violence was moderately related to both "got startled or spooked easily" ($r = 0.19$; $P < .001$) and "acted aggressively" ($r = 0.18$; $P < .001$).

DISCUSSION

In this study we examined several forms of personal victimization, witnessing violence, and indirect victimization among infants in the United States. Using data from a large and contemporary national survey, we were able to address infant exposure to victimization in the general population and to consider a wide range of victimization types. To our knowledge, this is the first such effort to date.

With respect to child maltreatment, we found lower rates for infants than for older, preschool-aged children. This pattern is different from official statistics that often show the highest maltreatment rates among infants. The discrepancy likely reflects a difference in the types of maltreatment situations being revealed, because official statistics typically capture more serious cases than those identified in population surveys. In respect to serious maltreatment, official statistics may be confounded with age-related processes of disclosure or discovery that do not equally apply to survey research. For example, given the fully dependent nature of infants, caregiving failures and abuses may have more immediate and catastrophic consequences for infants and, therefore, be detected more often at this stage. More frequent contact with medical, nursing, and social services in the postnatal period may also facilitate greater identification of maltreatment among infants. Both these processes would lead to a higher representation of infant-maltreatment cases in official statistics. Setting aside potential differences in detection and visibility, there is some logic to the survey revealing that maltreatment increases as children get somewhat older, become more mobile and more resistant, and require more complicated forms of care.

Although only suggestive, several risk factors associated with maltreatment were identified. Many of these factors seem to reflect family and household instability: single-parent family structure, residential moves, unrelated adults regularly spending the night,

and residence in more than 1 household were all associated with higher rates of child maltreatment.

Study findings indicate elevated levels of symptomatology among infants who have witnessed family violence. Given the limited cognitive development of infants, it is unclear whether these findings reflect the same kinds of harmful stress reactions characteristic of older children exposed to such violence[36,37] or whether the presence of family violence in the home is a proxy for other damaging family characteristics. For example, 1 study that used the same measure revealed that witnessing severe intimate partner violence (violence directed at mothers by male partners) was most strongly related to infant symptomatology when mothers also experienced trauma symptoms.[33] It is clear that more research is warranted to better delineate the link between witnessing family violence and emotional and behavioral symptoms in this youngest age group.

Arguably the most important finding of this study is the apparent frequency with which infants are victims of assaults at the hands of siblings. Sibling assaults have not typically been considered a significant source of victimization among infants, but our findings suggest that this assumption is worthy of reconsideration. In this sample, more than one-fifth of the infants with any siblings in the household experienced an assault from a sibling in the previous year. More important is that victims of sibling assault had significantly higher symptom scores than those without this form of exposure. Although our study could not establish that the symptoms were caused by the sibling assaults, it is both plausible and consistent with the data that infants subjected to physical attacks, even by quite young siblings, could experience substantial stress and emotional impairment from such exposure. In a previous study with older children, our research also confirmed associations between sibling violence and mental health symptoms.[38]

If sibling violence does pose a common peril to infants, it is probably not at the level of severe maltreatment reflected in familiar child-maltreatment scenarios involving such dynamics as abusive head trauma or failure to thrive. However, exposure to assaultive siblings may result in some of the problems of hyperarousal and emotional dysregulation that have been discussed as sequelae of early maltreatment.[39]

Our findings do suggest that child-protection specialists might wish to develop more interventions to protect very young children from sibling assault. For example, home visitors to families with both new infants and somewhat older children may be instructed to inquire about aggressive behavior by siblings toward infants. Parents in such families may benefit from suggestions about how to discourage such behavior, including such techniques as establishing clear rules, maintaining physical barriers, and using consistent limit setting and discipline to discourage aggression. Child-protective workers and domestic violence specialists also should become sensitive to the potential for sibling abuse, even with infants, and be prepared to educate and train parents about its management.

More research also is warranted to help delineate more clearly the potentially traumatic conditions and elements of sibling violence toward infants. Parents and child development specialists could benefit from evidence-based guidelines about sibling behavior that is harmful as opposed to playful or accidental or physically rough interaction that is benign.

Our results also highlight the discrepancies that frequently are apparent when results from community-based surveys are compared with those obtained from official agency statistics of child maltreatment. A better understanding of the inconsistencies across different data sources and the ways that epidemiologic data might be usefully combined with official reports would require conducting extremely large surveys. Large-scale projects such as the National Children's Study, based on more than 100 000 children,[40] would allow a sufficient number of official report cases to be captured within a population-based sample.

Several limitations of this research should be acknowledged. First, it is possible that families who expose infants to maltreatment are reticent to disclose such behavior or are less likely to participate in community surveys, which could underrepresent infant maltreatment in population-based surveys. However, although not specific to infant samples, the results of similar survey-based studies have demonstrated considerable willingness of caregivers to report violent and maltreating acts perpetrated by themselves and other household caregivers[6,41] and have provided evidence that caregivers do not underreport compared with other observers.[29]

Second, our limited sample size of infants meant that we were unable to conduct multivariate analyses to determine the independent influence of different sources of victimization on infant symptoms. Because children are often exposed to multiple types of victimization,[29] it was not clear from our analyses which types of victimization exposure have the greatest impact. Related to this issue, the relatively small incidence of certain kinds of victimization (such as maltreatment from caregivers) precluded any confident conclusions about factors that increase victimization risk. Although our study was unique in its ability to address infant victimization within a community context, future epidemiologic research may need to obtain larger population-based infant samples to allow greater

precision of victimization rates and greater specification of risk factors.

