Preventing Adolescent Violence

A Guide for Medical Students

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American Medical Student Association
Task Force on Health Through Peace

Preventing Adolescent Violence: A Guide for Medical Students

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AMSA Policies Concerning Violence

As a national organization, AMSA has clearly defined principles regarding violence. The following excerpts from AMSA's *Preamble, Purposes and Principles (PPP)* are examples of AMSA's stance with regard to violence:

AMSA—
"[Urges] that all medical schools provide in the core curriculum information regarding violence as a public health issue."

"Supports a medical school curriculum that stresses the physician's unique position and responsibility for recognition and initial intervention in cases of child and spouse abuse."

"Stresses the importance of education in the prevalence, incidence and inter-relatedness of these problems, in presenting signs and symptoms, and in counseling skills for use in conjunction with available social services."

In regard to hate crimes, AMSA—
"Supports violence prevention by education, research and funding of community services on a national, state and local level."

"Urges vigorous enforcement and prosecution efforts against individuals and groups perpetrating such crimes."

"Urges the education of all Americans about the known facts about violence and encourages further studies on violence as a public health emergency."

Adolescent Violence: The Problem

The Centers for Disease Control and Prevention defines violence as "the threatened or actual use of physical force or power against another person, against oneself, or against a group or community, which either results in, or has a high likelihood of resulting in, injury, death or deprivation."

The statistics concerning youth violence in America are startling. The number of adolescents dying as a result of homicide doubled in the five years between 1985 and 1990.[1] Death involving a firearm is presently three times more common for an African-American male age 15 to 19 than death resulting from a motor vehicle accident. For all youth aged 10 to 19, violence involving a gun is the second leading cause of death.[2] Not only are more adolescents dying as a result of violence but more are becoming perpetrators. The number of 15-year-old males charged with murder increased by 217 percent between 1985 and 1990.[3] Younger children are now committing violence that previously was committed by older adolescents; initiation of violence is occurring at younger and younger ages. In most cases of youth violence, the victim and perpetrator are not very different and the line between the two is hard to draw.

These statistics do not begin to take into account the nonlethal violence that occurs with serious consequences, such as lifelong morbidity and post-traumatic stress disorder. As future physicians, we must be aware of these threats to the health of our patients and must work to prevent further violence.

Although rape, sexual abuse, elder abuse, hate crimes, terrorism, war and human rights abuses are all forms of violence, their discussion is beyond the scope of this guide due to space limitations. However, it is important to keep in mind that the etiologies and consequences of these forms of violence most likely overlap with those of adolescent violence. Similarly, some of the actions that we can take to counter the different types of violence are the same, such as routinely asking patients about exposure to violence and working to promote human rights.

Factors Contributing to Violence

Over the last few years, there has been an increasing emphasis on research into violence and how to prevent it. This research has been conducted by public health professionals, psychiatrists, other physicians, anthropologists, economists, basic scientists and others. Ethnographers have looked closely at individuals and neighborhoods prone to violence. Many interesting findings have been made and plausible hypotheses proposed; yet the exact etiology remains to be understood. While there is a general consensus that there are many factors that contribute to violence (as will be discussed below), questions remain: Why don't all children who grow up in impoverished neighborhoods commit violence? Why aren't all people who use drugs and alcohol violent? Why don't all children who witness domestic violence continue the cycle? and Why do individuals without the risk factors commit violence? Violence is also difficult to study for methodological reasons, such as the difficulty of proving causality in the face of multitude of confounding factors.

While we're waiting to discover the answers to these questions[3], violence can, with fair certainty, be viewed as a result of the combined influence of various factors. This does not mean that everyone with these factors will behave violently, but it does mean that they will be at an increased risk for violence; just as not everyone with risk factors for heart disease will have an MI, but they will be at higher risk. Additionally, it does not mean that individuals or groups at high risk are responsible (or culpable) for their risk status (just as someone who is male, has a family history of heart disease, or has familial hypercholesterolemia is not at fault for having those risk factors). It does mean, however, that as physicians we need to recognize the risk factors and empower the patient or change societal attitudes in order to counter the risks, without blaming the individual.

Developmental

Early childhood is the time period when there are rapid changes in the central nervous system and when basic beliefs and habits of children are formed.[4] There is increasing evidence that early childhood development affects a person's tendency for violent behavior.[5] Three broad categories of developmental risk factors include child health and neurological status, early academic skills and success, and family functioning and parenting style. It is likely that violent behavior is dependent on interaction of these factors themselves and societal factors that promote violence.[6]

One study has shown that birth complications in combi-

nation with early childhood rejection predispose to violent crime, while birth complications combined with a nonrejecting early home environment do not.[7] This shows the importance of considering both biological and social factors together as causes of violence, and of considering prenatal, perinatal, and early postnatal health-care interventions when developing programs to reduce violence. Alternatively, if a good psychosocial home environment can protect against the negative effects of birth complications, then psychosocial interventions aimed at improving parents' caregiving skills may help decrease the biological predisposition to future violence.

A review of early risk factors for chronic juvenile delinquency and early intervention programs suggests that comprehensive family support with early education may show protective effects on multiple risks, and, therefore, possibly decrease future delinquency.[8] Since these multifaceted interventions may also prevent substance abuse and teen pregnancy and are a form of primary prevention, there may be less stigmatization of program participants than interventions targeted towards "juvenile delinquents."

The Infant Health and Development Program was a multi-site clinical trial, which provided support for low-birth-weight infants, beginning with discharge from the neonatal nursery until 36 months of age, including home visits, child development centers and parent groups. It showed significantly higher mean IQ scores at 36 months for the group receiving the program.[9] At follow-up at five years of age, it demonstrated positive effects on heavier low-birth-weight infants' IQ and verbal performance but no difference in IQ and verbal performance for the lighter low-birth-weight infants.[10] Despite this evidence of some residual effects two years after the end of the intervention program in some children, it is possible that interventions to improve school performance of biologically vulnerable (premature, low-birth-weight) children need to extend beyond 36 months of age and to include special services after school entry in order to gain maximum effectiveness. More research is needed in this area.

An interesting phenomenon concerning adolescent antisocial behavior is that while a small group of the population participates in antisocial behavior starting early and continuing throughout all stages of life, there is a larger group that is antisocial only during adolescence.[11] The second group, for some reason, outgrows the antisocial behavior. For this group, lack of antisocial behavior may actually be the abnormality. This has important implications for prevention strategies, since prevention efforts may need to target the two groups differently.

Developmentally, adolescents are at a high risk for violence. Adolescents normally are narcissistic as they struggle to form an identity separate from that of their family, and this narcissism makes them especially vulnerable to extreme reactions over insults. They also are at a period of forming their sexual identity, which often includes extremes of sex role stereotypes and may set the stage for the use of violence. In addition, the presence of peer pressure to fight and the danger associated with being seen as weak if one does not fight is an extremely strong influence on violent activity during this time. Adolescents who experience chronic anger due to poverty and racism are at even greater risk for violence.[12]

Children Who Witness Violence

It is not uncommon for children to witness violence, both on the streets and in the home. Frequently no thought is given to these children, yet recent literature shows that the effects are serious.

Children exposed to multiple forms of family violence, such as partner violence, generalized hostility or child maltreatment commit more than twice the amount of youth violence as children from nonviolent families.[13]

Although awareness of and intervention in domestic violence has increased in recent years, the children who witness violence between adults in their families still remain the forgotten victims. Yet many recent studies have demonstrated that children who witness domestic violence, even if never directly abused, experience shame, guilt, fear, anxiety, decreased trust, hypervigilance, difficulty managing tension, frustration and transition, and are more likely to commit youth violence. They often suffer poor school performance, low self-esteem, depression, stress disorders, poor impulse control and feelings of powerlessness. Even infants and toddlers exhibit effects such as insomnia, nightmares, psychosomatization, and regression to earlier stages of functioning. Children who witness violence in the home learn that violence is an acceptable means of conflict resolution, an appropriate means of stress management, and that it has an important place in the family.[14]

Approximately 60 percent of mothers of abused children are also being battered themselves (as opposed to 16 percent of mothers of non-abused children).[15] Most commonly, child abuse is perpetrated by the child's father or mother's boyfriend. Punitive treatment of women (reporting them to child protective services) serves only to assign responsibility for abuse to mothers regardless of who assaults the child and often causes withholding of vital resources or removal of the child to foster care. When mothers are treated as the cause of child abuse, the entrapment and inequality from which battering and child abuse originate are increased. Furthermore, the mother is placed in a situation where she cannot protect her children unless she is protected from her batterer, but if she asks for protection for herself, her children may be taken away.[16]

Child Abuse

Child abuse is very common, with between 2 to 10 percent of children being physically abused and 27 percent of girls and 16 percent of boys being sexually abused.[17] Sexual abuse is just as likely to occur in middle- and upper-class households while physical abuse is more common in lower-class homes.

