Peer violence and violence prevention

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INTRODUCTION — An overview of peer violence and prevention of violence is reviewed here. Violence in the media, domestic violence, and child abuse are discussed separately. (See appropriate topic reviews).

OVERVIEW — Violence is a major cause of death and disability for American children. Violence or witnessing violence has both physical and psychiatric sequelae, including posttraumatic stress disorder, adjustment reactions, severe grief reactions, and depression.

Pediatric care providers play an important role in prevention of violence. Universal (primary) prevention centers on screening and anticipatory guidance for the promotion of resilience and the avoidance of risk. Secondary prevention involves treatment, counseling, and referral for children and adolescents who have experienced violence-related injury. In addition, pediatric care providers can advocate for school policies and state and federal legislation to reduce the risk of violence for children. The newer view of violence prevention, discussed below, puts violence squarely in the context of improving individual and family resilience, and positively engaging adolescents.

EPIDEMIOLOGY — The United States has the highest youth homicide rate among the 26 wealthiest nations [1]. Homicide is the second leading cause of death among 15- to 19-year-olds and the leading cause of death among black youth [2,3].

Data describing nonfatal violence come from national surveillance systems and emergency departments. Local and national data are available from the Web-based Injury Statistics Query and Reporting System. These statistics underestimate the prevalence of nonfatal violence because many victims do not seek medical treatment or legal recourse, or because the cause of injury is not coded completely or correctly.

- The US Department of Education reported 188,000 fights or physical attacks not involving weapons, 11,000 fights involving weapons, and 4000 incidents of sexual assault in schools during the 1996-to-1997 school year [4]. Nevertheless, schools remain the safest place for children. Vital statistics estimate that less than 1 percent of child and adolescent homicides occur in school (WISQARS™), and the overwhelming proportion of assaults that do occur in school are of relatively minor severity (National Pediatric Trauma Registry, unpublished data courtesy of Director Carl DiScala, PhD).
- One-third of high school students in the Youth Risk Behavior Surveillance Survey reported having been in a fight in the 12 months before the survey in 2011; fights were more common among boys than girls (41 versus 24 percent), and 4 percent of students received medical attention for injuries sustained during a fight [5].
- Assaultive trauma recurs; hospital readmission rates for subsequent assaults and subsequent homicides are as high as 44 and 20 percent, respectively [6-8].

- Most violence in the United States occurs between friends, acquaintances, or intimate partners, and the distinction between victim and perpetrator is not always clear [9-11].

- Nearly 17 percent of high school students in the Youth Risk Behavior Surveillance Survey reported carrying a weapon (gun, knife, or club) on at least one day in the month before the survey in 2011 [5]. Weapon carrying was more commonly reported among boys than girls (26 versus 7 percent), and 5.4 percent of students reported carrying their weapons to school. The percentage of students carrying weapons decreased between 1991 and 1999 and stabilized between 1999 and 2011 (26 percent and 17 percent, respectively).

RESILIENCE FACTORS — Data from the National Longitudinal Survey of Youth (NLSY) and from the Vermont Youth Risk Behavior Survey each demonstrate powerful protective effects of youth engagement [12]. The NLSY analyses demonstrated that parental expectations and connectedness with parents and adults and with school protected against violence. The results showed the power of these protective factors, even in the presence of substantial risk factors. Social assets can be measured on a population level using proprietary surveys developed by the Search Institute [13]. They describe 40 positive attributes that protect young people and their communities. The Vermont Department of Public Health used similar constructs to add to the Youth Risk Behavior Survey. Their work showed there was an inverse correlation between measured assets and health risk behaviors [14].

On a community level, the Chicago neighborhood study showed that among neighborhoods in Chicago with similar economic and demographic characteristics, improved neighborhood cohesion and self-efficacy were associated with large decreases in youth violence [15].

Current programs directed at reducing youth violence are largely based on the positive youth development model, which has strong evidence of success [16]. Programs for positive youth development are defined by the National Academy of Sciences as programs that seek to [17]:

- Promote bonding and social, emotional, cognitive, behavioral, or moral competence

- Foster resilience, self-determination, spirituality, self-efficacy, clear and positive identity, belief in the future, and prosocial norms

- Provide recognition of positive behavior and opportunities for prosocial norms

The American Academy of Pediatrics has implemented the resilience approach for primary care clinicians, Bright Futures, and their violence prevention program, Connected Kids: Safe, Strong, Secure [16,18-20].

