Correlates of Community Violence Exposure in Hospitalized Adolescents

Dwain C. Fehon, Carlos M. Grilo, and Deborah S. Lipschitz

To examine psychological and behavioral correlates of community violence exposure in psychiatrically hospitalized adolescents, 89 inpatients were administered a battery of psychometrically well-established self-report instruments. Violence exposure was assessed using the Child's Exposure to Violence Checklist (CEVC). Half of the patients reported exposure to multiple incidents violence in their community (52%) and home (53%). Sixty-one percent were victims of physical assault, and 39% were victims of sexual assault. Patients who had witnessed community violence reported significantly more post-traumatic stress disorder (PTSD) symptoms, drug use, and violence potential than patients without a history of witnessing community violence. Patients exposed to community violence were also more likely to be the victim of childhood maltreatment, as well as a perpetrator of violence. In conclusion, traumatization via exposure to community violence may serve as one important determinant in the development of mixed internalizing and externalizing psychopathology in adolescent inpatients, thus necessitating accurate assessment and treatment planning.
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THE PROBLEM of youth violence in the United States has been identified as a major public health issue.[1] Adolescents are increasingly involved, either as witness, victim, or perpetrator, in a range of violent acts within their homes, schools, and communities.[2] One area of increased concern is the high rate at which children and adolescents are witness and victim to violence in their community.[3-5] Estimates of having directly witnessed serious community violence such as a robbery, stabbing, shooting, and/or murder range between 60% and 75% for urban and suburban adolescents.[6-9] Similarly, in a national survey of 10- to 16-year-olds, 40% reported being the direct victim of either a physical or sexual assault at some point in their lifetime, with girls more likely the victim of a sexual assault and boys more likely the victim of an aggravated physical assault.[10] Childhood maltreatment (i.e., physical and sexual abuse) is also a prevalent form of violence against America's young people.[11] Sexual abuse, for example, is thought to occur to approximately 20% to 30% of all children.[12]

Given the high rate of violence to which children and adolescents are exposed, youth are increasingly forced to accommodate in their psychological development to chronic threat and lack of safety.[13] Not surprisingly, researchers have found strong links between violence exposure and depression,[14] post-traumatic stress symptoms,[15] childhood maltreatment,[16] family conflicts,[17] and a range of externalizing behaviors[18] including substance abuse, aggression, and delinquency for children and adolescents.

Adolescents referred for inpatient psychiatric treatment frequently report a wide range of behavioral and psychological problems and are assumed to have high base-rates of childhood trauma and violence exposure relative to nonpsychiatric, community samples of adolescents. Similarly, adolescents are increasingly referred for inpatient treatment due to their potential dangerousness to others. As such, violent behavior is a common feature among hospitalized adolescents and is an area of primary focus in treatment planning.[19] Despite the scope of this problem, few studies have actually documented the frequency with which inpatient adolescents actually report histories of violence exposure. In addition, most clinicians that work with adolescents do not inquire about the extent to which their patients are exposed to community violence. Rather, clinicians tend to be more aware of and sensitive to the types of violence and problems that children experience within their homes or schools. This omission becomes increasingly important given the likely frequency with which patients seen in clinical settings have experienced violence in their community. The potential cycle of

From the Yale-New Haven Psychiatric Hospital, the National Center for Posttraumatic Stress Disorder, the Connecticut Veteran's Affairs Medical Center, and the Department of Psychiatry, Yale University School of Medicine, New Haven, CT.

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Address reprint requests to Dwain C. Fehon, Psy.D., Yale-New Haven Psychiatric Hospital, 20 York St, New Haven, CT 06504.

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violence—from witness to victim to perpetrator—deserves careful clinical exploration. A better understanding of the impact of violence exposure on youth receiving treatment for psychiatric disorder may ultimately aid in their case conceptualization, treatment planning, and prevention efforts designed to address violence.

In the present study, we attempt to better understand the association between violence exposure and psychopathology in psychiatrically hospitalized adolescents. As such, we compared inpatients with a self-reported history of community violence exposure to a relative comparison group of inpatients with no history of community violence exposure on a range of prominent psychological and behavioral domains. The relationship between community violence exposure and violence victimization and violence perpetration was also examined.

We hypothesized that community violence exposure would be a prevalent problem, and that patients exposed to community violence would report higher levels of general psychopathology than patients not exposed to community violence. Lastly, we hypothesized that community violence exposure would be associated with violence perpetration.

