



Research Article

Forensic Evaluation: Damages of Children and Adults with Intellectual and Developmental Disabilities

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Abstract

The purpose of this article is to both expand awareness of the prevalence of abuse of people with disabilities and to describe responses to this problem both in preparation for abuse occurring to individuals and in care programs, and the post-assault actions that can be taken to support the victims and their families following the discovery of the abuse. This article focuses on work with individuals with Intellectual and Developmental Disabilities (I/DD), although the information can be useful for working with individuals with any type of disability.

Keywords: Abuse; Developmental disabilities; Intellectual disabilities; Support

Introduction

Part one: Brief overview of the problem of abuse and individuals with disabilities representation in population

According to the U.S. Census Bureau in 2010, of the 303.9 million people counted in the U.S. population, approximately 56.7 million Americans were living with disabilities [1]. In other words, 18.7 percent of the total population had a disability. Of those individuals, 38.6 million had a disability that is considered severe. Concerning an individual, the term 'disability' means "a physical or mental impairment that substantially limits one or more major life activities of such individual" [2]. Contributors to disability continue to include both

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preventable and non-preventable factors including the use of alcohol and drugs during pregnancy where Fetal Alcohol Spectrum Disorders (FASD) is the primary result [3] other contributors include accidents, illnesses and improved identification of disabilities both prenatal and postnatal.

Health and educational researchers at the Centers for Disease Control and Prevention focused on the prevalence of developmental disabilities over a 12-years (1997-2008) period. Parents completed National Health Interview Surveys (NHIS) that produced data on children aged from 3 to 17 years [4] the researchers found that developmental disabilities among children are common. During the years 2006-2008, at least 1 in 6 children had developmental disabilities. Results from the NHIS surveys show almost a fourfold increase in the estimated prevalence of autism: from 1.9 per 1,000 children from 1997 to 1999 to 7.4 per 1,000 children from 2006 to 2008. The researchers found that the number of children with some specific developmental disabilities (autism, attention deficit hyperactivity disorder, and other developmental delays) had increased and so concluded that more health and education services will be required.

Incidence of abuse

Statistician "Erika" Harrell [5] of the Bureau of Justice Statistics (BJS) reported on crime victims with disabilities over the age of 12 during the years 2009 to 2015. The article states that in 2015, the rate of violent victimization against persons with disabilities (29.5 per 1,000) was 2.5 times more than the rate for non-disabled peers (11.8 per 1,000). Serious violent victimization (i.e., rape/sexual assault, robbery, aggravated assault) was over three times the rate for non-disabled peers: 12.7 per 1,000 persons with disabilities compared to 4.0 per 1,000 neurotypicals. The rate of simple assault against persons with disabilities (19.6 per 1,000) was more than twice the rate for persons without disabilities (8.7 per 1,000). When Harrell (2017) examined victimization rates of all disability types by victims' age during 2011 through 2015, it was found that persons with cognitive disabilities were at highest risk for total violent crime: (57.9 per 1,000), serious violent crime (22.3 per 1,000), and simple assault (35.6 per 1,000). Rates of violent victimization for both disabled males (31.8 per 1,000) and females (32.8 per 1,000) were higher than both genders without disabilities (males 14.1 per 1,000; females: 11.4 per 1,000). Overall, Harrell (2017) found that persons with a single disability type (29.6 per 1,000) were less likely than persons with multiple disability types (35.2 per 1,000) to be violently victimized (90% confidence level). This same BJS statistician, Erika Harrell, was interviewed in 2018 by Joseph Shapiro, a National Public Radio (NPR) News Investigative Correspondent, in his eight-part series, *Abused and Betrayed*, on abuse of adults with intellectual disabilities. After a yearlong investigation, Shapiro's series was presented on-air on *All Things Considered*. Shapiro Stated: "There is an epidemic of sexual assault against people with intellectual disabilities; that these crimes go mostly unrecognized, unprosecuted, and unpunished. One frequent result: the abuser is free to abuse again. The victim gets victimized over and over". Erika Harrell responds to: "It is not surprising because they do

have that high level of victimization; that high vulnerability is just reflected in our numbers”. Shapiro at this point in the recording, cuts in: “That’s Erika Harrell. She’s a statistician at the U.S. Department of Justice. She writes an annual report about crime against all people with disabilities. NPR asked her to break out her unpublished data about sexual assault and intellectual disabilities. And she came up with stunning numbers!”.

