

Adolescent Perspectives on Addressing Youth Violence in the Primary Care Setting

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ABSTRACT

BACKGROUND: Youth violence is one of the leading causes of morbidity and mortality among adolescents, yet rarely discussed during preventative care visits. The aim of this study was to understand the perspectives of adolescents on youth violence and health, and to determine facilitators and barriers to discussion in the primary care setting.

METHODS: We conducted 5 structured focus groups with adolescents from a local community organization. Each focus group was made up of 3–10 male and female participants ranging from ages 12–24. Transcripts were analyzed for recurrent themes.

RESULTS: All participants had personal experience with violence or close contacts affected by violence, though few had discussed violence with their primary care physician. Themes included (1) violence plays a large role in youth's health, well-being, and behavior choices; (2) youth do not inherently trust physicians; (3) physicians do not ask about violence; and (4) youth have mixed feelings on how physicians could help them with the violence in their lives.

CONCLUSIONS: Barriers to youth violence discussions include youths' discomfort, mistrust, and discordant expectations of their providers, and lack of physician inquiry about violence in the primary care setting.

KEYWORDS: youth violence, focus groups, community pediatrics, physician-patient communication

INTRODUCTION

Youth violence represents a critical health issue disproportionately affecting young people in the US.¹ Homicide is the third leading cause of death for individuals ages 10–24.² In 2013, 4,481 youth aged 10–24 years were homicide victims and more than 500,000 were treated in U.S. Emergency Departments for non-fatal assault injuries.² Rhode Island is similar to national statistics, with 23% of male high school seniors reporting a physical fight in the past year and over 12% carrying a gun in the past 30 days.³ In 2011, nearly 1,000 adolescents and young adults presented to the Emergency Departments of Rhode Island Hospital and Hasbro Children's Hospital with an assault-related injury.⁴

Numerous medical organizations, including the American Academy of Pediatrics (AAP), have adopted policy statements declaring youth violence to be not just a social or judicial concern, rather a public health issue that should be addressed by physicians.^{5–8} Additionally, a task force which included representatives from the Centers for Disease Control and Prevention (CDC), the American Medical Association (AMA), and youth violence experts established core competencies for health professionals in addressing youth violence, including expertise in history-taking, risk assessments, and effective counseling and referral.⁹ Despite the support of prominent, national public health and medical organizations and the high prevalence of violence in the lives of adolescents, violence screening and counseling by pediatricians remain low.¹⁰ A small body of literature of youth violence interventions in primary care clinics has demonstrated success,^{11–14} such interventions have not been widely studied or implemented, and brief interventions to reduce violence have been successful in the emergency department.

A paucity of research exists examining adolescent perspectives of youth violence as a health issue.^{15,16} A better understanding of patient perspectives could improve screening and inform intervention design. In this study, we aimed to describe adolescent perspectives on youth violence as a health issue, and to understand adolescents' perceived barriers and facilitators to discussing violence in the primary care setting.

METHODS

Participant Recruitment

Participants were recruited by word of mouth with the assistance of youth coordinators from the Institute for the Study and Practice of Nonviolence (ISPN), a non-profit violence prevention organization in Providence. Focus groups were held at "Rec Night," a weekly open gym session led by ISPN staff, or at the ISPN organization building. These venues were chosen as convenient community locations known to prospective participants. Participants received \$20 gift cards. Youth under 18 required written parental consent and signed assent, and those 18 years and older gave informed consent prior to participation. The study was approved by the Lifespan Institutional Review Board.

Data Collection

We conducted five focus groups ranging in size from 3–10 youth between the ages of 12–24. Focus groups were led by 3 of the study investigators (AR, AGF, and NF). Focus group leaders underwent training with a cultural anthropologist (BO) experienced in focus group methodology and

qualitative research. Confidentiality was discussed at the start of each focus group and verbal acknowledgment of understanding and agreement was obtained. Participant safety was addressed in the following ways: the ISPN staff members, with explicit knowledge of gang activity and conflict, observed the group composition and could intervene if necessary, and a clinical social worker was on call for each session in the event of acute participant distress or disclosure of mandated reportable events. Focus groups followed an open-ended question format and lasted approximately one hour. The number of focus groups was determined by feasibility and repetition of themes.

Data Analysis

Participant responses were audiotaped and hand-annotated by investigators. Audiotapes were transcribed verbatim, and field notes were used for comparison and supplementation of thematic analysis. Transcripts were iteratively reviewed by all five investigators to identify recurrent narrative themes. Coding by identified narrative themes was checked and approved for concordance by each investigator.