Most families involved in child fatalities were couples in which the father of the child or the boyfriend of the mother was the perpetrator.[18]

Child abuse is a risk factor for future violent activity. A

history of abuse and family violence has been shown to be the most significant variable in a group of symptoms which was able to predict delinquent subjects from non-delinquents 84 percent of the time.[19] The long-term consequences of childhood physical abuse shows that adolescents who exhibit aggressive and violent behaviors, including extrafamilial and dating violence, show higher rates of prior physical abuse than do the general population. Homicidal, depressed outpatients reported higher rates of physical abuse than did a non-homicidal, depressed sample. College students with a history of abuse both received and inflicted higher rates of dating violence than non-abused students.[20]

It has been found that childhood victimization is a significant predictor for the extent of symptoms and diagnosis of antisocial personality disorder.[21] This suggests the importance of asking about a patient's childhood history of abuse and neglect, especially when symptoms of antisocial personality disorder are present.

Another study has shown that being abused or neglected as a child increases one's risk for delinquency, adult criminal behavior and violent criminal behavior; however, the majority of abused and neglected children do not become delinquent, criminal or violent.[22] This shows that the intergenerational transmission of violence is not inevitable, but that intervention and prevention programs are even more important for this high risk group. More research is needed to understand the potential protective factors that may allow for resilience, the ability of a child to not succumb to the social problems which placed him or her at higher risk.

Child abuse can also be viewed within a societal context in which concern needs to be given to high-risk neighborhoods as well as families.[23] Poverty is one factor significantly associated with an elevated risk of child abuse. Since poverty is increasing, especially in geographically segregated areas, there is a risk that child abuse will increase as well. When times are hard in a neighborhood, everyone is affected and the social support systems tend to break down as well. Another risk factor is a neighborhood that is socially impoverished, i.e. , is less socially integrated, has less positive neighboring, and represents more stressful day-to-day interactions for families. In this way, child abuse is not just an individual or family problem, but a neighborhood and community problem as well. Therefore, when attempting to reduce child abuse in an impoverished and socially disorganized neighborhood, it is important to address the negative social momentum through social mobilization and investment in resources.

Racism

Violence disproportionately effects people of color. Homicide is the leading cause of death for African-American men between 15 and 34 years of age and women between the ages of 25 and 34. There are three levels of racism (this applies to all -isms): institutionalized, personally-mediated, and internalized. Institutionalized racism is that which is perpetuated by society and frequently comes from a historical basis, e.g., a business that is less likely to hire a person of color or a lower quality school system in a location populated primarily by minorities. Personally-mediated racism is that in which one individual discriminates against others on a personal level. Internalized racism occurs when an individual turns society's view of himself or herself inward.

The rate of unemployment for African-American males in the United States is twice that for white males. Even African-American men with college educations and job experience do not receive the same income as white men. In 1991, African-American men who were recent college graduates with one to five years work experience earned an average of $11.26 per hour while white men with similar education and experience earned an average of $12.85 per hour, with African-American women and white women in the middle pay range making an average of $11.41 and $11.38 per hour, respectively.[24]

The historic racism in the United States is an important contributor to an environment that permits violence. One of the forms of historic racism is the concentration of a large African-American underclass in the central cities, resulting from discrimination during the early 1920's.[25] Another is that even if income for African-Americans and Caucasians were more equitable, the overall wealth of African-Americans is much less than that of whites. Wealth refers to savings and capital in addition to income. The disparities are a result of historical inequities, such that whites are able to pass their wealth down through the generations while African-Americans were not able to own property or have high enough wages to save money to transfer to the future generations.

A disproportionate number of minorities have interactions with the criminal justice system. Despite studies showing no substantial difference in the rates of delinquency between races, there are many more minority youths incarcerated and the difference in incarceration is increasing rapidly, with the greatest increase among Hispanics.[26] Research suggests that minority youth are more likely to be arrested for serious crimes than are comparably delinquent Caucasian youth.[27] This is an example of institutionalized racism. It may actually increase violence as minority youth realize that the legal system is unjust, perpetuating a culture in which the mainstream is not highly-esteemed, and resulting in anger, frustration and hopelessness which may lead to acting out in violence.

The high incidence of joblessness of African-American males may be closely associated with violence. One study has shown that the rates for violence during adolescence are approximately the same for African-American and white males. But as the group is followed over time, white men are able to find employment and decrease their violence while black men between 25 and 30 years of age become four times as likely to be involved in violence than white men of the same age. Employed African-American males and employed white males have similar rates of violent behavior, pointing to a difference in employment as the motivating factor for violence. If a young man is employed, he stops his violent behavior; if not, he continues it.[28]

Most individuals who commit violent acts feel justified

in doing so for one reason or another.[29] The social inequalities and stigmatization that minorities are subjected to may therefore lead to increased violence. The stigmatized individual has been harmed by society and thus feels justified in acting violently.

Most violence committed by African-Americans victimizes other African-Americans. This may be an example of internalized racism and is supported by the increasing trend in successful suicides among African-Americans over the past few years. Suicide and homicide are not opposites but are closely linked; if an individual does not value his or her own life, he or she tends to not value (and may feel justified in taking) the lives of others.

Another factor in the expansion of a black urban underclass is the change that took place in the late 1960s regarding "vertical integration".[30] Vertical integration is the phenomenon that occurred when African-Americans of all economic classes lived together as a result of limited housing choices for the richer residents due to segregation and discrimination. When the civil rights movement allowed the middle- and upper-class African-Americans to leave the inner city, those remaining were left with few positive role models.

Violence is also affected by race in that there is a lack of hope and faith on the part of impoverished African-Americans in their ability to improve their lives since the quieting of the civil rights movement. When children grow up in an environment in which violence and inequality appear inescapable, children feel abandoned to danger and express their rage in the only way they know—with violence.[31]

Although African-American married couples with families are only one-fourth as likely to live in poverty as families with a single mother, there are many more African-American families headed by single females than white families headed by single females. The most likely reason for this is that 43 percent of African-American men are jobless. [37] While the rates for violence may be the same per single female-headed households regardless of color, more African-Americans live in these families .

Economic

Poverty is closely linked to violence. Growing up in poverty robs children of opportunities, leaves them malnourished and teaches them that success through education and a mainstream job is not possible. Poverty creates hopelessness, which in turn makes children and adolescents more likely to use violence, against both themselves and others.

Economic opportunity, even that which comes from low wage jobs that do not offer opportunities for upward mobility, such as fast food work, is developmentally important for adolescents. These legitimate jobs provide a sense of independence, personal responsibility and dignity, while helping adolescents to establish positive work habits and make significant contributions to their households. These aspects of adolescent development are especially important in the inner city communities where there are few legitimate alternatives to the downward spiral of illegal activities.[33]

The advice given by those of the middle and upper classes to the impoverished is often, "get a job." But getting a job is not always that easy. A recent study of the minimum wage labor market in Harlem showed that there are many more people applying for jobs such as those in the fast food industry than there are available jobs. In fact, there were an average of 14 job applicants for every fast food position available. As a result, successful applicants now tend to be older (in their 20s rather than their teens) and are more likely to have a high school diploma. Job applicants were less likely to be hired if they were young, African-American, lived in an inner city neighborhood (as opposed to commuting to the area from a different neighborhood), if they did not have "connections" (friends or family who already had jobs), if they were native born African-American as opposed to a recent legal immigrant, and if they had little or no prior job experience. The majority of individuals looking for jobs had already applied to between four and eight other jobs before applying for the fast food job and were willing to accept wages lower than the minimum wage. In conclusion, it is not so easy to find even a minimum wage job in the inner city.[34]

In many ways economic factors that influence violence are linked closely with racism. There is a strong and important correlation between unemployment and crime.[35] The relatively recent transition from manufacturing to retail operations has caused black unemployment to skyrocket compared to white unemployment. The closing of manufacturing plants hit minorities the hardest because the plants had employed primarily minorities, while the retail industry that replaced manufacturing is far more likely to discriminate against minority youth. The loss of manufacturing jobs also cut off an entry into the job market where an unskilled worker could make a respectable wage and work his or her way up in the company. Between 1973 and 1986 there was a decrease of 40 percent in the income of young black males without high school diplomas.[36] Currently, jobs with the potential for advancement are obtainable only with education or experience, which minorities often do not have the opportunity to obtain. This is important in that it creates a permanence of the situation of African-Americans occupying the lowest class. The result is increasing marginalization and further exclusion from the privilege of opportunities available in the mainstream, and therefore, the emergence of an underclass.

Social Capital

Social capital refers to the components, such as trust, obligations and expectations, networks (or information channels), and social norms which contribute to social organization, allowing coordination and cooperation for benefit of oneself and others.[37] Just as physical and human capital are necessary prior to building a manufacturing plant, social capital is important in the building of a community that has the resources to support and guide its children. Social capital is not a physical substance but is based on the relationships between people. It is easier for communities with more social capital to work together. Social capital acts as a form of collateral for individuals who would otherwise be excluded from job

markets or credit sources. It is also closely linked to economics in that social capital is an important contributor to economic development.