Finally, reports of both victimization exposure and symptoms came from the same sources (caregivers), which led to a possibility of method covariance. Information from the same source can yield substantially higher correlations than information from different sources (eg, parents and child-protection professionals).[42]

CONCLUSIONS

Our results highlight the need for attention to infant victimization within the general population that considers a wider array of victimization sources than has been typical in maltreatment studies. Findings that demonstrate significant victimization risk to infants at the hands of young siblings, and elevated symptomatology associated with such exposure, suggest the need to broaden the scope of maltreatment prevention and intervention efforts to include sibling-related risk.

APPENDIX: VICTIMIZATION SCREENERS ADMINISTERED TO CAREGIVERS OF INFANTS

Note that only previous-year victimizations were counted in this study.

Personal Victimizations

PV1: Sometimes people are attacked with sticks, rocks, guns, knives, or other things that would hurt. At any time in your child's life, did anyone hit or attack your child on purpose with an object or weapon? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?

PV2: At any time in your child's life, did anyone hit or attack your child WITHOUT using an object or weapon?

PV3: At any time in your child's life, did someone start to attack your child, but for some reason, it didn't happen? For example, someone helped your child or your child got away?

PV4: When a person is kidnapped, it means they were made to go somewhere, like into a car, by someone who they thought might hurt them. At any time in (your child's/your) life, has anyone ever tried to kidnap your child?

PV5: Not including spanking on (his/her) bottom, at any time in your child's life did a grownup in your child's life hit, beat, kick, or physically hurt your child in any way?

PV6: When someone is neglected, it means that the grownups in their life didn't take care of them the way they should. They might not get them enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. At any time in your child's life, was your child neglected?

PV7: Sometimes a family fights over where a child should live. At any time in your child's life did a parent take, keep, or hide your child to stop (him/her) from being with another parent?

PV8: At any time in your child's life, did any kid, even a brother or sister, hit your child? Somewhere like: at home, at school, out playing, in a store, or anywhere else?

PV9: At any time in your child's life, did a grownup your child knows touch your child's private parts when they shouldn't have or make your child touch their private parts? Or did a grownup your child knows force your child to have sex?

PV10: At any time in your child's life, did a grownup your child did *not* know touch your child's private parts when they shouldn't have, make your child touch their private parts or force your child to have sex?

PV11: Now think about other kids, like from school, a boy friend or girl friend, or even a brother or sister. At any time in your child's life, did another child or teen make your child do sexual things?

PV12: At any time in your child's life, did anyone TRY to force your child to have sex; that is, sexual intercourse of any kind, even if it didn't happen?

Witnessing Family Violence

FV1: At any time in your child's life did your child SEE a parent get pushed, slapped, hit, punched, or beat up by another parent, or their boyfriend or girlfriend?

FV2: At any time in your child's life, did your child SEE a parent hit, beat, kick, or physically hurt (his/her) brothers or sisters, not including a spanking on the bottom?

FV3: At any time in your child's life, did one of your child's parents threaten to hurt another parent and it seemed they might really get hurt?

FV4: At any time in your child's life, did one of your child's parents, because of an argument, break or ruin anything belonging to another parent, punch the wall, or throw something?

FV5: At any time in your child's life, did one of your child's parents get pushed by another parent?

FV6: At any time in your child's life, did one of your child's parents get hit or slapped by another parent?

FV7: At any time in your child's life, did one of your child's parents get kicked, choked, or beat up by another parent?

FV8: Now we want to ask you about fights between any grownups and teens, not just between your child's parents. At any time in your child's life, did any grownup or teen who lives with your child push, hit, or beat up someone else who lives with your child, like a parent, brother, grandparent, or other relative?

Other Witnessing and Indirect Victimization

WI1: At any time in your child's life, in real life, did your child SEE anyone get attacked or hit on purpose WITH a stick, rock, gun, knife, or other thing that would hurt? Somewhere like: at home, at school, at a store, in a car, on the street, or anywhere else?

WI2: At any time in your child's life, in real life, did your child SEE anyone get attacked or hit on purpose WITHOUT using a stick, rock, gun, knife, or something that would hurt?

WI3: At any time in your child's life, did anyone steal something from your house that belongs to your child's family or someone your child lives with? Things like a TV, stereo, car, or anything else?
WI4: At any time in your child's life, was anyone close to your child murdered, like a friend, neighbor or someone in your child's family?
WI5: At any time in your child's life, did your child see someone murdered in real life? This means not on TV, video games, or in the movies?
WI6: At any time in your child's life, was your child in any place in real life where (he/she) could see or hear people being shot, bombs going off, or street riots?
WI7: At any time in your child's life, was your child in the middle of a war where (he/she) could hear real fighting with guns or bombs?

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How Good Is That First Pick?: *While we are all familiar with various drafts for professional sports where the weaker teams get to pick first, just how much of an advantage is having an early pick? According to an article in* The New York Times *(Thaler RH, April 4, 2010), the first pick in the draft is on average the least valuable in terms of value per dollar—a lesson that may apply to not just professional sports but to any organization trying to select their best applicants on the basis of talent. For example, in the National Football league, there is about a 50 percent chance that a player picked first for a given position is better than the player picked second in that position based on the number of games played in their first five years in the league. This is equivalent to a coin toss—yet the dollars expended in salary dollars or trades made to get that first pick can be quite extravagant—hence the diminished return on investment involved with that initial pick. As further proof of the players further down on the list (who are paid less for doing just as much or more) being a better value, consider New England Patriots quarterback Tom Brady, who was the 199th pick in the 2000 draft and has thus far played in four Super Bowls, winning three.*

Noted by JFL, MD

Infant Victimization in a Nationally Representative Sample

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