RISK FACTORS — Serious violence-related injuries result when people who have learned to use violence to solve problems have access to means of violence. Law enforcement agencies traditionally attempt to assign culpability in cases of violence, determining who was the victim and who was the perpetrator of a particular violent act. However, from a public health perspective, it most often emerges that both victims and perpetrators are caught in a culture of violence. Children and adolescents who fight regularly are at risk of severe injury.

Several key risk factors for violence and violence-related injury have been identified; they are complex, interdependent, and influenced by individual and societal variables [12,21-29]:

- Previous history of fighting or violence-related injury
- Violent discipline
- Access to firearms
- Alcohol and other drug use
- Gang involvement
- Exposure to domestic violence and child abuse
- Media violence

Children begin to develop aggressive behavior and violent habits of thought in the early years. In one prospective

study, 8-year-old children in rural New York were followed for 22 years [30]. Television watching and peer-nominated aggression (being described as aggressive by peers) were independently associated with criminal conviction for violent crimes by the age of 30 years. Another study reported long-term follow-up of children observed beginning in infancy [31]. The investigators concluded that children begin to learn to control their innate aggression beginning at age 17 months, supporting the importance of influences in early childhood on subsequent violence and aggression.

Later in life, experiencing violence (being shot, stabbed, or beaten) among men aged 17 to 29 years was identified as a risk for violent behavior [32]. Those who reported more serious traumatic experiences, such as incarceration, witnessing violence, or carrying a weapon, had the highest risk of violent assault (odds ratio 10, 95% CI, 4-25). Girls too, are more likely to behave violently if they have been victims of violence [33].

Violent discipline — The use of violent discipline methods teaches children that violence is an appropriate means of shaping behavior. In addition, children whose parents are unable to set effective limits may develop dysfunctional behavior patterns of interaction, particularly if corporal punishment is used extensively [34,35]. Dysfunctional interaction may lead to poor performance and social isolation in the early school years and, later, association with peer groups that reward violence and antisocial behavior [36].

Access to firearms and weapon carrying — Approximately 25 million households in the US keep handguns, and one-half of gun owners keep their weapons loaded [37]. Handgun owners typically keep the guns for self-defense. However, deaths caused by suicide, homicide, or unintentional injury outnumber deaths associated with self-defense by 40 to 1 [38]. Teenagers are five times more likely to die from suicide if there is a gun in the home [39,40]. Each year, more than 100 American children younger than 4 years of age die from firearm injuries. The prevention of firearm injuries is discussed in detail separately. (See "Prevention of firearm injuries in children", section on 'Prevention of firearm injuries'.)

The carrying of weapons also increases the risk of violent behavior and violence-related injury by providing a false sense of security that contributes to impulsive behavior. In a probability survey of more than 3000 high school students in Massachusetts, weapon carrying on school property was associated with increased frequency of physical fights on school property [41].

Overall, firearms-related injuries account for thousands of hospitalizations in children younger than 14 and an estimated 3200 cases of long-term disability in children younger than 18 each year [42,43]. It is estimated that approximately one-half of these nonfatal injuries are the result of assaults.

Preventing access to firearms is clearly an adult responsibility, as child-centered programs designed to teach firearms safety to grade-school children do not prevent children from handling real weapons [44,45]. (See "Prevention of firearm injuries in children", section on 'Prevention of firearm injuries'.) Clinicians may be more successful in preventing firearm injuries when counseling focuses on characteristics of the child, rather than on firearms [46].

Alcohol/drug use — Substance abuse, which alters the dynamics and decisions in violent or near-violent episodes, is associated with an increased risk of exposure to violence, carrying weapons, and homicide among adolescents and street gangs [47-49]. Early onset of alcohol or drug use increases the risk of abuse-related violence that continues into adulthood. In one survey of more than 40,000 adults between 18 and 44 years of age, those who began drinking alcohol before age 14 years were 14 times more likely to report having been in an alcohol-related fight within the past year than those who began drinking after age 21 years [50].

Gang participation — The National Youth Gang Survey (1996-2009) estimates that there are approximately 26,000 gangs and 775,000 gang members in the United States [51]. Children and adolescents who participate in gangs are more likely to promote aggressive attitudes, report victimization experiences, be involved in fights, carry weapons to school, and use drugs or alcohol at school [52-54].