Social capital in communities provides trust; for example, trust that neighbors will keep an eye on each other's children and that debts will be repaid. It creates networks that can share information regarding jobs, housing and political opportunities. Social norms can facilitate or constrain individuals' activities, allowing an adolescent to walk away from a fight or keeping a drug dealer from selling to young neighborhood children.[33]

Programs to improve social capital in a community must go beyond job-training and education initiatives in order to create networks among different segments of the community: schools, community groups, employers, and residents. Rather than focusing on individual development, the focus is placed on community development. While governmental policies can help to improve social capital, social capital can also help governmental programs run more smoothly in a particular community. One example of a tremendous source of social capital has historically been the black church, which provided the organizational infrastructure for political activism in the civil rights movement.[39]

A lack of social capital profoundly affects minority groups. Minorities in the inner cities do not have equal access to the "good ole boys" connections. Rather they must rely on the resources of their parents and their ethnic group. Since middle- and upper-class families have left the inner city, those remaining have even less social capital available.

Gun Availability

The availability of guns in America is one of the most compelling explicatory factors for the difference in homicide rates between the U.S. and other industrialized countries. While guns may not intrinsically cause violence, the severity of their consequences affects the outcome of conflicts in which guns are used.[40] Guns often turn what would otherwise have been a minor fight or confrontation into a lethal experience. In other words, the deadliness of the weapon used in a violent action has an important effect on whether the outcome is life or death. It is not merely the intent to injure another or oneself but the type of weapon used. Homicide and suicide are not usually planned and deliberate but occur during a heated moment. Between 77 percent and 91 percent of homicides are committed with a gun.[41] Criminals may find other weapons to use if guns were unavailable, but homicide attempts with guns are more often successful, leaving no opportunity for intervention. Guns are the weapon of choice in almost all gang-related homicides.[42]

Guns are easily obtained by children from older friends, unknowing parents and illegal street sales. Nationwide surveys show that one in five high school students carry weapons and one in eight report physical fights requiring medical attention each month.[43]

A study published in the *New England Journal of Medicine*[44] compared robberies, burglaries, assaults and homicides in Seattle, Washington, and Vancouver, Canada, two cities that are similar in many respects. Despite comparable rates of criminal activity, assault and homicide by means other than guns, the risk of death from homicide, after adjustment for age and sex, is significantly higher in Seattle than in Vancouver. This is primarily explained by a 4.8-fold increased risk of being murdered with a handgun in Seattle. This suggests that gun control is an effective means of decreasing homicides in a community.

Many Americans have guns in their homes; however, it is rare that they are used for self-defense. While guns are used in over 800,000 violent crimes per year, they are used only about 80,000 times per year in attempts to defend against assault, robbery, rape or burglary. Some studies have shown that as many handgun owners who report using a gun in self-defense report being involved in a gun accident.[45] Furthermore, guns are not likely to be good deterrents to burglars and robbers since, although they are aware that they may be confronted with a gun while committing a crime, there are not lower robbery or burglary rates in neighborhoods with a higher gun ownership than others.[46] In fact, rather than providing protection, the presence of guns in the home is associated with a higher risk of homicide by a family member or intimate acquaintance.[47]

Another interesting study demonstrated that increased training in gun safety, which is often advocated as a means of improving gun storage practices and therefore decreasing homicide, suicide and accidental firearm injuries, is actually associated with storing guns loaded and unlocked. Therefore, it is unlikely that firearm training will significantly decrease the inappropriate storage of firearms that often leads to injury or death.[48]

Media and Violence

In the United States, children spend more time watching television than they spend in school.[49] Violent acts occur approximately eight to 12 times an hour on prime time television and approximately 20 times an hour on children's shows, resulting in a tremendous cumulative exposure to violence.[50] The violence on television is portrayed as being an effective means of resolving conflict without having to compromise and without any of the long term psychological and physical consequences that occur in real life. The influence of the media is pervasive, especially among adolescents.

There is general agreement that there is a relationship between viewing violence on television and resulting violent behavior of the viewer.[51] The association between childhood viewing of television and development of violent behaviors meets all five of the criteria by which epidemiological causality may be established, according to a report by the Surgeon General.[52] A meta-analysis of randomized, case-control studies showed that exposure to media violence caused a significant overall increase in children's aggressiveness.[53] A comparison of violence rates before and after the introduction of television in the U.S., Canada and South Africa (where TV was introduced at different times) concluded that the introduction of television caused a subsequent doubling of the homicide rate and an increase in the rate of other forms of violence.[54]

Alcohol, Drugs and Violence

The concept of drugs, including alcohol, as an etiology of violence is somewhat controversial. According to the National Institute of Justice (*Research in Brief*, Feb. 1994), of all psychoactive substances, alcohol is the only one that has been shown to commonly increase aggressiveness. Research from the National Institute of Justice has shown that alcohol drinking has immediately preceded approximately 50 percent of all violent incidents; chronic drinkers are more likely to have histories of violent behavior than non-drinkers; those who use illegal drugs commit robberies and assaults more frequently than do non-users; and 53 percent of homicides in New York City in 1988 were drug-related. Despite these statistics, the National Institute of Justice concedes that the correlation between violence and psychoactive substances has not been established with enough certainty to call for a national policy for preventing violence related to these substances. Instead, further research on the link between violence and substance use and strategies for prevention is called for.

The other drug which is often linked to violence is crack cocaine. Cocaine's influence on violence may be that it gives the user a sense of courage and confidence while physiologically causing irritability, paranoia and increased motor activity. These factors are catalysts to increased violence, especially when combined with the culture of the drug trade in which violence is an acceptable and necessary means of conducting business.[55]

However, the aggressiveness is also dependent on factors such as social expectations that heavy drinking or drug use and violence go together. Use of illegal drugs also contributes to violence through drug marketing, due to the need for drug dealers to protect their property and their economic interests, and maintain control of the drug market. Violence occurs indirectly during activities such as property crimes committed to obtain drug money.

Another way in which drugs indirectly lead to violence is by causing parents addicted to drugs to neglect their children, which leads to the increased risk of violence in those children. When parents are addicted, the family is more likely to live in poverty and more likely to be jobless or homeless.

Children growing up in an impoverished environment often see selling drugs as the only way of becoming successful. Parents are often struggling so much that they are unable to refuse a child's contribution of money to the household, even when they know it is a result of involvement with drugs. Some turn to using drugs as a means to cope with the environment in which they live. Even for the children who initially resist drug use, once they begin selling, the cycle of use, violence and addiction takes over and they are left without opportunity to escape from the inner city.[55]

Overall, violence by drug users can be seen as the result of one of two primary categories: physiological effects (the drugs create aggression or allow disinhibition of violent tendencies), or sociological and economic effects (lack of mainstream jobs, subcultural style, a criminal lifestyle, and economic incentives lead to violence). If violence is believed to be due to physiologic mechanisms, then legalization of drugs would theoretically increase crime. If the violence related to drug use is determined to be a result of sociologic and economic factors associated with trafficking, then legalization would theoretically decrease violence.

Given that there is currently a legal prohibition on drugs, poor communities pay the price for the prohibition but do not receive any of the protection prohibition conveys. This is because members of poor communities are most susceptible to the economic benefits of drug trafficking. For an individual with extremely limited opportunities for obtaining mainstream jobs, the risks of participating in an illegal activity appear smaller, and for someone living in poverty, the economic benefits seem greater. Since there are fewer police, fewer streetlights and more abandoned buildings, the inner cities are conducive to illegal activities, forcing the families that live there to be exposed to the drugs and the associated violence. Economic opportunities are also affected in that legitimate small businesses are less likely to locate in an area in which a large amount of illegal and potentially dangerous activity is occurring. Furthermore, the easy availability of drugs in these areas causes drug abuse to be a greater problem among an impoverished community's members, subjecting them to the health consequences of drug use and addiction. Meanwhile, upper class communities are not subjected to the daily environment of the drug market since the police are more active and participation in drug dealing is not as lucrative. Middle- and upper-class drug users are able to drive into and out of low-income communities in order to obtain their drugs.

Gangs

Gangs are not independent risk factors for violence as much as they are a result of many of the same factors that contribute to violence. However, being in a gang puts one at risk for violence. Gang involvement is a logical step for many adolescents, especially those living in the impoverished inner cities. Gang members are usually "successful" role models and gangs are often viewed as the only form of protection in an otherwise dangerous neighborhood. Gangs also provide the sense of family or peer community for which most adolescents, especially those who have been neglected, yearn. These advantages of gangs seem particularly strong to adolescents who have no hope in the future.

Not all gangs behave in the same way. Some gang violence may be related to turf battles while some is motivated by the drug trade. Due to this variety between gangs in different neighborhoods, it is important that programs to reduce gang violence be targeted to the specific problems in each neighborhood and that the intervention strategies are built on continuously updated information.[57] Four factors that contribute to both individual and collective gang violence are fear, ambition, frustration and personal or group testing of skills.[58]

Gangs develop a process of socialization to interaction with the criminal justice system in order to deal with the fact that many of their members will go to court and to prison.