Then Erika Harrell states: “It was seven times higher than the rate for persons with no disabilities.” Shapiro repeats: “People with Intellectual Disabilities are sexually assaulted at rates at least seven times the rate for other people. And that is almost certainly an undercount. Because those numbers are from household surveys of people 12 and older and they don’t count people living in institutions where Harrell says research shows people are even more vulnerable to assault or in group homes”.

When that same unpublished Justice Department data on sex crime was separated by gender, women were found to be victimized at a rate twelve times higher than non institutionalized residential Americans without disabilities. Other researchers have found abuse is more common among disabled persons than might be assumed. In 2012, the Lancet published a meta-analysis of 17 observational studies conducted by Lisa Jones and colleagues, who examined the prevalence and risk of violence against children (aged 18 years and younger) with disabilities. Sample sizes of the 17 studies were from 41 to 5,503 children, with a combined total of 18,374 children with disabilities [7] Pool risk estimates were 3.68 (2.56-5.29) for combined violence measures, 3.56 (2.80-4.52) for physical violence and 2.88 (2.24-3.69) for sexual violence. The results of this meta-analysis support the premise that children with disabilities are approximately three times more likely to be victims of abuse than are their peers who do not give disabilities.

Children with I/DD appear to be more vulnerable to volitional abuse than other populations. The national study published by Westat in 1993, found that children with I/DD were abused at 1.7 times the rate of children in the generic population [8]. By the year 2000, the rate of abuse of children with I/DD doubled to 3.4 times the rate of abuse of children without disabilities [9]. In 2012 the Disability and Abuse Project of Spectrum Institute conducted a national study receiving 7,289 responses. Reviewing only the responses of those with disabilities and/or their family members, over 70% of those responding to the survey (2,560 responses) reported that they had experienced abuse during their lifetime. Of these, 42% were sexual abuse, 51% physical abuse, 87% verbal and emotional abuse. Overall, as in other studies, the perpetrators were well-known to the victims. As to reporting, 46% did not file a report, fearing that nothing would be done. In fact, of those who did report the abuse to the authorities, 54% say that nothing was done. Also, of interest, was that 66% were not referred for post-trauma therapy. Of those who received therapy, 83% said it was helpful yet 34% never were informed of the option.

Additional resources can be found in the weekly newsfeed produced by the Disability and Abuse Project, providing information on incidents by type of abuse, by whom the abuse was committed, and the location of abuse.

Issues

Increase awareness of the problem before abuse occurs

In my experience, parents and caregivers of children and adults

with I/DD fear that their loved one may experience abuse, however, there has been an absence of preparation of parents to recognize and respond to abuse. Parents of minors and adults who have become victims of abuse had no preparation to identify and respond to suspected abuse. Significant changes in the health, personality, of their children signaled that something had happened, but they were at a loss to know the cause.

Of the families with whom I have worked forensically, 100% took their loved one (child or adult) to a physician to address the changes they had witnessed. None of the practitioners mentioned/identified abuse as a possible cause or contributor, but all prescribed medications such as antidepressants, anxiolytics or antipsychotic medications. None recommended psychotherapy. All families subsequently learned that abuse had occurred. They then contacted law enforcement to report the abuse, but in most cases, there was no prosecution as they were told that the victims could not be reliably interviewed and were not considered viable witnesses due to their disability. All parents had sought either counseling and/or legal action against the perpetrator or entity where the abuse occurred (school, place of worship, workplace, transportation provider, etc.). In response to this problem, the Disability and Abuse Project created the “Rule out Abuse Campaign: A Physician’s Educational Guide,” Finding that these parents had received no guidance from agencies serving their children, the Disability and Abuse Project developed a “Ten Tips to Respond to Abuse” guide (see <https://disabilityandabuse.org/10-tips.pdf>) to provide guidance before. It is essential to prepare parents and individuals with disabilities to recognize what abuse is, learn the signs of abuse, and most importantly, what to do when abuse is about to occur or has occurred.

How to reduce the risk of abuse and impact of abuse: Risk reduction workbook

To reduce the risk of abuse happening, and to enhance the well-being of victims, it is essential to prepare for this unwanted but likely life experience. It is generally understood that one does better with knowledge about known dangers when they occur rather than if they are a complete surprise. For example, knowledge of what one must do when an earthquake occurs may save lives or reduce injury, and certainly reduces psychological trauma, as the potential danger is known in advance. The same logic applies to the danger of abuse. Knowing that it can occur and what it is, equips the vulnerable person. Knowledge is power is a motto that fits well in this planning approach. Preparing individuals with I/DD and their parents and caregivers, is a powerful tool to both reduce the risk of experiencing abuse as well as surviving it better. The Risk Reduction Workbook [HYPERLINK “file:///C:/Users/User/Documents/\(https://disabilityandabuse.org\) books/”\(https://disabilityandabuse.org/books/\)](https://disabilityandabuse.org/books/) provides caregivers of people with I/DD an effective tool to use. A companion Workbook for individuals with I/DD is also available and can be found at:<https://norabaladerian.com/books.htm>.