Witnessing violence — The witnessing of violence by children increases the risk that they will react violently later in life [55]. More than one-half of the 6-year-old inner-city children in a cross-sectional study of exposure to violence

had witnessed some form of violence [56]. The children who witnessed violence had more behavioral, emotional, attention, and social problems than did those who did not.

Domestic violence — Domestic violence and child abuse are the greatest risk factors for violence for infants and toddlers. Exposure to violence and victimization is associated with subsequent acts of violence by the witness [57,58]. Children who witness domestic violence are harmed cognitively, emotionally, and developmentally [59,60]. (See "Childhood exposure to intimate partner violence", section on 'Effects'.)

Television violence — Children and adolescents in the United States spend an average of 4.5 hours per day watching television and more than seven hours per day when all types of media are included (eg, video games, computers) [61]. (See "Television and media violence".) According to the National Television Violence Study [62]:

- Nearly two-thirds of all programming contains violence
- Children's shows contain the most violence
- Portrayals of violence usually are glamorized
- Perpetrators often go unpunished

Television violence differs from real violence in important ways. Violence on television typically is socially acceptable, being used by heroes and villains alike. Young children, unable to separate fact from fantasy, are more affected by television violence than are adults. Viewing violence can lead to increased aggressive attitudes, values, and behavior, particularly in children [63]. Children who view violence on television are more likely to experience violence and less likely to intervene in tense situations when they are bystanders [64]. (See "Television and media violence".)

Bullying — Bullying is the repeated infliction of harm on younger, smaller, or less powerful peers [65]. Almost 10 percent of students in grades 6 through 12 report having been bullied at school, school activities, or on the way to or from school [65,66]. Both the bully and the victim are affected by bullying. Effects on victims include physical injury, difficulty concentrating, physical symptoms (eg, nausea, anorexia), symptoms of anxiety or depression, poor self-esteem, and high rates of school absence [67-69]. Bullies, however, often feel powerful and effective. In contrast to the situation in childhood, the long-term outcome (at age 30 years) for bullies themselves is especially poor. They are more likely to be incarcerated and are less likely to be employed, married, or in other stable adult relationships than are their peers [70].

Community violence — Studies conducted in poor urban neighborhoods identified a pattern of violence in which fighting and the willingness to fight are key components of a protective strategy for coping with dangerous environments [71]. Young people who are unwilling or unable to defend themselves are prey to multiple and repeated attacks in the "code of the streets". Some parents understand this culture and may actually encourage their children to become able fighters to defend themselves. However, parents can play a crucial role in encouraging safe behavior. They can teach their children how to defuse tense situations [20,46]. Resources to help parents encourage safe behaviors are available through the American Academy of Pediatrics (eg, the “Talking with your teen: Tips for parents” and “Staying cool when things heat up” brochures) [20]. (See 'Resources' below.)

Certain neighborhood factors can mitigate community violence. In an observational study, a higher concentration of resources for young people and adults was associated with lower levels of community aggression [72].

SCREENING — Pediatric care providers should screen for violence and violence risk factors at routine healthcare visits. The screening questions depend upon the child's age and developmental stage and the cultural background of the family. In most cases, children may be asked directly whether they have been involved in or witness to any violence [11]. The assessment of family functioning, family stress, coping mechanisms, and support systems, always a key component of routine healthcare maintenance, also is an important dimension of preventing violence. Environmental factors, chiefly access to guns, should be assessed periodically. Finally, abrupt deterioration in school performance may indicate violence or a related health risk factor including bullying, depression, substance abuse, domestic abuse, or family illness. Emotional and behavioral problems can be assessed using the Pediatric Symptom Checklist or the Child Behavior Checklist. (See "Developmental and behavioral screening tests in primary

care", section on 'Broad-band instruments'.)

In addition, pediatric care providers should screen for domestic violence at all healthcare visits, particularly in the perinatal period. Pregnant and postpartum women should be asked about a history of domestic violence [73]. Many healthcare providers post domestic violence hotline numbers in women's restrooms. (See "Intimate partner violence: Epidemiology and health consequences", section on 'Pregnancy' and "Intimate partner violence: Diagnosis and screening".)

Adolescent screening — Violence clusters with other high-risk behaviors in adolescents. In addition to being questioned regarding drug use and sexual risk, all teenagers should be asked directly about violence. The "FISTS" questions help to identify those who are at risk of violence-related injury (table 1) [74]:

- Fighting
- Injuries
- Sexual violence
- Threats
- Self-defense

Risk stratification — Additional information is used to assess the level of risk for violence-related injury in teenagers because risky behaviors tend to cluster [41,75].