Gang members who go to prison are given high status, especially those who remain active in the gang while in prison and those who serve long terms. In fact, the criminal justice system frequently increases the commitment and fraternity of gangs, rather than weakening it.[59]

Being on parole has been shown to have a limited effect on gang members' behavior, despite the strictness of the parole rules. This is for several reasons. Many gang members earn a large income through illegal activities (especially dealing drugs) and do not want to incur the opportunity costs of not conducting these activities while on parole. They often think they will not get caught. They also frequently believe that their parole officer will not be able to find them a legitimate job or is not sincere in trying. Therefore, gang members will usually comply with all of the formalities of parole while at the same time resisting the system.

Environment

Many of the other factors that put people at risk for violence are combined in the environment of the inner city. This high concentration of risk factors—poverty, racism, drugs, witnessing violence, teen parenthood, joblessness and homelessness—come together to overwhelm individuals living in such an environment.

Furthermore, there are additional factors in inner city environments that may be risk factors in themselves. Chronic overcrowding is one example. Studies have suggested that chronic overcrowding, which often occurs in the inner city and especially in housing projects, may increase the impact of acute social stressors.[60] It can be hypothesized that increases in stress such as this may make violence more likely to occur.

The Public Health Approach vs. the Criminal Justice Approach

The public health approach to violence is different than that of the criminal justice system. While the criminal justice system assigns importance to agency (free will and, therefore, responsibility) of those who commit violent acts and seeks to punish them, those in public health do not make moral judgments on agency because they see an individual's actions as being secondary to societal influences. The criminal justice approach is also costly, with the average cost of incarcerating a minor for a year being greater than $29,000 (Children's Defense Fund, 1992).

While the criminal justice system takes action only after violence has been committed and does little or nothing to prevent future violence, public health professionals stress that violence is preventable.

Violence prevention under the public health model involves interventions at each of the levels of prevention: 1) primary prevention—reduction of the risk factors that effect all members of society; 2) secondary prevention—screening for and intervention in high risk populations; and 3) tertiary prevention—intervention and rehabilitation for those who have already been involved with violence.[61]

Examples of Current Public Health Approaches to Violence Prevention

Alcohol, Drugs and Violence

The promotion of preventive education, increased availability of drug treatment programs, placement of "sin" taxes on alcohol, and efforts geared toward changing norms and peer pressure concerning alcohol and drug use are means of attempting to decrease the violence associated with alcohol and drugs. The development of pharmacological therapies to decrease the aggression-promoting effects of alcohol and drug craving and withdrawal is being explored.

Conflict Resolution

Conflict resolution and peer mediation programs in schools are intended to provide needed skills and techniques to improve communication, understanding, problem solving, critical thinking, and self-esteem. By providing adolescents with these skills, they are more likely to be able to work through potentially violent situations peacefully.

One of the advantages to peer mediation programs is that through involvement of the children themselves, the social norms regarding violence are changing. However, schools also need to change the attitudes and prejudices that lead to violence by helping students to develop intercultural, antibias skills to address interpersonal, interracial, interethnic, interreligious, and homophobic, sexist, or anti-disabled incidents of violence. Therefore, cross-cultural awareness and schoolwide prejudice elimination programs are being implemented along with some of the conflict resolution and peer mediation programs.[62]

There are currently many conflict resolution programs in schools across the nation. One of the lessons learned since these programs have been implemented is the need for more than a one-time class or intervention. Rather, a long-term and school-wide interaction and reinforcement is needed, which should be guided and evaluated by the youth themselves. If possible, expansion of these programs to include parents and neighborhoods is being attempted by some programs, such as the Resolving Conflict Creatively Program developed by Educators for Social Responsibility.

Development

Some public health officials[63] are advocating for broad-based and comprehensive universal programs for preschool children analogous to public schools for later childhood. The services should cover medical care, mental health services and early education, with targeting of supplemental services for families and children at highest risk. An example of such a program is the Infant Health and Development Program (which was experimental rather than universal). There are a variety of approaches including increasing local programs to a national scale or expanding the services provided by Head Start, the only current national early intervention program to include comprehensive family support services with its preschool education program.[64]

Gun Control

There are several different public health approaches to attempting to decrease morbidity and mortality due to guns. Best known is the legislative approach. Groups such as Physicians for Social Responsibility and the Coalition Against Handgun Violence lobby Congress for increased gun regulations and bans on gun ownership or possession. However, public health professionals are also beginning to look at other methods of decreasing gun violence: attention to the black market on guns, regulation at the end of gun manufacturing and modification of gun design.

Federal gun legislation mainly affects new guns sold by licensed dealers but the black market in guns, where most of the action takes place, is essentially local.[65] With an emphasis on regulation of the black market, success is more likely. Like other anti-violence strategies, the counter against black market gun trade must take a multifaceted approach. Measures could include regulation of selling and buying, measures to decrease gun movement from the legitimate market to the black market, and efforts to address the root causes of why children carry guns (primarily fear). This approach depends on having timely information about youth gun markets, much of which police departments already have or which is easily attainable.

An article by Hemenway and Weil[66] discusses the possibility of developing a “Star-Trek”-like phaser gun to stun, similar to an animal tranquilizer gun, which can leave a victim immobilized but unharmed. This would satisfy the public’s desire to own a gun for self-defense but would decrease unintentional injury and would decrease lethality when used intentionally. This approach is interesting from the injury control perspective which shows that the most

effective way to reduce injury is through changes in product design. This is far easier to accomplish than convincing populations of individuals to change their behavior.

Improving Community-Police Interaction

In an attempt to build trust and collaboration, initiatives such as police-youth-community dialogues[67] and community policing are being implemented. The intent is to encourage police and the community to work together to combat crime. The first steps in this process include enhancing understanding between police and the community, especially on racial issues, building professional networks and personal relationships that prevent tension in communities, and providing opportunities for youth to have positive experiences with adults in authority, such as the police.

Media

One positive use of the media is in attempting to change the social norms towards violence. For many adolescents, walking away from a fight, even a dangerous one, is not seen as an option. Social norms dictate that walking away is a sign of weakness. However, the "Squash It" campaign developed by researchers at the Harvard School of Public Health is attempting to change these norms. This campaign encourages youth to "squash it" before an argument becomes violent by saying "Squash it!" accompanied by a hand gesture of an open palm hitting a closed fist. This gesture and slogan were developed by inner city youth and are meant to show assertiveness while allowing a conflict to end without a fight. The campaign is using the traditional media such as posters and public service announcements but, more importantly, has convinced major television networks to incorporate its usage into the storylines of its shows (you may have seen it on an episode of Beverly Hills, 91210).

Social Capital

Activities include support of policies which encourage formation of social capital, such as tax exemptions for community organizations and programs like the Clinton Administration's Empowerment Zone/Enterprise Community program and others similar to it, which are being introduced as a means of crime control and revitalization for communities. These programs seek to combine law enforcement, economic development, human services and community organizing to improve public safety and the quality of community life by addressing the problems of violence, fear and community conditions together.[68]

What Medical Students Can Do To Prevent Violence

Violence is pervasive throughout society. In order to prevent violence, actions need to be taken at all levels: individual, familial, community and societal. Give yourself a break from the books and get involved! When planning the following activities, try to form a diverse group and include community members in the planning activities if possible.

AMSA Local Project Grants are available as a potential funding source for violence prevention activities. Contact your local chapter president or the national office (800-767-2266) for more information.

Child Witnesses to Violence

An effective response to this problem involves several components. First, the capacity and willingness to identify domestic violence as being detrimental to children while maintaining respect for the mother needs to be increased. Availability of services, including economic and housing aid, is needed to ensure immediate and long-term safety for both the adult and child victims. Long-term treatment services for battered women and their children should be available to help prevent the continued psychological effects of abuse. Commitment to on-going training, education and networking for all community, professional and social service providers is needed. Professionals must shift their focus from blaming the mother to insuring that the abuser ends his violence. Finally, societal attitudes towards violence against women and children must be changed. As medical students we can begin to effect these changes by routinely screening all of our patients for violence in their families, by working in the community and with legislators to effect these changes and by being aware of our own attitudes toward violence.

Clinical Settings

Arrange for a preceptorship in an inner city health clinic in between your first and second year, and schedule your third- and fourth-year clerkships in clinical settings that work with underserved populations. Then put the following tips into practice with all of your patients.

Pediatrics

Encourage parents to teach their children to handle anger through verbal rather than physical expression and to promote positive, nonviolent strategies in resolving conflict.

Promote the use of "time-outs" instead of corporal punishment.

Urge parents to be aware of the methods they use in resolving their own conflicts, especially in front of their children.

General anticipatory guidance for adolescents[69]

Ask questions such as:

- How many fights have you been in the past month?
- Have you ever been threatened with a weapon?
- Have you ever carried a weapon?
- Do you ever fight with your boyfriend or girlfriend?
- Do you witness or experience violence at home?

Offer informal counseling and the opportunity for follow-up to those with a positive history for violence. Advise adolescents that the most serious threat to their health comes from fighting and that serious injuries and deaths often result from fights between friends. Help the adolescent to identify strategies for avoiding violent situations and for developing alternatives to fighting.