METHOD

Subjects

Subjects for this study were a nearly consecutive series of 89 adolescents admitted to a short-term, inpatient adolescent unit of a private, university-affiliated, urban, psychiatric hospital. Adolescents were admitted to this unit based on their clinical need for inpatient care—typically acute suicidality or dangerousness to others. At the time of admission, all subjects and their parents (or legal guardians) provided written informed consent for evaluation.

Patients were between the ages of 12 and 18 years (mean, 15.5 years). Fifty-one (57%) were female and 38 (43%) were male. Sixty-four (72%) were Caucasian, 14 (16%) were Hispanic, and 11 (12%) were African-American. Patients were predominantly middle and lower-middle class, with roughly 40% of patient's hospital costs paid for by Medicaid.

Excluded from this study were patients whose cognitive status (e.g., mental retardation) or psychiatric condition (e.g., acute psychosis) prevented them from completing a standard self-report psychological assessment battery.

Procedures

Within 1 to 4 days of admission, each patient was administered a standard battery of self-report psychological assessments as part of their overall hospital evaluation. The assessments were computer administered and scored, and served to provide clinical data to the treatment team working with each patient. The assessment battery included 11 well-established measures of psychopathology, substance abuse, trauma, and childhood maltreatment. Exposure to violence was assessed using the Child's Exposure to Violence Checklist (CEVC).[20] Six categories of self-reported violence exposure were identified based on patient's responses to individual CEVC items. The six categories are as follows: (1) witness to community violence, (2) witness to family violence, (3) victim of physical assault, (4) victim of sexual assault, (5) perpetrator of physical assault, and (6) perpetrator of sexual assault. Subsequent identification of patients with and without a history of community violence exposure was made based on whether or not patients had ever witnessed someone threatened with a knife or gun, or witnessed an actual stabbing, shooting, or homicide.

Measures

Trauma- and Violence-Related

Child's Exposure to Violence Checklist. The CEVC[20] is a 33-item, self-report checklist that assesses levels of witnessing violence and other victimization by children and adolescents. The checklist is adapted from the measure, *Things I've Seen and Heard*[21] and contains items of different types of violence that is heard about, witnessed, or experienced. Examples of the types of violence subjects are asked to rate are shootings, stabbings, sexual assault, muggings, drug deals, arrests, and murders. Also included are items involving being a victim of physical and/or sexual assault, and being a perpetrator of physical and/or sexual assault. Responses are typically coded on a 5-point Likert-type scale ranging from "never" to "more than 10 times." For the purpose of this study, scoring criteria were modified to a scale of 0 to 2 (0 = no exposure, 1 = happened once, 2 = happened more than once).

Psychometric information about this survey is limited. However, we analyzed the internal consistency and test-retest reliability of the CECV and found good internal consistency, with coefficient alphas ranging from .51 to .90 for each violence category. One-week test-retest reliabilities were also performed using a subgroup of 31 inpatients. Kappa coefficients for agreement ranged from .47 to .85 for the different categories of violence.[22] We also note that previous literature has shown that psychiatrically hospitalized adolescents' self-reports of maltreatment experiences concur well with best estimate sources consisting of data from police reports, medical records, child protective services, and clinician reports.[23]

Childhood Trauma Questionnaire. The CTQ[24] is 28-item, self-report inventory designed to assess three domains of childhood abuse (sexual, physical, and emotional), and two domains of childhood neglect (physical and emotional). Items are rated on a 5-point Likert-type scale with responses ranging from "never true" to "very often true." Cut-off scores exist for each of the five categories and have been shown to have excellent sensitivity and specificity in correctly classifying cases of abuse and neglect in adolescent psychiatric patients.[25]

Child Post-Traumatic Stress Checklist. The PTSD Checklist[26] is a 28-item scale that asks subjects to rate the degree to which each of the 17 symptoms of PTSD was present during the past month. This scale is derived from DSM-IV[27] criteria and uses a 4-point Likert-type scale to establish symptom severity. The checklist can be used to generate a symptom-based diag-

nosis of PTSD based on three possible thresholds (i.e., symptoms present "some of the time," "most of the time," or "all of the time"). The PTSD Checklist yields an overall score and three composite scores reflecting the primary classes of PTSD symptoms (re-experiencing, hypervigilance, and avoidance). For the purpose of this study, patients were asked to respond to the PTSD checklist based on the most difficult or upsetting event endorsed on the CEVC. Concurrent validity of the PTSD Checklist was established by comparing diagnoses generated by the checklist to those obtained on a semistructured interview for PTSD, the Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA).[28] The mean intensity rating across the 17 items on the CAPS-CA showed a correlation of .64 with the child PTSD Checklist.[29]

