Abstract:
Emergency medicine practitioners often see young patients who are treated for injuries sustained during a violent encounter, most often with a peer from the same neighborhood. In addition, many more of the children and adolescents that we see are affected by the violence that surrounds them in their homes, neighborhood, and schools. This article reviews the prevalence and impact of interpersonal violence on our young patients, offers a suggested management approach to assault-injured children and adolescents who visit the emergency department, and reviews multidisciplinary outpatient programs for which the emergency department practitioners can advocate within their medical and social services systems.

Keywords:
violence; adolescence; assault; trauma; emergency medicine

The Assault-Injured Youth and the Emergency Medical System: What Can We Do?

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Interpersonal violence occurs between 2 or more noncaretaker individuals in which at least one individual intended to harm the other. These altercations frequently occur in the school, schoolyard, or street. Interpersonal violence differs from family violence, such as child abuse and domestic violence, in which an individual has a significant power or caretaking responsibilities over another within the relationship. Although most health care systems have protocols for the management of child abuse and some for domestic violence, there is no mandated reporting system or accepted psychosocial protocol for patients who are injured through interpersonal violence.

The 2 most widely understood facts about youth violence are as follows: (1) violence victimization and perpetration peak during the adolescent and young adult years, and (2) a very small percentage of adolescents perpetrate the most serious forms of violence, and correspondingly, a very small percentage of adolescents require medical attention as a consequence of violent

victimization.[1,2] Less well known is the fact that there is significant overlap among adolescent victims and perpetrators; victims of violence are more likely to have histories and subsequent likelihoods of violence perpetration and vice versa.[3] Being a victim of physical assault increases the risk of subsequent violent offending by up to 350%.[4] Indeed, these individuals tend to have a common set of risk factors and engage in similar lifestyle activities in high-crime areas.[5] The phenomenon of the same individuals appearing repeatedly in the same hospital has led to much frustration among emergency department (ED) physicians[6] and has prompted the American Academy of Pediatrics to issue a model protocol to address the needs of adolescent assault victims.[7] In that same year, the Society of Academic Emergency Medicine issued its own report and recommendations regarding the role that the emergency physician can play in reducing subsequent violence among assaulted victims treated in the ED.[8]

Clearly, serious violent injury provides a tragic and potentially teachable moment in an adolescent's life.[9] Moreover, there is growing evidence and consensus that much can be done in the hospital setting to reduce the rate of injury recurrence and subsequent retaliatory violence.[10]

A NATIONAL PROBLEM

Interpersonal violence remains a major issue in American society. Homicide is the second leading cause of death for all Americans aged 15 to 24 years, accounting for almost 4700 deaths in this age group in 2010, a statistic that is unchanged in more than a decade.[11] Homicide rates do not tell the entire story, however; in 2011, almost 800 000 youth aged 15 to 24 years were cared for in an ED for injuries caused by violence, and 11% of these patients were hospitalized.[12] In urban communities, interpersonal intentional injuries account for 25% of all youth injuries, 45% of hospitalizations, and 85% of injury deaths.[13] However, children from all settings are vulnerable; one study found that 89% of students in a suburban school knew someone who had been robbed, beaten, stabbed, shot, or murdered, and 57% had witnessed such an event. In a comparative urban school, 96% of students knew the victim of a violent crime, and 88% had witnessed an attack.[14] Similarly, in a study of multiple towns and cities in Connecticut, although a higher proportion of poor, urban children witnessed violence, those in non–poor, suburban communities were not immune.[15] Johnson and colleagues[16] report that rural teens were as or more likely than urban and suburban teens to display violent behavior or experience victimization.

Importantly, even homicide rates combined with hospital visits do not paint a complete picture of violence-related morbidity. Recently, more subtle effects of "indirect" exposures to violence have been identified. Adolescents, especially girls, who witness violence are more likely to experience symptoms of posttraumatic stress disorder than are adolescents who do not witness violent events.[17]

ASSESSMENT OF THE ASSAULT-INJURED YOUTH

Given the significant impact of interpersonal violence, we need to consider our assessment of assault-injured youth. Similar to how we assess patients with asthma, diabetes, or other illnesses for their risk of returning in similar or worse condition, we can try to assess how likely the youth is to return with another violent injury or subsequently injure another individual, frequently motivated by retaliation and a norm of retribution.[18] This assessment can be divided into 3 components: a brief screening for immediate safety risk, a screening instrument to identify longer-term psychosocial risk, and a more thorough assessment of problem areas identified by the screening instrument. Based on the results from such assessments, risk and protective factors can be identified and a posthospital release plan established.

A systematic and sensitive approach to questioning adolescents removes blame and judgment, discusses confidentiality and reporting requirements, and engenders the adolescent's trust that the ED team is interested in his or her safety and well-being. The entire ED staff should be well attuned to the complexities that may lead to a single violent injury.[6] As mentioned, it is not useful to apply the terms "victim" and "perpetrator" because, often, the "victim" that presents to the ED may have instigated the fight that he or she subsequently "lost." Receptive and positive attitudes are key: adolescents do not generally view the ED as the appropriate place to be counseled about violence.[19] They are remarkably attuned to nonverbal and verbal cues about the feelings of the adults around them, and it is important to convey to them that the downward path into ever increasing and repeated violence is not inevitable. To write these patients off as hopeless or forever caught up in the mire of violence is akin to a self-fulfilling prophecy.[20,21] Although they, like all of us, are responsible for their actions, multiple factors contribute to violence, some of which are out of their control.