Secondary prevention for adolescents who have been injured as a result of violence

Help develop treatment protocols modeled after those used for suicide. (Allen, N. Homicide prevention and intervention. *Suicide Life Threat Behav* l981, 11:167-179.)

Start an intervention project for victims of intentional injuries in emergency departments.

Assess the following factors and make necessary and timely referrals for intervention and support services: Circumstances of the event in which they were injured, the relationship of the patient to the assailant, use of drugs or alcohol, the presence of underlying risk factors such as family violence, a history of violent injuries or behaviors, availability of weapons, predisposing biologic risk factors and intent to seek revenge.[70]

Child Abuse Detection

Routinely ask all patients about a history of abuse. While it may be difficult to obtain accurate disclosure of maltreatment during childhood and adolescence and many patients who were abused deny the history of abuse when interviewed as adults, there are techniques used during the interview that increase the likelihood of disclosure.[71]

Maintain your focus on the child, especially in cases involving allegations of a specific adult. Interview children separately from their parents if they are old enough and parents separately from each other.

Ask directly. Use open-ended questions.

- What is the worst thing that has happened to you?

Ask questions about the caretakers temperament:

- What happens when your parents drink?
- We all argue at home, what happens when you fight in your home?

Ask questions about the patient's medical history:

- What is the origin of scars, the cause of repeated hospitalizations?

Ask about specific instruments and methods of punishment:

- Have you ever been hit with a belt, board, extension cord, or other object?

Ask about maltreatment outside of the home:

- Has anyone outside of your home ever hurt you, such as the police, teachers, foster families or others?

Include probes following all questions, such as: Who else? Where else? What else? What other times? Tell me about it.

When interviewing parents, ask:

- How was the pregnancy?
- What was your child like when she or he first came home from the hospital?
- Has anyone been hurting you?

Always leave time at the end of the interview for the child or parents to ask you questions.

Community Outreach

Start a conflict resolution and/or peer mediation program at a local school. Become a tutor or mentor. Participate in AMSA projects such as ASAP (Adolescent Substance Abuse Prevention Project) or CATCH (Coaching Adolescents Towards Careers in Health). Start a teen pregnancy prevention project. Implement a dating violence prevention curriculum. Organize a violence prevention team that can link patients seen in the emergency department for intentional injuries and their families with support services, such as counseling, job programs, housing and educational services, and alcohol or drug treatment programs.

Get involved with community programs such as Lift-A-Hammer (sponsored by the Task Force on Community Health in conjunction with Habitat for Humanity) or work with the Sierra Club Inner City Outings program (where you'll go on outdoor adventures with kids from the inner city who otherwise wouldn't be able to experience the outdoors). These are two activities that'll get you out in the sun, working side by side with members of low-income communities, while helping improve opportunities and alternatives to violence.

Education

Design a bulletin board on violence prevention. Write articles for the school newspaper. Do a presentation on violence as a public health issue. Write letters to the editor of your local newspaper.

Legislative Action

Have a letter-writing campaign: buy some paper, envelopes and stamps, and have information material on a particular issue and Congressional addresses available. Write letters on local, state or national issues such as gun control, improved (not diminished) welfare laws, parent support programs, economic development for inner cities, implementation of school conflict resolution and violence prevention programs, access to drug and alcohol treatment programs, access to mental health treatment for children who experience or witness violence, affirmative action, teen pregnancy prevention and any of the other issues that relate directly or indirectly to violence. Original letters from individuals are more effective than preprinted form letters.

Visit your legislators (at state and national levels), get to know their staff members, tell them what you think about these issues, work on their campaigns, invite them to speak at your school.

Take advantage of current events that highlight a specific issue (i.e., the Oklahoma bombing and gun control).

Use/recruit celebrities to help support your viewpoint.

Use symbolism, such as wearing a white coat and stethoscope when speaking about violence prevention.

Work together with other organizations, especially community groups.

At the national level, AMSA has a full-time student lobbyist (the Legislative Affairs Director, or LAD) who lobbies on behalf of medical students according to AMSA's policies as listed in the *PPP (Preamble, Purposes and Prin-*

ciples). The LAD can help keep you updated on current legislation, can help arrange meetings with your legislators, and can provide samples of general letters to your representatives. The LAD can be reached via AMSA voicemail or email [(703) 620-6600, ext. 211, amsalad@aol.com].

Movie Nights

Grab some popcorn, rent a movie and follow it up with a discussion on violence. Recommended movies (most of these can be rented at your local video store):

American Me
Lives in Hazard (on the making of *American Me*)
Stand and Deliver
Boyz N the Hood
Kids Killing Kids, Kids Saving Kids

Preventing Effects of the Media on Violence

- Write letters to companies that advertise during violent television shows telling them you will not buy their products if they continue to support such programs. Write to the networks to notify them that you will not watch their shows containing violence.
- Advise parents of your pediatric patients that the American Academy of Pediatrics recommends parents limit their children's television viewing to one to two hours per day and to avoid violent programs. Tips for anticipatory guidance concerning television viewing:[72]
  - Begin with a "television viewing history" —Where are household televisions located? How much TV does the child watch? Ask the child to name a few of his or her favorite T.V. shows.
  - Explain to parents why TV viewing is a concern, including factors such as obesity, cognitive development and perpetuation of stereotypes.
  - Advise parents that children should not have their own television in their rooms where parents cannot see what they are watching, parents should monitor their children's viewing choices, parents should limit viewing to no more than two hours a day, and, if necessary, parents should use devices to block unauthorized television viewing by their children.
- Parents should be encouraged to watch TV with their children in order to help them learn how to analyze the content of programs. Good questions to ask include: Is this real or pretend? Is this how we do things at home?,What do you think would happen if you did that?
- Promote child-care alternatives (TV is often used as a babysitter by overworked mothers).
- Lobby for school systems to adopt curricula that include critical TV viewing skills.
- Encourage a mandatory rating system for violence on television so that parents can judge how violent a program is and make decisions accordingly as to whether their children should be allowed to watch it.
- Arrange for a radio talk show on violence. This may be easier than you think. Just find someone who is an expert on violence (possibly a leader of a community violence prevention program) and call radio stations until you find one that is willing to put your speaker on the air, hopefully a station targeted to a young audience and that has a pre-existing call-in type program.
- For those of you with a creative side, try filming a video. You could make a documentary or a develop an educational video on conflict resolution targeted to adolescents or a video educating medical students on how to talk to patients about violence.

Speakers

Sponsor a noon-time speaker, a brown-bag lunch series or a weekend conference. Speakers could be physicians working on violence issues, local experts on violence, community activists, police officers, teachers, battered women's shelter workers, or members of the public health department. Arrange a debate on gun control or media violence. Use your imagination.

Volunteering

Volunteer at a battered women's shelter or for a rape crisis hotline. Work in a community center. Volunteer at a school or day care center.

Resources

Articles:

JAMA: The June 14, 1995 issue (Vol. 273, No. 22) is devoted entirely to issues of violence.

Health Affairs: The Winter 1993 issue (Vol. 12, No. 4) is a special issue on violence and public health, including possible grant sources for violence prevention projects. This is an excellent collection of articles by the leading experts in the field of violence prevention.

The New Physician: The December 1994 issue is devoted to violence.

MS. Magazine, Vol V, No. 2, Sept/Oct 1994 has a series of excellent articles on domestic violence.

DeJong, William. "Preventing Interpersonal Violence Among Youth: An Introduction to School, Community, and Mass Media Strategies." *Issues and Practices in Criminal Justice.* U.S. Department of Justice, Office of Justice Programs: National Institute of Justice.

Centers for Disease Control and Prevention. A framework for assessing the effectiveness of disease and injury prevention. *Morbidity and Mortality Weekly Report.* Vol. 41. March 27, 1992: 1-12.

Program evaluation is essential to continuity of prevention programs; this is a good reference for either beginners or those experienced in program evaluation.

Stringham, Peter and Spivak, Howard. What pediatric primary care clinicians can do when confronting aggressive youth. *Bulletin of the New York Academy of Medicine.* Winter 1994: 1-17.

A great article with detailed descriptions of techniques and practical skills for talking to patients about violence.

New Jersey Medicine Vol 91 (12): The December 1994 issue is dedicated to violence issues, including the ethical basis for concern about violence, what physicians can do to prevent firearm injuries, and a primer on domestic violence for clinicians.

Books/Booklets:

Cohen, Richard. *Students Resolving Conflict: Peer Mediation in Schools.* Good Year Books, 1995. 256pp. For a catalog, write to: GoodYear Books, Scott Foresman, 1900 East Lake Avenue, Glenview, IL 60025.

Includes descriptions of twelve conflict resolution lessons that can be used in groups from grades 6-12, as well as information on how to start a peer mediation/ conflict resolution curriculum in schools, and sample consent, evaluation, and other forms.

Creighton, Allan and Kivel, Paul. *Helping Teens Stop Violence: A Practical Guide for Counselors, Educators, and Parents.* Hunter House, Alemeda, CA, 1992. 152pp. (510) 865-5282.
Includes background information on working with adolescents, curriculum which can be used in classrooms with little advanced preparation for one-hour to three-day workshops, and guidelines for setting up adolescent support groups.