Following a recent training program conducted in another country, one couple used the Risk Reduction Planning format but applied it to respond to their son’s seizure disorder. Three weeks after the training program, their son experienced a severe seizure to which the now well-trained staff responded as planned, including calling 911. The emergency responders told the parents that “but for the quick and informed response by staff,” their son most likely would not have survived. There have been many other positive reports following parental/caregiver implementation of the Individual Response Plan.

Response to abuse

Those who respond to abuse include not only the caregivers, but law enforcement, protection and support agencies and organizations. For the most part they do not receive any or adequate or ongoing training and support when working with suspected crime victims with disabilities. Specialized training in working with any cultural subgroup is important. Included in trainings for these professionals is information about the Americans with Disabilities Act [HYPERLINK "file:///C:/Users/User/Documents/\(https://www.ada.gov/\)"\(https://www.ada.gov/\)](https://www.ada.gov/), and the legal rights of victims with disabilities to receive at least equal level of response from these agencies. Training materials are available online from the U.S. Department of Justice through the NCJRS library of resources. Included are videotapes of actual officers and other response personnel demonstrating the "how to s" with individuals with IDD.

Providing excellence in psychotherapeutic service to abuse victims with Intellectual and developmental disabilities

There are reported difficulties for parents of trauma victims with IDD in locating psychologists and other mental health practitioners who specialize in trauma therapy for this population. This is a professional gap that needs to be filled. There are some efforts across the country to fill the gap, but so far there has not been any largely concentrated effort to serve this unique population. One two-day curriculum has been approved by APA for CEU's at the William James College in Boston, MA. There are plans to disseminate this training program nationally, pending funding.

Part two: Forensic evaluation of damages suffered by abuse victims with intellectual/developmental disabilities

When children or adults with intellectual or developmental disabilities have been abused, like any other crime/abuse victim, they are affected by the maltreatment [10-12]. Changes in the individual become apparent to the parent/caregiver. These changes are apparent to the parents, but the parents I have interviewed have universally felt at a loss to understand why the changes are occurring prior to learning of the abuse.

These changes fall into a variety of categories:

Mood: The onset of withdrawal, including no longer participating or wanting to participate in previously enjoyed activities (watching TV, going to a movie, playing). This also includes a change in communication including no longer speaking or using prior alternative methods of communication.

Daily habits: There is a change in activities of daily living, such as not sleeping at night but only during the daytime, refusing to go to school, work, or other usual daytime activity. No longer performing normal activities at home, such as self-care, dressing, eating, participating in family activities. Some begin to wear many levels of clothing; others wear less clothing. Some do not want to change clothes from one day to the next. Some might want to change clothes multiple times a day.

New fears: Most resist going to location X or with person X. Sometimes it is a resistance to use the school bus or work van, which indicates possible abuse either on the transportation mode or at the place they usually go.

Reversal in maturation: Often there is a regression in the child's / adult's independence, with a need to sleep with the parents at night, need for increased lighting at home, need for more attention, need to be fed, bathed, and clothed.

Change in mood: There may be an increased the level of anger, irritability, refusal to engage in previously enjoyed activities, also increased levels of fears in general and, in particular, regarding specific locations or individuals.

These are the major areas of change reported by the parents. Parents of school-age children typically initially considered that something may have happened at school, but dismiss this, as their confidence in the schools overwhelms these suspicions. Numerous times many parents have said, "We thought that there might be something at school but dismissed this idea as the schools are designed to protect our children as well as educate them. They are a haven for our child." Unfortunately, parents are not universally informed that maltreatment can and does occur in any setting where children and adults with IDD are served. Thus, the abuse may continue for long periods of time before it is discovered. When the abuse is discovered, parents universally have removed their children from the program or service and made a report to the police or other entity. When law enforcement declines to interview or prosecute the case, parents have engaged an attorney to sue for damages.

