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Editorial

"Leave Out the Violence": Can we Really Afford to?

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When asked to be a guest editor in this issue, I pondered what topic I would cover with the vast array of medical and psychosocial concerns we address from day to day in our practices. However with the shockingly violent acts involving youth that have made headline news of late from the Newton Massacre, to the teen sexual assault in Maryville, Mo, to the multiple teen victims of gun violence on a given night on the Southside of Chicago, it seemed appropriate to look again at ways we may address youth violence in primary care. While "**L**eave **O**ut the **V**iolenc**E**" is a catchy messaging phrase for youth, as PCP's we cannot afford to leave it out during visits with our patients.

In recent months, the number of teens in my practice that are victims of violence either directly or indirectly and the depth of the violence have been alarming. Three cases in particular come immediately to mind. The first is a17 year old girl with a history of depression that had attempted suicide for the third time. She had been sexually assaulted over a period of three years, first by a male relative then by her mother's boyfriend. Soon after, a 15 year old girl presented to my practice for the first time. Her history was notable for depression and PTSD which developed after being the victim of a brutal gang rape. Both of these cases made me pause and reflect back on the description of sexual assault as "spirit murder" at a conference I attended. In the third case where there was a positive history of violence, the violence was experienced indirectly. A 16 year old boy who presented for a routine physical had no concerns and his psychosocial history was benign except for his violence screen. While he had not been a victim or perpetrator of violence, he had lost two close friends to violence over a two month period. One was a victim of a gunshot wound to the back of the head and the other was the victim of blunt trauma to the head during a physical altercation. In discussing these traumatic events with the teen, he revealed he was having trouble dealing with the losses and was open to counseling. In each case, violence has had a detrimental impact on the lives of these teenagers. "Leaving out violence" during office visits represents missed opportunities to possibly prevent its occurrence, begin the healing process for its victims, or end the violence for its perpetrators.

- Although these cases are from an urban practice, we know that youth violence has become an increasing problem across the U.S. Youth violence statistics show that youth violence escalated in the 1990s and has remained high. An average of 13 young people, ages 10 -24, are killed each day in the U.S. and over 80% of those killed are killed with firearms [1].
- In 2011, violence statistics report 707,212 young people age 10 -24 were treated in Emergency Departments for injuries sustained from physical assaults [1].
- In a nationally representative survey of youth grades 9 -11 in 2011, 33% of students reported being in a physical fight in the 12 months preceding the survey, 16% reported carrying a weapon (gun, knife, or club) on one or more days in the month prior to the survey and 12% reported being in a physical fight on school property. In addition, 20.1% of students reported being bullied in the 12 months preceding the survey and 16.2% reported being bullied electronically via email, chat room, website, or test. 1 in 10 students also reported being hit, slapped, or physically hurt on purpose by a dating partner [2].
- In the 2010 Intimate Partner and Sexual Violence Survey, 1 in 5 women reported being raped in their lifetime with 42% experiencing their first rape before age 18. For men, 1 in 71 reported being raped with 28% first being raped when they were 10 years of age or younger [3].

The phenomenon of youth violence has been widely studied. We know that youth violence can affect anyone but some groups are more at risk than others. There are also factors that make individual teens more likely to be involved in teen violence. Research has shown particularly important risk factors for violent behavior include family conflict/ violence, households under economic stress, peer hierarchies/rejection from peer groups, emotional stress, availability of weapons, and extensive exposure to violent videogames/media which leads to desensitization to violence. However, no single profile for a violent youth exists. Some teens have many risk factors but yet do not resort to violence, and some violent teens do not have obvious identifiable risk factors [4-6].

For two decades youth violence has been a focus of policymakers, educators, researchers, practitioners, the juvenile justice system, and community members. Through research, several evidence-based violence prevention and intervention strategies and programs have been identified. Most focus on protective factors and promoting resilience and are offered in

schools, community centers, and juvenile justice programs [7-10].