Drew, Naomi. *Learning the Skills of Peacemaking: An Activity Guide for Elementary Aged Children on Communicating, Cooperating, Resolving Conflict.* Rolling Hills Estates, CA: Jalmar Press, 1987.

Edelman, Marian Wright. *Families in Peril: An Agenda for Social Change.* Cambridge: Harvard University Press, 1987.

Einstein, Vivian. *Conflict Resolution.* St. Paul, MN: West Publishing Company, 1985.

Fisher, Roger, and Ury, William. *Getting to Yes: Negotiating Agreement Without Giving In.* New York: Houghton Mifflin, 1981.

Gelles, Richard and Loseke, D. *Current Controversies on Family Violence.* Sage Publications, CA, 1993.

------. *Healthy Relationships: A Violence-Prevention Curriculum. Men For Change.* Second edition, 1994.

Available for Grade 7: Dealing With Aggression; Grade 8: Gender Equality and Media Awareness; and Grade 9: Forming Healthy Relationships. Write to: P.O. Box 33005, Quinpool Postal Outlet, Halifax, Nova Scotia, Canada B3L4T6. (902) 492-4104, FAX: (902) 425-7778. e-mail: aal 16@cfn.cs.dal.ca.

Jenny, Carole. *National Health Service Corps Educational Program for Clinical and Community Issues in Primary Care: Child Abuse, Neglect and Domestic Violence Module.* The American Medical Student Association. 1994. Write to: Joan Hedgecock, The AMSA Foundation; 1902 Association Dr., Reston, Virginia 22091 or voicemail, ext. 208.

Easy-to-run educational modules for health professional students on child sexual abuse, child physical abuse, adult survivors of child sexual abuse, domestic violence, and a

community-oriented primary care approach to domestic violence.

Kotlowitz, Alex. *There Are No Children Here: The Story of Two Boys Growing Up in the Other America.* New York: Doubleday, 1991.

A moving story that is easy to read but hard to forget.

Massachusetts Coalition of Battered Women Service Groups. *For Shelter and Beyond.* To order: MCBWSG, 107 South Street, Boston, MA 02111, (617) 426-8492.

Provides an excellent background for understanding and working with battered women and changing society to prevent violence against women. Discusses racism, sexism, homophobia, ableism, ageism and prejudice against immigrants.

Massachusetts Department of Public Health. *Boston Area Violence Prevention Resource Directory.* Boston, MA, 1993. 223pp. Write to: Massachusetts Adolescent Violence Prevention Project, Massachusetts Dept. of Public Health, 150 Tremont Street, Boston, MA 02111.

An in-depth listing of organizations that work to prevent violence, many of which produce materials for use by other programs, ranging from brochures to videotapes. Includes resources for domestic violence, survivors of violence, rape, sexual assault and sexual abuse, counseling and therapy, substance abuse, health, mediation, employment, education and skills training, residential programs, youth development/peer leadership, recreation, curriculum development and dissemination, and technical assistance.

Miller, Robert. *Community Resource Guide: Act Against Violence—Join the New Peace Movement. National Campaign to Reduce Youth Violence, 1995.* Write to: ACT AGAINST VIOLENCE, Community Resource Guide, Thirteen/WNET, P.O. Box 245, Little Falls, NJ 07424-9876.

An excellent guide to violence prevention activities, including a section on finding resources and raising funds and extensive information on organizations, publications and videos.

National Center for Injury Prevention and Control. *The Prevention of Youth Violence: A Framework for Community Action.* Atlanta: Centers for Disease Control and Prevention, 1993.

National Crime Prevention Council. *Preventing Violence: Program Ideas and Examples.* Washington, DC: National Crime Prevention Council, 1992.

National Criminal Justice Reference Service. *PAVNET Resource Guide* (Volumes I & 2).

For a free copy of this comprehensive listing of more than 500 programs to reduce youth violence, write to: PAVNET Resource Guide; The National Criminal Justice Reference Service, Box 6000, Rockville, MD 20850. Also on the Internet.

New Society Publishers. 1 (800) 333-9093 or (215) 382-6543.
A not-for-profit publishing house dedicated to promoting social change through nonviolent action. Publishes a wide variety of books and materials on peace, feminist, environmental, bioregional, social justice, economic justice, anti-racist, decentralist and human rights movements.
Pollack, Stanley. *Teen Empowerment Program: Implementation Manual.* Boston: Teen Empowerment, 1987.

Poussaint, Alvin. *Violence Prevention: A Curriculum for Adolescents.* Dept. of Psychiatry, Harvard Medical School.

Prothrow-Stith, Deborah. *Deadly Consequences: How Violence is Destroying Our Teenage Population and A Plan To Begin Solving the Problem.* New York: Harper Collins, 1991.

An excellent book for background description and analysis of violence as a public health problem. Easy to read and informative.

Reiss, Albert J., Jr., ed. *Understanding and Preventing Violence.* Washington, DC: National Academy Press, 1993.

Rodriguez, Luis. *Always Running: La Vida Loca, Gang Days in L.A.* Curbstone Publishers.

Rosenberg, Marc L., ed. *Violence in America: A Public Health Approach.* New York: Oxford University Press, 1991.

Sousa, C., Bancroft, L. and Hanson, K. *Preventing Teen Dating Violence—Three Session Curriculum for Teaching Adolescents.* Transition House Productions. Write to: Transition House, P.O. Box 530, Harvard Square Station, Cambridge, MA 02238.

Sousa, C., Bancroft, L. and Hanson, K. *Peer Leader Training Manual.* Transition House Productions. Write to: Transition House, P.O. Box 530, Harvard Square Station, Cambridge, MA 02238.

Ury,William. *Getting Past No: Negotiating with Difficult People.* Bantam, 1991.

Wood, Erica and Dooley, Jeanne. *Targeting Disability Needs: A Guide to the Americans with Disabilities Actfor Dispute Resolution Programs.* AARP, Washington, DC, 1994, 52pp.

Its purpose is to help dispute resolution programs serve persons with disabilities and resolve conflicts under the new Americans with Disabilities Act. Available from AARP and the National Institute for Dispute Resolution (NIDR) for $10.00.

Telephone Hotlines:

Family Violence Prevention Fund, 1-800-313-1310. For information: (202)371-1999.

Callers to the hotline of the special service library on domestic violence can request resource materials, including general information on strengthening health-care providers' response to domestic violence, materials specifically designed for a variety of health care specialties, technical assistance, including help with developing hospital- or clinic-based domestic violence programs, and library services, including advice from trained information specialists who can provide customized computer searches, research studies and other published materials.

Project Vote Smart is a non-profit, non-partisan organization that provides free information on congressional voting records, campaign promises and other legislative updates. Call (800) 622-SMART. An informed voter and lobbyist can make a difference!

National Gay and Lesbian Hotline, (800) 347-8336.

Victim Recovery Program, (800) 834-3242 ext. 311. (support, referrals and information on anti-gay harassment)

Videos:

The following videos may be available at a department of public health library in your state:

Crossing the Line: The Truth About Gangs. VHS, 1993 18 minutes. Provides an inside look at the consequences of joining a gang. Includes tips for avoiding gang participation. Presents the hard reality of gang life.

Dealing With Anger by Rodney Hammond, Ph.D of Positive Adolescent Choices Training (PACT). One series targeted toward African-American males and one toward African-American females. (217) 352-3273, fax (217) 352-1221.

Heart on a Chain. VHS, 1991. 17 min. Deals with dating violence among teens. Gives teens a clear understanding of what constitutes abuse in a relationship, why it happens, and what is a healthy, rewarding relationship.

Justice Is Done, VHS, 31 min. 1994. Distributed by Center to Prevent Handgun Violence, Washington, DC, (202) 289-73 19.

The Last Hit: Children and Violence. VHS, 1994. 20 minutes. A resource for dealing with conflict resolution and violence prevention. Young children candidly share their experiences with violence in their schools, homes and communities and how they avoid it.

Listen To Me: Physical Child Abuse. VHS, 1988. 15 minutes. Teaching young viewers how to distinguish between discipline and abuse, this awareness-building program makes it clear that abuse is a problem that can occur in any family and tells children that assistance is available to them.

Love Them One by One: An Overview of the Ten Point Program. VHS, 31 min. 1994. Distributed by Ten Point Coalition, Boston, MA, (617) 524-4331.

The Power to Choose. VHS, 20 min. 1988. Distributed by Agency for Instructional Technology, Bloomington, Ind., (800) 457-4509.

Teens Talk.... Violence. "In the Mix" Series. VHS, 30 min. 1993. Distributed by WNYC, New York, NY, (800) 328-7271

Teen Violence: Where Have All the Children Gone? VHS, 1990. 27 minutes. Utilizes role-play and audience participation. Helps teens and adults identify causes of teen violence.

Violence: Dealing With Anger by Centre Communications (303) 444-1166, fax (303)444-1168. Targeted for junior high and older elementary school students, it uses concepts from non-aggressive martial arts.