- Low risk – Adolescents who are in school and neither fight nor use drugs are at low risk for violence-related injury. These patients deserve a positive comment about their ability to handle conflict without fighting.
- Moderate risk – Adolescents who attend school with passing grades but who either fight or use drugs are at approximately three times the risk for violence-related injury than are those who neither fight nor use drugs. Many moderate-risk patients can be counseled successfully in the office. Identify specific risk factors (eg, trouble on the school bus) and help the teenager work out a strategy to avoid the situation.
- High risk – Adolescents who are failing or have dropped out of school, or who both fight and use drugs are at approximately seven times the risk for violence-related injury than are low-risk teens. Prompt referral to a social worker or other counselor is indicated.

Parents of all teenagers should be counseled concerning the dangers of storing a firearm, particularly a handgun, in the home.

ANTICIPATORY GUIDANCE — The American Academy of Pediatrics and the American Medical Association recommend violence prevention counseling [76,77]. (See "Guidelines for adolescent preventive services", section on 'Anticipatory guidance for adolescents'.) Children visit their healthcare provider frequently during infancy and early childhood. These visits furnish multiple opportunities for the provider to provide focused interventions toward prevention of violence. The provider can identify and attempt to modulate risk factors for violence. In addition, he or she can attempt to enhance the protective factors (eg, intact family structure, positive peer groups, self-esteem, and confidence). Pediatric healthcare providers can encourage parents to model nonviolent behavior, anger management, and conflict resolution for their children. In addition, children should be encouraged to participate in activities that are socially acceptable and build useful life skills [76].

Some aspects of violence prevention counseling, such as the presence of guns in the home, media violence, or the need to maintain family relationships, apply to all age groups. Other aspects should be adapted to the age and developmental stage of the child. Conversations with older children and adolescents, for example, may be initiated by specific events or by a history that indicates a risk of violence-related injury.

The AAP released its Connected Kids: Safe, Strong, Secure counseling program after several years of research and development. The program includes clinical information, training materials, and information for parents and teens. The counseling topics utilize the positive parenting/positive youth development model described above, and

the Web site includes training and implementation information [20].

Firearms — Although the safest home for children is a home without guns, evidence suggests that there is incremental benefit in safer storage of firearms. Families who nevertheless maintain handguns at home should be counseled that the weapons should be stored locked and unloaded, and the ammunition stored in a separate locked location. Some pediatric healthcare providers in regions with a high prevalence of handgun ownership distribute gun locks (see www.projectchildsafe.org for information concerning one such program). (See "Prevention of firearm injuries in children", section on 'Prevention of firearm injuries'.)

Media — The AAP Committee on Public Education recommends that pediatric healthcare providers encourage parents to [78]:

- Limit children's total media time to less than one to two hours per day
- Remove television sets from children's bedrooms
- Discourage television viewing for children younger than 2 years
- Monitor the shows that are viewed by children and adolescents
- View programs and discuss the content with their children
- Use controversial programming to initiate discussions about family values, violence, sexuality, and drugs
- Encourage alternative entertainment for children (eg, reading, athletics, hobbies, and creative play)

Domestic violence — Pediatric offices should provide information and support to women experiencing domestic violence. Social work contacts and referral phone numbers should be available to providers and other office staff. Healthcare providers should be aware of the strong associations between domestic violence and child abuse [79].

Age-specific anticipatory guidance

Birth to four years — The pediatric healthcare visits from birth to age 4 years typically center on the establishment of good parenting practices, environmental safety, and behavior concerns. These topics are related directly to violence prevention. Careful screening and support in the primary care setting is associated with measurable decreases in child maltreatment [80].

Violence-free discipline — Family discipline patterns usually are established as children enter the second year of life. The American Academy of Pediatrics recommends that parents be encouraged and assisted in developing methods other than spanking to shape the behavior of their children [81].