RESULTS

Participant Characteristics

A total of 28 adolescents and young adults between the ages of 12-24 participated in the study, with 33% (n=9) of participants under age 18. The study population was 33% female (n=9). Breakdown by participant self-identified race/ethnicity was 86% Hispanic or African-American (n=24), 7% Laotian (n=2), and 7% Non-Hispanic white (n=2). All participants had personal experience with violence or close contacts affected by violence. Many had visited emergency rooms for shootings, stabbings, or assaults.

Violence plays a large role in youth's health, well-being, and behavior choices

Violence was described as commonplace in the daily lives of focus group participants. Many youth shared stories about witnessing, participating in, or being the victim of assault. Often they described violence escalating beyond verbal and physical fighting to the use of firearms with the intent to injure or kill. Throughout the discussions, participants expressed a common theme of the inevitability of violence in their community; simply avoiding or walking away was not a realistic possibility. Consequences on psychological wellbeing were expressed by a shared sentiment of worry. Youth described a need for constant vigilance to avoid violent situations, in areas including their neighborhoods, schools, and even their homes and backyards. Constant fear of victimization limited social interaction for many youth, fostering isolation in an effort to avoid conflict. Despite the ubiquity of violence in our participants' lives and its effects on their lifestyle, mental and physical health, participants all agree that they rarely discuss this part of their lives with their primary care providers. [See Table 1]

Table 1. Common themes and quotes from focus group participants

Violence plays a large role in youth's health, well-being, and behavior choices
When you think nothing's going to happen, that's when stuff happens. Me and my cousin walk here and back...just to play ball. We were playing around the whole way, but at the same time we're alert.
You shoot at me, ...my mind's just flipping over. I'm going to stop going to church, and stop going to these houses.
You can't go nowhere.
Youth do not inherently trust physicians
I don't trust nobody, so I definitely don't trust my doctor, because everything I say my mom seems to know.
When you only have a couple bruises I don't think you should tell them because they'll just make a little joke about it with their other doctors, and I don't think you want them to do that because that makes you feel like you're a joke to them.
I wouldn't even tell them I got beat up or jumped or whatever. I'd just be like, yeah I fell...I don't ask you about your personal life, don't ask me.
I don't really, like, know him like that, so I don't know if I could trust him with certain things....He's like my physical doctor, but sometimes he talks to me like a psychiatrist. I don't really know if I could tell him personal stuff.
I trust my doctor because he's been taking care of me since I was, like, two.
Yes, he tells me personal questions that I don't like to answer, but I got to know him in time then, yeah, I started sharing. It kind of feels strange at first, but once you start going to your doctor you get used to [it]....It took a while..., like 4 years.
That's like a bond that you make with somebody,...after you've known them for a couple years already,...and you know all their family....You got to know how they live, know who they are.
Physicians do not ask about violence
My doctor really doesn't care.
They don't ask.
Cause they don't ask. If they got engaged in a conversation like this then maybe, yeah, I'd tell them.
Yeah, I mean some doctors care; some doctors, like, they care for your well-being, but some doctors, they just there to do their job. They just care about getting paid, so they could care less for asking you.
[Doctors] don't do nothing to help us. Don't ask me if you're not going to help me.
Youth have mixed feelings on how physicians could help them with the violence in their lives
They're not trained in how to deal with this stuff...They could be trained.
Don't rush into it. Take your time when you ask things like that....Um, just ask comfortable questions then, I mean, start getting a little deeper in.
Some people get touched by words easier than other people, so maybe you just change some person's mind about something if you just happened to be talking about it.
Maybe if they got together and did something, seeing that they are the people who can save us, who can help us. Because at the end of the day they gotta help us. Without the doctors we're gonna die. So maybe if they got together and did something...
Teach the public, go on the news.
I think it would be a good message to send the younger kids that come up into the next generation, so that they know that they shouldn't do it.

Youth do not inherently trust physicians

Participants were divided on whether they could trust physicians. Some mistrust resulted from specific experiences with physicians. One youth explained, "I don't trust my doctor. I asked for condoms and she said no. I don't trust her at all." Others felt that physicians would share their personal information with their parents or other doctors. One participant felt he would become the source of office gossip. Many felt that their experiences with violence were too personal to tell a physician.

Youth identified a longitudinal relationship as critical in the development of trust. They also noted that trust developed not only from knowing an individual for a long period of time but also by having a long-term relationship with his or her family. Many participants reported no continuity relationship with their provider. They described seeing different doctors each visit, and seeing physicians infrequently. One observed, "Your doctor's only on the side of you for one day, for only like, what, a half hour? And then send you off right back to the street."