Violence: Myth vs. Reality. VHS, 1994. 13 minutes. Six myths that lead to violence are explored - needing a weapon, joining a gang for protection and the impact of drugs and alcohol on violence. Offers valuable skills to avoid and stop the cycle of violence.

Violence Prevention: Inside Out. VHS, 60 min. 1993. Distributed by National Association for Mediation in Education, Amherst, MA, (413) 545-2462.

Weapons and You. VHS, 1993. 18 minutes. Shows high school students the real consequences of bearing and using weapons. A police officer discusses the purpose of using a gun and how teens get a distorted view of gun-related violence through TV and movies.

What Can We Do About Violence? A Bill Moyers Special. VHS, 240 min. 1995. Distributed by Films for the Humanities and Sciences, Princeton, N.J., (800) 257-5126.

Organizations:

Big Brothers/Big Sisters of America
National youth-service organization based on the concept of a one-to one relationship between an adult volunteer and an at-risk child. Volunteers serve as mentors and role models to help these youth increase their self-esteem.
230 North Thirteenth St., Philadelphia, PA 19107, (215) 567-7000.

Bikes Not Bombs
Works with inner-city youth and in developing nations repairing and distributing used bikes while teaching skill development, leadership training, and providing economic opportunities and affordable transportation.

Boys and Girls Clubs of America
National movement providing youth development activities with emphasis on those from disadvantaged circumstances.

Gang Intervention Services
1230 W. Peachtree St. NW, Atlanta, GA 30309, (404) 815-5764.

Center for Media Literacy
Translates media literacy research and theory into practical information, training, and education tolls for teacher, youth leader, parents, and childcare givers.
1962 S. Shenandoah St., Los Angeles, CA 90034, (310) 559-2944.

The Center to Prevent Handgun Violence
A national education, legal action, and research organization on gun violence and prevention.
1225 Eye St. NW, Suite 1100, Washington, DC 20005, (202) 289-7319.

Center for the Study and Prevention of Violence
The center collects literature, offers technical assistance, and maintains basic research on the causes of violence and the effectiveness of prevention and intervention programs.
University of Colorado at Boulder, IBS #9, Campus Box 442, Boulder, CO 80309-0442, (303) 492-1032.

The Clothesline Project
A group of people from all backgrounds standing together committed to challenging outward and internalized homophobia, racism, and sexism and other oppressions. They make the connection between these violences and the violence experienced as women.
The Clothesline Project, Box 727, East Dennis, MA 02641, (508) 385-7004; FAX: (508) 385-7011.

Coalition to Stop Gun Violence
The Coalition's purpose is to stop the sale of handguns and assault weapons to private individuals, with exceptions for the police, military, collectors and target shooters willing to leave their guns at a licensed shooting range.
100 Maryland Ave, NE; Washington, DC 20002; (202) 544-7190; FAX (202) 544-7213.

The Community Crisis Response Team of Cambridge Hospital
Works closely with local agencies and grassroots organizations when providing assistance to traumatized community settings (i.e., when communities witness violence or lose community member through violence or suicide).
The Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139, (617) 498-1180.

The Dating Violence Intervention Project
A collaboration between a shelter for battered women and their children and an intervention program for violent and abusive men, the DVIP facilitates its model curriculum in public schools in the U.S., Canada, New Zealand and Australia. One of their goals is to continue to work upon addressing dating violence in young gay and lesbian relationships.
Transition House, P.O. Box 530, Harvard Square Station, Cambridge, MA 02238.

Education Development Center, Inc. (EDC)
Addresses educational, health and social problems of people of all ages, races, ethnicities, and cultures.
55 Chapel St., Newton, MA 02160, (617) 969-7100.

The Educational Fund to End Handgun Violence
A non-profit educational charity dedicated to ending violence caused by the use of firearms, particularly as it affects children.
110 Maryland Ave, NE, Box 72, Washington, D.C. 20002, (202) 544-7214.

Educators for Social Responsibility
ESR's primary mission is to help young people develop the convictions and skills to shape a safe, sustainable, and just world. They offer many publications (books and videos) on conflict resolution, violence prevention, intergroup relations, and character education, including emphasis on countering racism, sexism, homophobia, classism and ageism.
ESR; 23 Garden Street, Cambridge, MA 02138, (617) 492-1764. To order, call: (800) 370-2515.

Gang Peace
A Boston-based group which works to stop urban violence by providing an alternate to violence. Involves youth in education, mentoring/tutoring programs, street and community outreach to at-risk youth, community needs assessment and referral service.

Handgun Control, Inc.
Washington, DC
Yoshi Takeda
(202) 289-5789
yoshita@igc.apc.org
Lobbies for anti-handgun legislation. Was one of the major forces in the passage of the Brady Bill. Currently has a large studentís network for legislative action and initiatives specifically geared toward medical students.

Joey Fournier Services
Presents a violence-prevention curriculum in public schools for pre-school through grade 12 to help prevent violent crime before it starts by educating children to the long-term effects of violence on the victim and the perpetrator.
The Joey Fournier Services, 14 Beacon Street, Boston, MA 02108, (800) 533-JOEY.

National Association of Social Workers
Produces pamphlets and posters on stopping violence.
NASW, 750 First Street, NE, Suite 700, Washington, DC, 20002-4241.

National Institute Against Prejudice & Violence
Studies and responds to problems of violence and intimidation motivated by prejudice. Also involved in legislation and education.
31 S. Greene Street, Baltimore, MD 21201, (410) 328-5170.

The Network for Battered Lesbians
Formed to address battering in Lesbian communities, to provide support to battered lesbians and bisexual women, and to work toward the elimination of violence against women.
Box 6011, Boston, MA 02114, (617) 424-8611.

Physicians for Social Responsibility
Violence prevention projects have been initiated by many regional chapters. TARGET: GUNS is a new project of PSR's which focuses on gun control. Has an active e-mail network.
1101 14th St. NW, Suite 700, Washington, DC 20005, (202) 898-0150

Physicians for a Violence-Free Society
5323 Harry Hines Blvd.
Dallas, TX 75235-8579

Prevent Handgun Violence Against Kids
A public education campaign funded by the California Wellness Foundation. They produce a resource book as a part of their educational activities.
6320 Canoga #1700
Woodland Hills, CA 91367-7111
(818) 593-6600

Student Conflict Resolution Program
A part of the West Oakland Health Council, the SCRP's goal is to provide an early intervention strategy for the prevention of interpersonal violence among young people.
SCRP; West Oakland Health Council, Mental Health Department, 2730 Adeline Street, Oakland, CA 94607, (610) 465-1800, ext. 326.

Teachers and Physicians Against Media Violence
Jim Paxinos
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Teaching Tolerance
A part of the Southern Poverty Law Center, this organization publishes a magazine and videos designed to help teachers explore issues of diversity and tolerance as a way of preventing hate crimes.
400 Washington Ave., Montgomery, AL 36104.

Violence Prevention Coalition of Greater Los Angeles
An alliance of public health advocates, educators, providers, law enforcement officials and other community activists working to prevent violence through the development and implementation of several different projects.

Violence Policy Center
National foundation conducts research on firearms violence and develops violence reduction policies.
1300 N St. NW, Washington, DC 20005, (202) 783-4071.

Women of Color United Against Domestic Violence and Rape
This group will provide training and work with you on projects in order to promote an awareness of domestic violence and rape and its impact on people of color in order to reduce the prevalence of these crimes. (617) 427-4470, ext. 444.

References

[1] Pierce and Fox. *Recent trends in violent crime: a closer look.* National Crime Analysis Program, Northeastern University, October 1992: 2-3.

[2] *Kids and Guns Fact Sheet.* The Educational Fund to End Handgun Violence. Washington, D.C.

[3] Pierce and Fox. Op. cit.

The Project on Human Development in Chicago Neighborhoods, an epidemiologic study of 11,000 children in Chicago followed over eight years, assessing development from birth to 32 years of age is currently being conducted to generate answers about the causes of violence. Stay tuned for the results of this study.

[4] Buka, Stephen, and Earls, Felton. Early determinants of delinquency and violence. *Health Affairs.* Winter 1993:46-64.

[5] Ibid.

[6] Ibid.

[7] Raine, A., Brennan, P., and Sarnoff, M. Birth complications combined with early maternal rejection at age I year predispose to violent crime at age 18 years.

[8] Yoshikawa, Hirokazu. Prevention as cumulative protection: effects of early family support and education on chronic delinquency and its risks. *Psychological Bulletin.* 1994; 115 (1) 001-0027.

[9] The Infant Health and Development Program. Enhancing the outcomes of low-birth-weight, premature infants: a multisite, randomized trial. *JAMA.* 1990; 263: 3035-3042.

[10] Brooks-Gunn, J. et al. Early intervention in low-birth-weight premature infants: results through age 5 years from the infant health and development program. *JAMA*. 1994; 272: 1257-1262.