Adolescent Dissociative Experiences Scale. The A-DES[30] is a 30-item, self-administered questionnaire that asks respondents to indicate the frequency with which certain specific dissociative or depersonalization experiences occur. The A-DES uses an 11-point Likert-type scale ranging from 0, labeled as "never," to 10, labeled as "always." The total A-DES score is equal to the mean of all item scores. The instrument has high test-retest reliability, excellent split-half reliability, and good criterion-referenced validity for an adolescent population.[30]

Depression-Related

Beck Depression Inventory. The BDI[31,32] is well known, and widely used 21-item self-report inventory of the cognitive, affective, motivational, and somatic symptoms of depression. It has been researched extensively and been shown to have excellent psychometric properties.[33]

Hopelessness Scale for Children. The HSC[34] is a 17-item true/false scale for children and adolescents that taps negative expectations about the future. Internal consistencies of .97 and test-retest reliability of .52 have been reported.[34]

Suicide Risk Scale. The SRS[35] is a 15-item true/false self-report measure that deals with feelings of depression and hopelessness, present suicidal feelings, past suicidal behavior, and other items that have been shown to be associated with suicide risk. The instrument has good internal reliability with a coefficient alpha of .74 with adolescents, as well as good sensitivity and specificity. The SRS has also been cross validated with other inpatient samples, and has been shown to discriminate between groups of patients who have made a suicide attempt in the past and those who have never made such an attempt.[36]

Aggression and Impulsivity

Impulsivity Control Scale. Designed to assess impulsivity that is independent of aggressive behavior, the ICS[36] is a 15-item, self-report scale where items are answered on a 3-point frequency scale. With adolescents the ICS has good internal reliability, and correlates well with other measures of suicide and violence risk.

Past Feelings and Acts of Violence Scale. The PFAV[37] is a 12-item, self-report scale where responses are coded on a three-point continuum of frequency. The scale inquires about the frequency of feelings of anger, past acts of violence toward others, use of weapons, and history of arrests. The scale has been demonstrated to have good discriminative validity with adult psychiatric inpatients, and with adolescents has been shown to have good internal consistency, item sensitivity and specificity.

Drug- and Alcohol-Related

Adolescent Alcohol Involvement Scale. The AAIS[38] is a 14-item, self-report screening measure for alcohol abuse relevant for adolescent populations. The measure identifies adolescents whose alcohol use interferes with psychological, social, and family functioning. The AAIS has demonstrated good psychometric properties in adolescent samples, including excellent test-retest reliability in clinical and nonclinical samples (.91 and .89) and positive discriminative power for distinguishing alcohol abusers from infrequent users using a cut-off score of 42.[38,39]

Drug Abuse Screening Test-Adolescents. The DAST-A[40] is a 27-item, self-report scale based on the original adult version[41] intended to help identify adolescents who are struggling with drug-related problems. The DAST-A has been found to have good psychometric properties in an adolescent inpatient sample with a coefficient alpha of .91 and a test-retest reliability of .89. The DAST-A also has excellent concurrent and predictive validity with a positive predictor power of .79.[40]

Statistical Analysis

Statistical analysis involved first obtaining the self-reported frequency of violence exposure for each of the six violence categories.

Second, chi-square analyses were performed and phi coefficients were calculated to determine the strength of association between each violence category. The phi statistic is an effect-size measure for contingency table analyses that reflects the strength of association between specific domains.[42]

Third, using t tests for independent samples, inpatients who reported a history of community violence exposure were compared to a relative comparison group of inpatients who reported no history of violence exposure on a range of psychological and behavioral domains tapping depression, trauma, substance abuse, and impulsivity/aggression.

Lastly, using the eta statistic, we determined the strength of association between the CECV community violence exposure groups with each measure of psychopathology. The eta statistic is used when one variable is categorical (e.g., violence exposure) and the other is quantitative (e.g., self-report instruments). Eta is a measure of association that reflects the proportion of variance in the dependent variable that is explained by differences among groups. A low eta value suggests that the two variables are distinct, and a high eta value suggests that the two values are associated.

Because of the relatively large number of comparisons performed in his study, we chose to report only those findings significant at the $P < .01$ level.