Some of these techniques include [76,81]:

- Maintaining a schedule of meal, nap, play, bath, and bed times to foster the child's feeling of mastery of his or her environment
- Satisfying the toddler's need for parental attention by providing positive reinforcement and praise for good behavior
- Using time-out from positive reinforcement, natural, or logical consequences when the child's misbehavior requires negative consequences
- Establishing family rules to address potential areas of conflict

The short-term effectiveness of anticipatory guidance by trained providers and written materials on the use of time-outs was demonstrated in a controlled clinical trial of 559 parents [82]. An increase occurred in the report of the use of time-out in the intervention group two to three weeks after the intervention (35 versus 2 percent of parents). Video-based parenting education for violence prevention also is available and appears effective in short-term trials [83,84]. Finally, a large national trial demonstrated the effectiveness of the use of brief motivational interviewing (an assessment of family interest and confidence in changing behavior to generate patient-centered solutions) and of giving families a kitchen timer (to monitor media-time and time-outs) [85].

School-age — Families of school-aged children (5 to 12 years) should continue to be counseled regarding guns, television, and exposure to violence. In addition, the pediatric healthcare provider should ask about bullying and fighting in school.

The parents of children who are victims of bullies should be encouraged to discuss the problem with the school principal or guidance counselor. They have a right to expect a physically and emotionally safe school environment for their children. School officials can intervene to control bullying. (See 'Schools' below.)

Bullies often come from disordered families, and their parents may be unwilling or unable to establish clear rules at home. Effective intervention programs include a strong parent education program for the parents of bullies, helping them learn to provide a structured home environment for their children [70]. Given the poor long-term outcomes for bullies, this intervention may be the most important component of a bullying prevention program.

Adolescents — Teenagers and their parents should be educated about violence; in particular, they should know that:

- Engagement in prosocial groups provides powerful protection for adolescents [12].
- Clinicians should inquire regarding participation in after-school programs, athletics, or church-based youth activities. Adolescents and their parents should be counseled regarding the importance of engagement during the summer with employment, camp, or volunteer activities.
- Skills-based intervention conducted in school interventions have been shown to be effective in reducing violence [86].
- Most violent injuries occur in fights between friends or acquaintances [10]. Teens should learn how to walk away from a fight. Parents should know their children's friends.
- The carrying of guns and other weapons encourages impulsive behavior and increases the risk of injury.

Adolescents who are identified to be at increased risk for violence-related injury should be counseled according to their personal situation and risk category. (See 'Risk stratification' above.)

Those who are at low risk should receive reinforcement for their ability to avoid physical confrontation. Counseling may focus on their progress toward independence, with a focus on positive peer and social group relationships. They should be warned of the dangers of carrying a weapon, encouraged to avoid dangerous places and situations, and cautioned to use nonviolent conflict resolution strategies (table 2).

Those who are at moderate risk should be told that the risk of injury is real and should receive education about techniques to defuse tense situations (table 2). These adolescents, who may not yet be able to think abstractly, may need to generate or be given lists of appropriate ways to react in tense situations. Making the list in anticipation of the situation provides the concrete-thinking adolescent with alternative behaviors before the situation arises. Moderate-risk teens should be counseled to evaluate their own risk-taking behavior. Their existent nonviolent problem-solving skills should be reinforced, and the clinician may provide support for their abilities to solve conflict without violence.

Adolescents who are at high risk for violence-related injury should be screened for mental health problems (eg, depression, posttraumatic stress disorder, drug use) and referred appropriately. Those who do not have mental health problems should be referred to a social worker, counselor, or street outreach worker. They may benefit from community agencies that offer adult mentoring or activities.

Adolescent health providers should stress the importance of follow-up to the high-risk teen and to his or her parents. Involvement of the parents and/or the extended family of the teenager is important. Parents should be taught to ask how fights started or could have been avoided, but not who won. If necessary, follow-up visits can be scheduled for another medical matter (eg, acne) to monitor the patient's progress.

Violence prevention counseling for adolescents is based upon a behavior change model that includes precontemplation, contemplation, and resolution.

- Precontemplation – Teenagers in this stage do not recognize that the behavior is a problem. They should be informed of their own personal risk and that other young people from their communities have managed to avoid fighting without losing face, as in, "I am concerned about you. You haven't yet learned how to avoid fighting, and some of my patients who fight a lot get seriously hurt". Clinicians embarking on this approach should understand the role that fighting plays in the lives of teens, and the real and perceived dangers inherent in being labeled as a "sucker" [71].
- Contemplation – Teenagers in this stage recognize that violence is a problem, but they have not yet begun to change their behavior. They should receive information about nonviolent conflict resolution (table 2).
- Resolution – Teenagers in this stage have adopted new behavior patterns to avoid violence. Those who are trying to use nonviolent techniques of problem solving should be encouraged for their efforts.

