Many children experience abuse, neglect, and other forms of violence, jeopardizing their physical and emotional health and their social and cognitive development. The study by Finkelhor and colleagues characterizes children and youth evaluated medically following their experience of some type of violence. The nationally representative sample consisted of 8503 children and youth aged 2 to 17 from 2 surveys conducted in 2011 and 2014. Caregivers responded via telephone interviews for children aged 9 years or younger regarding possible exposure to violence, other adversities, and trauma symptoms; the youth aged 10 years and older reported on themselves. There were follow-up probes regarding injury and medical treatment for those with any of the 16 types of violence. As many as 5187 were reported to have been exposed to violence; 3.4% had had a medical visit related to the experience, 1.9% in the past year. Those with a recent medical visit had more trauma symptoms and faced more adversities including multiple types of violence compared with those who experienced violence but without a medical visit. The authors point to the opportunities for medical professionals to identify the source of an injury, to help address the needs of children and youth exposed to violence, and to prevent further problems.

This study by Finkelhor et al adds attention to the enormity of how many children experience some form of violence. The 1.9% with recent medical care related to their experience translated to approximately 1.4 million children and youth with such visits in 1 year. Clearly, medical and other professionals need to be acutely aware of the challenges facing too many children and families. There is a need to be mindful of violence as a possible cause or contributor to children’s varied presenting symptoms and signs, particularly physical injuries. As stated by the authors, violence may not be disclosed in the history provided. In addition, when a child is injured due to possible physical abuse, evaluation of other children in the home is good practice to ensure their well-being and safety.

The authors point to other potential roles health care professionals can play to help address violence experienced by children and youth, including probing safety at home, at school, and in the neighborhood, assessing emotion dysregulation and parent-child relationships, and facilitating skills training to prevent further exposure to violence. These are laudable goals that extend well beyond a stopgap approach; yet, there are important questions as to whether medical professionals and systems are adequately equipped to play this expanded role, some of which the authors acknowledge. Beginning with medical education and training, relatively little attention is typically devoted to topics such as bullying, sexual assault, or assessing family relationships. Increased and creative efforts are needed to help medical professionals be competent and comfortable addressing such issues.

There are also the constraints on practice, particularly time pressures and the often limited availability of resources, such as integrated behavioral health. In both emergency departments and primary care practices, there is a need, perhaps partly self-imposed, to work as quickly and efficiently as possible. This context inhibits broadening the scope of work to include issues such as probing family relationships or a child’s school environment. An encouraging development, however, is the increasing appreciation of the need for integrated behavioral health and the value of physician extenders. Embedded care management is also valuable in facilitating help. Such team-based care offers good opportunities to provide more comprehensive care and help tackle the problems raised by Finkelhor et al.

There are clear financial implications associated with a broadened scope of work, particularly regarding additional staff. The traditional fee-for-service model in the US is unhelpful. However,
there is another encouraging development in the trend toward fee-for-value reimbursement, with
the incentive to maintain patients' health. New approaches to value-based care include incentives
for quality and cost control, shared risk and reward, as well as fully capitated payments with integral
quality metrics. Some payers or health systems use addressing adverse childhood experiences
(ACEs) or social determinants of health (SDH) as a quality metric or as an end in and of itself. Another
possibility is rethinking the content of primary care visits to prioritize issues that are especially
important for many children and families.

Addressing the adversities and other experiences of violence described in this study by
Finkelhor et al1 raises the questions of the availability of community resources and to what extent
they implement evidence-based interventions. For example, although there are well studied medical
health treatments for traumatized youth, such as cognitive behavioral therapy, medical professionals
need to be cognizant of the nature and quality of community resources. For bullying, the most
common trigger of medical visits in this study, evidence-based interventions exist but may not be
locally implemented. Furthermore, an array of possible logistical barriers may impede engagement in
services. In this regard, motivational interviewing, a recent advance in health care, should be a helpful
approach. Instead of the health professional simply instructing the patient or parent on what to do,
there is recognition of the need for a partnership. The approach begins by soliciting the patient’s
and/or parent’s own view of an issue and how they wish to address it. In this way, they feel as though
they own the plan, making adherence more likely.

Finally, the wide prevalence of children and youth being exposed to violence raises the question
as to underlying root causes. What explains the so-called normalcy of bullying or violent
neighborhoods? Despite an incomplete understanding, there is ample knowledge to apply to policies
and programs to help prevent or at least mitigate the immense harm violence inflicts upon too many
children and youth. One example is the Safe Environment for Every Kid (SEEK) model, helping
primary care professionals identify and address SDH and ACEs that are also risk factors for child
maltreatment. Another illustration is the recent federal legislation to expand the Earned Income Tax
Credit program; if sustained, it promises to substantially reduce the number of children living in
poverty. In sum, medical professionals working with colleagues and other community professionals
can make a valuable difference in the lives of violence-exposed children and their families. They are
also well positioned to be feisty advocates for better policies and programs to help address
underlying and systemic contributors to these problems.

ARTICLE INFORMATION
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REFERENCES
1. Finkelhor D, Turner H, LaSelva D. Medical treatment following violence exposure in a national sample of children
students’ knowledge of social determinants of health and confidence in working with underserved populations.