RESULTS

Table 1 shows the percentage of patients who reported being the witness, victim, or perpetrator of violence. Half of this sample (52%) reported experiencing one or more episodes of serious violence within their community. Seeing someone be-

Table 1. Distribution of Adolescent Inpatients Who Report Having Been a Witness, Victim, and/or Perpetrator of Violence (N = 89)

	Frequency (%)		
	Never	Once	More Than Once
Witness community violence			
Beating	11 (12.4)	11 (12.4)	67 (75.3)
Threat with knife	51 (57.3)	13 (14.6)	24 (27.0)
Stabbing	55 (61.8)	10 (11.2)	24 (27.0)
Threat with gun	57 (64.0)	11 (12.4)	21 (23.6)
Shooting	60 (67.4)	10 (11.2)	19 (21.3)
Homicide	68 (76.4)	14 (15.7)	7 (7.9)
Any community violence exposure	43 (49.3)	46 (51.7)	
Witness family violence			
Gun in home	55 (61.8)	10 (11.2)	24 (27.0)
Grown-ups hitting	65 (73.0)	2 (2.2)	22 (24.7)
Shooting/stabbing in home	76 (85.4)	7 (7.9)	6 (6.7)
Any family violence exposure	42 (47.2)	47 (52.8)	
Victim physical assault			
Threatened with homicide	48 (53.9)	18 (20.2)	23 (25.8)
Physically beaten up	54 (60.7)	14 (15.7)	21 (23.6)
Threatened stabbing/shooting	57 (64.0)	10 (11.2)	22 (24.7)
Shot or stabbed	78 (87.6)	6 (6.7)	5 (5.6)
Any physical victimization	35 (39.3)	54 (60.7)	
Victim sexual assault			
Inappropriate touch/kiss	56 (62.9)	10 (11.2)	23 (25.8)
Forced genital contact	63 (70.8)	11 (12.4)	15 (16.9)
Any sexual victimization	54 (60.7)	35 (39.3)	
Perpetrator physical assault			
Hurt someone really bad	56 (62.9)	15 (16.9)	18 (20.2)
Assault with weapon	59 (66.3)	13 (14.6)	17 (19.1)
Any physical assault perpetration	50 (56.2)	39 (43.8)	
Perpetrator sexual assault			
Forced genital contact	82 (92.1)	4 (4.5)	3 (3.4)
Any sexual assault perpetration	82 (92.1)	7 (7.9)	

ing beaten up was the most frequently observed form of community violence, with 88% reporting seeing one or more episodes. Unlike other events reported, witnessing someone being beaten up is a frequent occurrence among adolescents in general and could be a regarded normative adolescent event. Because this type of violence exposure is so common, this item was removed from the remaining analyses and not used to define our witness to community violence group. We show it here merely to note its frequency of occurrence. The remaining items reflect the types of community violence that are out of the range of normal experiences. Of these, seeing someone pull a knife on another person was the next most frequently observed form of serious community violence (43%), followed by witnessing a stabbing (38%), and seeing someone threatened with a gun (36%). Importantly, 23% of the patients reported having witnessed a homicide.

Instances of family violence were observed by 53% of the patients in this sample. Importantly, 38% reported having seen a gun in their home on at least one occasion.

Being the direct victim of violence was reported by 61% of the patients—46% were threatened with homicide at least once, 39% had been beaten up, and 36% had been threatened with a weapon. Twelve percent of the patients reported being shot or stabbed at least once.

Thirty-nine percent of the patients reported being the victim of sexual assault, and 8% reported

Table 2. Intercorrelation of Violence Witness, Victim, and Perpetrator Domains for Adolescent Inpatients (N = 89)

	Community Violence Witness	Family Violence Witness	Physical Assault Victim	Sexual Assault Victim	Physical Assault Perpetrator	Sexual Assault Perpetrator
Community violence witness	—					
Family violence witness	.53†	—				
Physical assault victim	.51†	.34*	—			
Sexual assault victim	.23	.25	.32*	—		
Physical assault perpetrator	.49†	.38†	.53†	.12	—	
Sexual assault perpetrator	.28*	.28*	.24	.28*	.16	—

NOTE. Data reflect phi coefficient.
* $P < .01$.
† $P < .001$.

having perpetrated at least one instance of sexual assault. Compared to the 61% of patients who reported being the victim of physical assault, 44% reported having perpetrated a physical assault. Importantly, 33% of the patients reported using a weapon as a means of assault.