Counseling may involve reviewing specific skills that can be used to defuse situations of potential conflict.

SECONDARY PREVENTION — Secondary prevention involves treatment, counseling, and referral for children and adolescents who have experienced violence-related injury. Children and adolescents who have been injured in a fight are at high risk for further violence, and crisis intervention is needed. They should be asked:

- Is the fight over?
- Do you feel safe leaving here?
- Is there someone who can mediate if the fight is ongoing?

Referral to a mental health provider may be necessary if the situation is volatile and cannot be resolved. When a specific individual is threatened, healthcare providers may have a "duty to warn". Also, the police should be notified. The child or adolescent and the parents should be informed of the risk of serious injury and techniques for successful injury prevention (eg, methods to de-escalate conflicts) (table 2).

The following steps are recommended for providers who care for children and adolescents who have experienced a serious violence-related injury:

- Ask the child to tell you about the problem; listen without interruption and avoid judgment. This approach permits the child to express feelings of vengefulness and allows the provider to understand the child's perspective before offering advice.
- Assess the other risks (eg, weapon carrying, alcohol or drug use, gang involvement) and discuss the risk factors for violence with the child or adolescent.
- Develop a plan for safety after leaving the hospital or clinic (eg, staying with a friend or relative who lives out of the neighborhood and involving the police if necessary).
- Discuss strategies for conflict avoidance at the time of injury and at subsequent visits. These strategies must respect the patient's need for peer approval. One strategy of conflict avoidance is for the patient to tell the person who insists on fighting that he/she will fight them later (eg, at 3 p.m.) but will not fight now. The forced time interval may reduce the fury and make it easier to talk about the conflict.
- Screen the child for emotional/behavioral symptoms (eg, using the Pediatric Symptom Checklist or the Child Behavior Checklist) [87]. (See 'Screening' above.)
- Refer the child for support services (eg, psychology, social work, church members, recreation departments, mentoring programs) [88,89]. Children and adolescents who are depressed should be referred to a mental health professional; those who were innocent victims may need posttraumatic stress counseling [90].

ADVOCACY — Youth violence is a serious health risk and complex social problem that requires broad-based public action for prevention. Pediatric healthcare providers, through the AAP and other organizations (eg, Children's Defense Fund), can advocate for social policies that benefit children.

Individuals — Pediatric care providers advocate for their patients to receive the care and services that they need (eg, mental health service, family support). Individual adolescent patients may be encouraged to discover activities and social groups that promote the mastery of new skills and that lead to membership in prosocial groups. Adolescents who have experienced loss may benefit from grief counseling or specific evidence-based treatment for posttraumatic stress. Parents of teenaged patients should be advised to restrict access to firearms.

Schools — School-based violence prevention programs are an effective means of reducing violent and aggressive behavior [91]. Pediatric consultants can help school systems reduce the incidence of violence. Middle and high school conflict resolution curricula have reduced the incidence of school fights and of suspensions or expulsions for fighting or weapon carrying. The Centers for Disease Control's sourcebook provides detailed information concerning numerous innovative curricula developed and evaluated during the 1990s [92]. Peer mediator programs also reduce serious violence at and near schools and provide a model for nonviolent conflict resolution.

Pediatric healthcare providers who serve as school consultants can advise school boards and principals regarding the importance of age-appropriate violence prevention programs and peer mediation programs [93].

- Primary schools can teach/model nonviolent problem-solving skills, focus on adequate playground supervision, and implement antibullying programs.
- Middle schools can incorporate antiviolence and conflict resolution curricula into health education programs.
- High school programs can use the school health clinic to provide services to students who have problems of violence, drug abuse, or pregnancy.

Antibullying programs — Antibullying programs are effective in reducing bullying [70,92,94]. Successful programs work, in part, by mobilizing the large number of bystanders to make bullying less acceptable. Bullying at school is addressed through increased adult supervision before school, during lunch and recess, and after school; and through the development of classroom discussions to reduce the social acceptability of bullying among the majority of children, depriving the bully of an appreciative audience.

Media — Pediatric healthcare providers can address violence in the media by endorsing community TV "tune-out weeks", encouraging schools to develop curricula for critical viewing skills, and working with local, state, and federal regulators and television producers to reduce the exposure of children to televised violence [95].

Youth development — A variety of programs that provide resources for adolescents, including after-school programs, summer jobs programs, and programs that find ways for young persons to participate in the community, are associated with improved outcomes, including decreased risk of violence [72,96].