[11] Moffitt, T. Adolescence-Limited and Life-Course-Persistent Antisocial Behavior: A Developmental Taxonomy. *Psychological Review*. 1993, Vol. 100 (4) 674-701.

[12] Spivak, H., Prothrow-Stith, D., and Hausman, A. *Dying is no accident: adolescents, violence, and intentional injury.* The Pediatric Clinics of North America. 35 (6) Dec. 1988: 1339-1347.

[13] Thornberry, Terence. *Violent families and youth violence.* Office of Juvenile Justice and Delinquency Prevention, Factsheet #21; December 1994.

[14] Hershorn and Rosenbaum. Children of marital violence: a closer look at the unintended victims. *American Journal of Orthopsychiatry.* 55 (2); April 1985: 261-266. Jaffe, Hurley, and Wolfe. Children's observations of violence: I. Critical issues in child development and intervention planning. *Canadian Journal of Psychiatry*. Vol. 35, August 1990: 466-470. Jaffe, Hurley, and Wolfe. Children's observations of violence: II. Clinical implications for childrens' mental health professionals. *Canadian Journal of Psychiatry*. Vol. 35, August 1990: 471-476. Jaffe, Wolfe, Wilson, and Zak. Similarities in behavioral and social maladjustment among child victims and witnesses to family violence. *American Journal of Orthopsychiatry*, 56 (1), January, 1986: 142-146.

[15] McKibben, L., DeVos, E., and Newberger, E., Victimization of mothers of abused children: a controlled study. *Pediatrics.* 1989; 84: 531-535.

[16] Stark and Flitcraft, Women and children at risk: A feminist perspective on child abuse. *International Journal of Health Services*, Vol. 18, No. 1, 1988.

[17] Newberger, Eli. *Pediatric interview assessment of child abuse: challenges and opportunities.* Pediatric Clinics of North America. 37 (4). Aug. 1990: 943-954.

[18] Pecora, P., Whittaker, J., Maluccio, A., Barth, R., and Plotnick, R. *The child welfare challenge: Policy, practice, and research.* Chapter 4, p 91-129. Aldine De Gruyter, New York.

[19] Lewis, D, et.al. Biopsychosocial characteristics of matched samples of delinquents and nondelinquents. *J. Amer. Acad Child Adol. Psychiat.*, 1987, 26 (5): 744-752.

[20] Mallinosky-Rummell, R. and Hansen, D. Long-term consequences of childhood physical abuse. *Psychological Bulletin.* 1993; 114: 68-79.

[21] Luntz, Barbara, and Widom, Cathy Spatz. Antisocial personality disorder in abused and neglected children grown up. *Am JPsychiatry*. 1994; 151: 670-674.

[22] Widom, Cathy. The cycle of violence. *Science.* 1989; 244: 160-166.

[23] Cicchetti, D., and Toht, S., eds. Child abuse, child development. and social policy. *Advances in Applied Developmental Psychology.* Vol 8, Chp 6. Garbarino, Kostelny, and Grady.

[24] Huge, Price. The black man in America. *The New York Times Magazine*. Dec. 1994.

[25] Wilson, William J., *The Truly Disadvantaged* (1987). The University of Chicago Press.

[26] Martinez, O. Minority youth and crime. *Crime and Delinquency.* April 1987; 33 (2): 325-328.

[27] Krisberg, B. et. al. The incarceration of minority youth. *Crime and Delinquency.* April 1987; 33 (2); 173-205.

[28] Huge, Price. Op. cit.

[29] Stone, Alan. Personal communication via class discussion.

[30] Prothrow-Stith, Deborah. *Deadly Consequences: How Violence is Destroying Our Teenage Population and A Plan To Begin Solving the Problem.* New York: HarperCollins, 1991. 64-129.

[31] Ibid.

[32] Joe, Tom. Economic inequality: the picture in black and white. *Crime and Delinquency.* April 1987; (2): 287-299.

[33] Newman, Katherine. *Working poor: low wage employment in the lives of Harlem youth. Transitions Through Adolescence: Interpersonal Domains and Context.* Graber, J.J. Brooks-Gunn and A. Petersen, eds. Erlbaum Associates Publishers. August 1994.

[34] Newman, K. and Lennon, C. *Finding work in the inner city: how hard is it now? how hard will it be for AFDC recipients?*

Department of Anthropology. Columbia University. February 1995: 1-13.

[35]Duster, Troy. Crime, youth unemployment, and the black urban underclass. *Crime and Delinquency,* April 1987; 33 (2): 300-316.

[36]Prothrow-Stith, Deborah. *Op. cit.*

[37]Putnam, Robert. The prosperous community: social capital and public life. *The American Prospect.* Spring 1993: 02-09.

[38]Coleman, James. Social capital in the creation of human capital. *AJS*. Vol 94, Supplement: S95-S120.

[39]Putnam, Robert. Op. cit.

[40] The Technology of Personal Violence, in Cook, Phiip J. *Crime and Justice: A Review of Research,* c 1991; 1-71. University of Chicago Press.

[41] Riley, D. *Kids and guns: a national disgrace.* The Educational Fund to End Handgun Violence. Washington, D.C.

[42] BIock, Carolyn and Block, Richard. *Street gang crime in Chicago.* National Institute of Justice. December 1993.

[43] Sege, R. Adolescent violence. *Current Opinion In Pediatrics.* 1992, 4: 575-581.

[44] Sloan, J., et. al. Handgun Regulations, Crime, Assaults, and Homicide: A Tale of Two Cities. *The New England Journal Of Medicine*. 1988; 319: 1256-62.

[45] The Technology of Personal Violence, in Cook, Phiip J. National Research Council, 1990; 1-6.

[46] The Technology of Personal Violence, c 1991, Op. cit.

[47] Kellermann, A., et. al. Gun Ownership as a Risk Factor for Homicide in the Home. *The New England JournalofMedicine.* 1993; 329: 1084-91.

[48] Hemenway, D., Solnick, S., and Azrael, D. Firearm Training and Storage. *JAMA*. 1995; 273: 46-50.

[49] Dietz WH, Strasburger VC. Children, adolescents and television. *Curr Prob Pediatr.* 1991; 21 (1): 8-31.

[50] Sege, R. and Dietz, W. Television viewing and violence in children: the pediatrician as agent for change. *Pediatrics.* 1994; 94: 600-607.

[51] Eron, L. and Huesmann, L. The Role of Television in the Development of Prosocial and Antisocial Behavior. *Development of antisocial and prosocial behavior.* 1986. Academic Press. 285-314.

[52] Sege, R. and Dietz, W. Television viewing and violence in children: the pediatrician as agent for change. *Pediatrics.* 1994; 94: 600-607.

[53] Wood W, Wong FY, Chachere JG. Effects of media violence on viewers' aggression in unconstrained social interaction. *Psychol bull.* 1991; 109: 371-383.

[54] Centerwall, B. "Television and Violence: The Scale of the Problem and Where to Go From Here". JAMA, June 1992; 267 (22) 3059-3063.

[55] Prothrow-Stith, Deborah. Op. cit.

[56] Prothrow-Stith, Deborah. Op. cit.

[57]Block, Carolyn and Block, Richard. *Street gang crime in Chicago.* National Institute of Justice. December 1993.

[58]Jankowski, Martin Sanchez. *Islands in the street: gangs and American urban society.* University of California Press. Chapter 5: 137-177.

[59] Ibid. Chapter 8: 252-283.

[60] Lepore, S., et. al. Social hassles and psychological health in the context of chronic crowding. *Journal of Health and Social Behavior.* Dec. 1991, 32: 357-367.

[61] Spivak, H., Prothrow-Stith, D., and Hausman, A. Op.cit.

[62] Moore, Pamela and Batiste, Deborah. Preventing youth violence: prejudice elimination and conflict resolution programs. *NIDR Forum.* Spring 1994: 15-18.

[63] Buka, Stephen, and Earls, Felton. Op. cit.

[64] Yoshikawa, Hirokazu. Op.cit.

[65] Kennedy, D. Can We Keep Guns Away From Kids? *The American Prospect.* Summer 1994 (18) 7480.

[66] Hemenway, D. and Weil, D. Phasers on Stun: The Case for Less Lethal Weapons. *Journal of Policy Analysis and Management.* Vol. 9 (1) 94-98 (1990).

[67] Munoz, Shirley and Tan, Norma. Organizing police-youth-community dialogues to prevent violence. *NIDR Forum.* Spring 1994: 20-24.

[68] Kennedy, David. Showcase and Sandtown: in search of neighborhood revitalization. *Issues and practices report prepared for the National Institute of Justice*. Sept. 1994.

[69] Sege, R. Adolescent violence. *Current Opinion in Pediatrics.* 1992, 4: 575-581.

[70] Spivak, H., Prothrow-Stith, D., and Hausman, A. Op. cit.

[71] Stein, A. and Lewis, D. Discovering physical abuse: insights from a follow-up study of delinquents. *Child Abuse and Neglect.* 1992; 16: 523-531.

[72] Sege, R. and Dietz, W. Television viewing and violence in children: the pediatrician as agent for change. *Pediatrics.* 1994; 94: 600-607.