They have no other recourse. I have worked on many such cases. The request of the attorney is to identify and assess the damage caused by the individual or program. What are the psychological changes the victim has experienced? How long will these changes continue? And what losses has the victim experienced, such as inability to concentrate, learn, trust adults in charge of them at school or work, etc.? If the victim has had changes in their mood, activities of daily living, among others, are these interfering with normal developmental progress, participation in school or work? What therapy can restore the victim to their prior level of well-being? Or, can previous abilities be restored? How long will the damage they have experienced last? Several cases have involved multiple victims, with either multiple perpetrators, or a single perpetrator protected by co-workers. The latter is more typical in school situations, where the teacher may be the abuser but s/he threatens others in the classroom (such as teaching aides or other paraprofessionals) into silence, in that if they reveal the abuse to anyone outside the classroom, they will lose their jobs. These threats have been sufficient for non-abusive staff to maintain their silence (in violation of laws to report maltreatment), and to lie to parents who make inquiries about what could be happening at school that frightens their child or causes their child to resist going to school.

When parents finally learn about the abuse and have made a police report, they often learn that there will be no prosecution due to the inability of the victim to talk about what happened. They then turn to civil litigation attorneys for help, to hold the school, workplace, transportation system (source of abuse) responsible for their actions.

The evaluation of damages in such cases includes a careful and thorough review of all records available on the child/adult including school (Individual Education Plans), medical, social services and psychological/mental health, among others. The review reveals the developmental progress of the child, and/or their usual activities, for the period before any problems arose, during the time of the abuse, and

subsequently, including direct treatment if this was made available to these abuse victims.

In addition to the records review, the evaluator meets with the injured child/adult and their family members, who serve as the source of information of changes noted in their child. When the individual is verbal, this is more easily accomplished, but in most cases, the child/adult is low-verbal or non-verbal. Thus, a comprehensive interview of the parents/caregivers is required, using a “before-during-after” approach to information gathering. It is important also to work with the child/adult directly. When the victim cannot verbally be interviewed, or cannot use assisted communication devices, the option of presenting photographs/images of pleasant memories can elicit obvious changes in the victim’s demeanor and behavior, revealing their feelings of well-being or not. For example, showing the individual a series of photos of family members, these individuals at family gatherings or celebrations such as religious holidays, national holidays, birthday gatherings, weddings, vacations usually elicit positive facial expressions and sometimes verbal expressions from the abuse victim.

This shift in the level of participation and positive response is noted by both the examiner and the family. Then a series of photos or other images of the place where the abuse occurred and/or the perpetrator (s) are shown to the victim. Their response to this set of images is usually met with a distinct change in the victim’s demeanor and behavior, often physically pushing the picture away, looking away, or becoming aggressive and angry. All these responses are documented by the evaluator. The presentation of photos then returns to the positive images shown before, to restore the victim to their prior level of interest, participation, and positive demeanor. This methodology has proven extremely useful in these cases. In one case, a child with autism who had limited but useful vocabulary was shown a series of photographs provided by the parents. He sat with the examiner and his parents verbally identifying the photographs, such as “Mommy,” “Fido” etc. When presented with one photograph, he immediately jumped up from his chair, ran around the table while tapping his buttocks, saying “Poo poo hurt,” repeatedly. The photograph was of his babysitter. The power of this response won the case.

By taking a thoroughly detailed history of the victim’s moods, behavior and developmental level prior to, during, and following the abuse, one can document these changes and pinpoint abuse at their day program as the only possible source of the negative changes in the victim. The interview with the parents supplements the evaluation, where often the parents identify changes that they were aware of but did not think were related to the abuse. One example of this was with one victim who had, for a period of time, isolated herself in her room from the time she came home from school until the next day, including a significant reduction in interacting with her parents and siblings. The parents had not discussed this change but when asked about it, revealed this sudden change in their child that had slowly improved over the many months since the abuse. However, they had not reported this to anyone, as they attributed it to other causes, perhaps a phase of growth, onset of puberty, etc.

When all of the pieces of the evaluation are put together, a profile of significant changes in the victim emerges. Thus, although the victim may not be able to verbally describe or discuss what happened or how it has affected him, a clear picture can be painted by the evaluator, using a “before, during and after” examination of the victim’s well-being and post-trauma status.