In 2009, the AAP signaled that youth violence should remain a priority of pediatricians by updating its 1999 Policy statement on the Role of the Pediatrician in the Prevention of Youth Violence. As you may be aware, it calls on pediatricians to take an active role in the prevention of youth violence in 4 areas – education, advocacy, research, and clinical practice and suggests the usage of AAP's program Connected Kids: Safe, Strong, Secure to assist us in doing so [11]. However, studies indicate that while pediatricians believe they should play a role in addressing youth violence, many barriers exist, including lack of knowledge/training, productivity demands and time constraints, and lack of multidisciplinary services/referral sources [12-14]. As pediatricians the time has come for us to adopt innovative ways that make use of computer technology to overcome barriers in addressing youth violence. For example we may:

- Continue to educate ourselves on youth violence and evidence-based strategies to address this issue by participating in Webinars or obtaining CD-ROMs on youth violence offered by our medical societies and other organizations
- Incorporate validated youth violence screening tools into our EMRs such as the Violence Injury Protection and Risk Screen or Interpersonal Violence Perpetration and Injury Scale and perform further assessment and management when indicated [15]
- Use computer technological tools to link teenage victims, perpetrators, or those at risk to youth violence to counseling, treatment resources, advocacy agencies, and evidence-based prevention and intervention programs.
- Use electronic communications to track referrals and maximize linkages by identifying a liaison for teens at each community resource site to assist teens in accessing services.

The efforts to quell youth violence must continue as its human and monetary toll is tremendous. These efforts must be applied to all our youth whether they are from impoverished and marginalized communities, Suburbia, or Rural America. As pediatricians we are uniquely positioned to integrate violence prevention and assessment in to our practices and therefore, when given the opportunity should not "Leave it out ".

REFERENCES

1. Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) 2010 (cited 2012 Oct 19).
2. Centers for Disease Control and Prevention. Youth risk behavior surveillance—United States, 2011. MMWR. Surveillance Summaries. 2012; 61: SS-4.
3. Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. National Center for Injury Prevention and Control. Centers for Disease Control and Prevention. 2011: 1 – 106.
4. Resnick MD, Ireland M, Borowsky I. Youth violence perpetration: what protects? What predicts? Findings from the National Longitudinal Study of Adolescent Health. J Adolesc Health. 2004; 35: 424.e1-10.
5. Department of Health and Human Services (DHHS). Youth violence: A report of the Surgeon General.
6. Rockville, MD 2001.
7. National Science Foundation. Report of Subcommittee on Youth Violence of the Advisory Committee of the Social, Behavioral, and Economic Sciences Directorate. 2013; 1 –45.
8. National Center for Injury Prevention and Control/Division of Violence Prevention. Best Practices of
9. Youth Violence Prevention: A Sourcebook for Community Action. 2002
10. Office of Juvenile Justice and Delinquency Prevention. Blueprint for Violence Prevention. Washington DC. 2004.
11. Office of Juvenile Justice and Delinquency Prevention. Model Programs Guide. Washington DC. 2007.
12. Hahn R, Fuqua-Whitley D, Wethington H, Lowy J, Crosby A, Fullilove M, et al. Effectiveness of universal school-based programs to prevent violent and aggressive behavior: a systematic review. Am J Prev Med. 2007; 33: S114-29.
13. American Academy of Pediatrics. Committee on Injury, Violence, and Poison Prevention. Role of the pediatrician in youth violence prevention. Pediatrics. 2009; 124: 393 – 399.
14. Trowbridge MJ, Sege RD, Olson L, O'Connor K, Flaherty E, Spivak H. Intentional injury management and prevention in pediatric practice: results from 1998 and 2003 American Academy of Pediatrics Periodic Surveys. Pediatrics. 2005; 116: 996-1000.
15. Ginsburg KR.Youth Violence: if we are not active in prevention efforts, who will be? Arch Pediatr Adolesc Med. 1998; 152: 527 – 530.
16. Chaffee TA, Bridges M, Boyer CB. Adolescent violence prevention among California Pediatricians. Arch Peditr Adolesc Med. 2000; 154: 1034–41.
17. Sigel E, Hart J, Hoffenberg A, Dodge M. Development and Psychometric Properties of a Violence Screening Tool for Primary Care. J Adolesc Health. 2011; 48: 358-365.

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