Firearms — Pediatric healthcare providers can advocate for the prevention of firearm injury by supporting state and federal initiatives to mandate the provision of trigger locks and prevent the marketing of certain kinds of weapons. (See "Prevention of firearm injuries in children", section on 'Prevention of firearm injuries'.)

RESOURCES

- The American Academy of Pediatrics counseling program, Connected Kids: Safe, Strong, Secure
- The Johns Hopkins Bloomberg School of Public Health Center for the Prevention of Youth Violence provides a list of resources for youth violence prevention
- The Maternal and Child Health Library provides resources and tools for adolescent violence prevention
- The Substance Abuse and Mental Health Services Administration provides resources for school violence

prevention

SUMMARY

- Violence is a major cause of death and disability for American children. Pediatric care providers play an important role in prevention of violence through screening and providing anticipatory guidance for promotion of resilience and avoidance of risk. (See 'Overview' above and 'Epidemiology' above.)
- Factors that protect against youth violence include youth engagement (eg, parental expectations, connectedness with parents, adults, and school), neighborhood cohesion and self-efficacy, and programs that promote positive youth development (eg, bonding, social, emotional, cognitive, behavioral, and moral competence, self-determination, spirituality, self-efficacy, belief in the future). (See 'Resilience factors' above.)
- Risk factors for violence include a history of fighting or violence-related injury, violent discipline, access to firearms, alcohol and other drug use, gang involvement, and exposure to violence in the home, media, school, or community. (See 'Risk factors' above.)
- Pediatric care providers should screen for violence and violence risk factors at routine healthcare visits. The screening questions depend upon the child's age and developmental stage and the cultural background of the family. (See 'Screening' above.)
- Teenagers should be asked directly about violence (table 1). Their risk for violence-related injury is stratified according to other factors, including school attendance, performance, violence history, and drug use. (See 'Adolescent screening' above and 'Risk stratification' above.)
- The American Academy of Pediatrics (AAP) and the American Medical Association recommend violence prevention counseling. Healthcare visits during infancy, childhood, and adolescence provide opportunities to identify and attempt to modulate violence risk and resilience factors. The AAP Connected Kids: Safe, Strong, Secure provides clinical information, training materials, and information for parents and teens. (See 'Anticipatory guidance' above and 'Resources' above.)
- Secondary prevention involves treatment, counseling, and referral for children and adolescents who have experienced violence-related injury. (See 'Secondary prevention' above.)

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Topic 593 Version 10.0

GRAPHICS

FISTS violence screening questions for adolescents

Fights: How many fights have you been in in the past year? When was your last fight?
Teens who have been in more than one physical fight in the preceding 12 months are at increased risk of violence-related injury.
Injuries: Have you ever been injured in a fight? Have you ever injured anyone else?
Multiple or serious previous injuries may indicate an increased risk of future injury. Patients who have been injured may be more likely to carry weapons.
Sexual violence: What happens when you and your boyfriend/girlfriend fight? Have you ever had sex against your will?
Teen-dating violence is associated with future domestic violence.
Threats: Have you ever been threatened?
Teenagers who have been threatened with a weapon are at future risk of weapons-related injury.
Self-defense: Have you ever carried a weapon to protect yourself?
Teenagers who arm themselves in self-defense are at increased risk for violence-related injury.

Adapted from Alpert E, Sege R, Bradshaw Y. Academic Medicine 1997; 72 (suppl):S41.

Six steps to conflict resolution for adolescents

1. Keep your temper; stay calm.
Anger increases the heart rate and initiates a "fight-or-flight" response.
2. Understand what triggers fighting.
3. Understand that sometimes people use fighting to make themselves feel better.
Remember that the other person is upset and wants to use fighting to solve the problem.
The provocation is a response to their need, not to an irrevocable circumstance.
Don't get manipulated into fighting because they want you to fight to solve their problem.
4. Understand that the other person is a decent human being.
5. Talk to the decent side of the other person instead of matching insults.
"This isn't worth fighting about."
"I have nothing against you. I don't want to fight you about this."
"If I have done something wrong, you can talk with me and I will apologize and try to fix it.
"If I haven't done anything wrong, I'll tell you that, but I don't want to settle this by fighting."
6. If these steps do not work, walk away from the situation. Try to use humor as you leave.

Adapted from Stringham P. Pediatr Clin North Am 1998; 45:439.