Unfortunately, in most cases, standardized tests to assess trauma cannot be used, due to the inability of the victim to communicate. However, using the significant changes in the wide array of normal living that have occurred since participation in and abuse at their day program (or evening at a hospital or other program), the examiner can detail and demonstrate a significant change in the individual from before beginning at the program until the child/adult was removed, due to these changes. Evaluating the changes in arriving at a diagnosis, the definitions in the Diagnostic and Statistical Manual of Mental Disorders-V (DSM-V; [13] provide the criteria that must be met. In all the evaluations I have conducted, the criteria for Posttraumatic Stress Disorder (PTSD) or onset of depression, anxiety, phobias, etc. have been met. A significant change in the victim’s psychological well-being has occurred, along with a list of significant changes in the individual’s activities of daily living, communication, developmental progress, and psychological status has been identified. The rate of rape and sexual assault against people with intellectual disabilities is more than seven times the rate against people without disabilities. Among women with intellectual disabilities, it is about 12 times the rate.

An example is that of one Los Angeles case when working with a prominent attorney, K. W. This involved the abuse of several adults who had been attending a day program, to which they had been referred by their local Regional Center. Initially, it seemed to the parents, that things were going well, but after a while several of the parents noticed significant changes in their adult children, including changes in mood (anger, withdrawal, self-isolation), decline in overall well-being, changes in adaptive skills (needing to be fed, showered, dressed), as well as the onset of night terrors and needing to sleep with the parents, as well as day terrors. These adults suddenly resisted getting on the van to take them to the day program. Their normal moods changed dramatically from their normal easy-going mood, enjoying family time, enjoying watching TV or movies, among others, to becoming withdrawn, sullen, angry and refusing to engage in a variety of activities. Mr. K.W. requested an evaluation of nine individuals, whose parents had contacted him to assist in taking an action against the agency where the abuse had occurred. I found that there was a universal negative reaction to discussion of or showing images of the day program to participants of the worksite, or the van that took them to the worksite. There had been among all nine individuals, significant and negative changes in their moods (anger, irritability).

Among several, in addition to psychological changes, were physical changes. One no longer was able to walk and required a wheelchair. Another developed a painful skin condition that did not respond to the treatment provided by her physician and lasted several months. Most of the individuals insisted in sleeping with the parents and insisted on having the bedroom lights on all night. Overall, each abuse victim displayed significant deterioration in their moods, behavior, physical and mental health. Attorney K.W. was remarkable in agreeing to fill a gap for these abuse victims, which was to make sure they received mental health care while the case was proceeding. He asked me to locate and recommend a practitioner who was bilingual (as most families were primarily Spanish speaking) and could effectively treat abuse victims with significant intellectual and developmental disabilities. I recommended a trauma therapist who began working with the victims before completing litigation. It is unusual for the attorney to support therapy before the conclusion of the case, and I was grateful that their well-being took top priority in the attorney’s

management of the case. Each of the families reported relief that the changes in the mood, communication, activities of daily living and other areas impacted by the abuse in response to the therapy provided to their children restored them to prior levels of well-being. The case against the day program was successful, and the families felt that their suffering and that of their adult children had been acknowledged through the legal system of civil litigation.

One critical remaining issue is that of trauma treatment for abuse victims with I/DD, which is access to effective trauma treatment. Currently, there are relatively few psychologists and other mental health practitioners who provide trauma treatment for individuals with I/DD. Emerging courses of training for this work have begun, but they are few and far between. More information continues to be available from the listserv of the Disability and Abuse Project [14].

Results

Rate per 1,000 people: 024684.42.10.6

Persons with intellectual disabilities, persons with disabilities and persons with no disabilities

Rate per 1,000 people with an intellectual disability, by gender: 024687.31.4

Women with intellectual disabilities and men with intellectual disabilities

Conclusion

The best news is that there is now an increase of awareness of the problems of abuse of individuals with I/DD and several ongoing programs across the nation and other nations to address the problem. Being aware of these programs, some long-term programs, some shorter-term for grant-based efforts, enhances the strength of the overall endeavor to increase awareness, intervention, and risk reduction programs. Also, there are efforts (such as in Ohio) to build Adult Advocacy Centers, to serve adult victims with disabilities in a setting designed for their age group; and in Arizona and New Mexico, there are programs addressing issues of sexuality and the crimes of abuse. In Massachusetts, the Disabled Persons Protection Commission has designed a program to enhance prosecution, provide therapy for victims and conduct training for community members that serve crime victims, among other programs. The ARC of the U.S. has had a program for nearly ten years to increase awareness of the problems of abuse, and supporting programs to help survivors who have I/DD.

To stay up to date on these and related issues, the disability and Abuse Project of Spectrum Institute maintains a list serve of professionals who wish to stay in touch, to share information, request assistance, or let others know of projects addressing related issues. The project also provides a weekly newsfeed on related articles, which are archived on the website.

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