Physicians do not ask about violence

A majority of participants reported that their physicians did not ask them about violence. Statements such as "They don't ask" and "My doctor really doesn't care" were common. The few exceptions revealed that some physicians would ask about violence, but only in the context of presentation for some resulting physical injury.

One time when I got jumped...[The doctor] brought it up, so I had to talk to him about it. He said, 'You got to stay away from violence, 'cause this will happen and you'll die or get hurt. Next time don't do that again.'

Participants were clear that they would be unlikely to bring up violence as a health concern to their physicians due to the personal nature of the subject. However, they commonly cited physicians not asking as the main reason, and said that if they felt engaged, they would talk about the subject.

Youth have mixed feelings about how physicians could help them with violence

Overall, youth reported being very selective about whom they will talk to about the violence in their lives. Many felt violence is not a health issue beyond physical injury. Several youth believed physicians simply do not care about the violence in their lives.

Beyond this perception of physician indifference, youth were skeptical of the ability of physicians to help them cope with violence and its ramifications. Some felt there was little that a physician could do, and therefore they should not ask in the clinical setting. They also felt that physicians were not trained in this area, but felt that having a physician trained in youth violence prevention and treatment of its sequelae might be helpful.

Focus group participants emphasized the value of a strong patient-doctor relationship when asked about advice for facilitating a discussion about violence. Several shared their view that a physician could approach the subject in a non-judgmental way spanning multiple visits to allow the teen to feel comfortable.

Participants recognized the social and emotional impact of violence on their mental well-being. Several thought the subject of interpersonal violence was the purview of behavioral health providers, and that primary care physician should focus on physical health. Other youth thought physicians could help, particularly in serving as a trusted adult to talk to, and as someone who could arrange services to address the mental health needs of youth exposed to violence.

Multiple participants felt that primary care physicians could effectively help patients address violence in their lives, both on individual and community levels. Many recognized potential for prevention if physicians actively discussed avoidance of gangs during visits with younger children. They also acknowledged the power physicians have to educate the community on violence as a health problem. They hypothesized that if physicians truly united and spoke up on this issue, their voices would be heard.

DISCUSSION

While many medical organizations have put forth policy statements on addressing youth violence, adolescents participating in our focus groups often regarded it as a "personal" rather than a health issue and did not necessarily trust their physician enough to disclose involvement. Youth questioned whether talking to their primary care physician about violence would have any effect on their well-being, although conceded that a caring interested provider could assist in coping and obtaining of mental health services.

Our work expands on prior research by Johnson,¹⁵ which explored adolescent perspectives on violence, including to whom they could turn for help. While street-wise role models were the main confidants cited, adolescents also noted willingness to discuss with primary care providers, if that was someone who knew them and showed them respect. An emergency department visit has been shown to be a "teachable moment" for youth violence prevention; however, adolescents may be uncomfortable in this setting.^{16,17}

The AAP urge pediatricians to inquire about violence and gun exposure starting in infancy and continuing through adolescence, in order to prompt discussion, parenting advice, and intervention.⁵ Engaging in these conversations may build relationships with youth, paving the way for future disclosures, and change current norms regarding the acceptability of youth violence discussions in the primary care setting.¹⁸ While not commonly incorporated, inclusion of youth violence on pre-visit risk behavior questionnaires can prompt discussions during primary care visits and were rated as favorable by adolescents and providers. At the same time, adolescents' reluctance to discuss this topic should be considered, and the effects of these conversations should be evaluated.

Our findings should be interpreted in the context of the limitations of this study. The participants were predominantly non-white older adolescent males with significant exposure to youth violence and some level of affiliation with a community-based violence prevention organization. While our findings may not be generalizable to adolescents of all ages or to other settings, we believe our study sample is likely representative of the population most at risk of

violence: young minority men in inner city neighborhoods. Limitations in focus group methodology also exist. While most participants appeared candid in the discussions, some may have held back for fear of “disrespecting” other group members or offending moderators. Finally, focus group moderators were the same study investigators who analyzed focus group transcripts to identify themes. Although thematic identification and analysis was reached by consensus among the investigators, there were no independent evaluators other than the cultural anthropologist who served in a training and advisory capacity.

CONCLUSIONS

In addition to physician lack of inquiry, youth barriers exist to the discussion of youth violence in the primary care setting. Youth articulate reluctance to disclose information for reasons of mistrust, discomfort, and the personal nature of the topic, however express willingness if engaged by compassionate, inquiring physician with whom they have a relationship.

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