Table 2 shows the strength of association measured by phi correlations between each category of violence exposure. Significant associations were observed between nearly every category of violence exposure. Exposure to community violence was significantly associated with witnessing family violence, being a victim of physical assault, being a perpetrator of physical assault, and being a perpetrator of sexual assault. Significant associations were also observed between witnessing family violence and perpetrating a physical assault, being a physical assault victim, and perpetrating a sexual assault. Being a victim of physical violence was significantly associated with being a victim of sexual assault and a perpetrator of physical assault. Lastly, sexual assault victimization was significantly associated with sexual assault perpetration.

Table 3 compares the self-report symptom profiles for patients with and without a self-reported history of community violence exposure. There were no differences between patients with or without a history of community violence exposure with respect to age, gender, or ethnicity. Patients exposed to community violence reported significantly more symptoms of PTSD, had a greater violence potential, and more drug use than did patients without a history of community violence exposure. Patients who witnessed community violence also reported significantly more instances of childhood maltreatment than did patients without a history of community violence exposure. Similarly, patients' self-reported history of childhood trauma, and symptoms of PTSD, violence potential, and drug use showed a strong association with community violence exposure.

DISCUSSION

The findings of this study indicate that community violence exposure is a potentially prevalent problem for psychiatrically hospitalized adolescents that is associated with serious psychological and behavioral symptomatology. Inpatients exposed to community violence reported significantly more PTSD symptoms, drug-related problems, and greater violence potential than patients not exposed to community violence. Patients who witnessed community violence were also more likely to have been the victim of childhood maltreatment, as well as a perpetrator of violence toward others. These findings underscore the cycle of violence to which victimized children are at risk.

Table 3. Comparison of Self-Report Symptom Profiles for Inpatients With and Without a History of Community Violence Exposure (N = 89)

	No Exposure (n = 43) Mean ± SD	Exposure (n = 46) Mean ± SD	$F_{(1,87)}$	Eta
Depression	15.40 ± 12.10	21.15 ± 15.92	3.65	.20
Suicide risk	5.74 ± 3.50	6.85 ± 4.00	1.91	.15
Hopelessness	5.88 ± 4.51	6.72 ± 4.06	0.84	.10
Childhood trauma	37.70 ± 8.81	51.04 ± 15.78	23.81†	.46†
PTSD symptoms	20.30 ± 17.00	32.00 ± 20.85	8.35*	.30*
Dissociation	2.14 ± 2.01	2.96 ± 2.07	3.57	.20
Violence potential	5.53 ± 4.04	10.91 ± 5.62	26.55†	.48†
Impulsivity	16.74 ± 5.02	17.96 ± 6.26	1.01	.11
Drug use	4.40 ± 5.01	8.78 ± 6.89	11.65†	.34†
Alcohol use	28.77 ± 17.99	33.33 ± 19.58	1.30	.12

* $P < .01$.
† $P < .001$.

The overall rate of community violence exposure for this inpatient sample was comparable to rates found in the literature of community-based, primarily minority and urban-based, samples of children and adolescents.[3-9] Rates of violence victimization among inpatients however, were somewhat higher than those reported by adolescents in a recent large national survey[10] (61% *v* 40%, respectively). The relatively high rate of victimization among inpatients may perhaps reflect the serious negative psychological impact that violence victimization has had on these individuals.

Our finding of higher levels of PTSD symptoms is complicated by the high rate to which inpatients also reported histories of childhood maltreatment. Given the cross-sectional nature of this study, it is difficult to determine which factors, or combination of factors, were responsible for the development of PTSD-related symptoms. However, the association between the two forms of trauma remains strong. Longitudinal studies are needed to help identify the developmental sequence of specific trauma-related symptoms and the cumulative risks associated with violence exposure and childhood maltreatment.

Similarly, the relationship between violence exposure and aggression and violence potential is a complicated one. Social learning theory[43] provides a partial explanation for the high violence potential seen in patients who report witnessing violence. For example, numerous studies have demonstrated a link between observed violence, either through television or other media, and aggressive behavior in children and adolescents.[44] These studies have found that the relationship is an enduring one, in part due to the strength of vicarious social learning. As such the repeated exposure to community violence may lead to the development of beliefs that aggression and violence are normal acceptable responses, thereby increasing the adolescent's potential to act violently. However, on the other hand, it is also possible that some adolescents may be exposed to violence because they are involved in activities that put them at greater risk for violence exposure. Similarly, the families of some patients may self-select for living in violent communities on the basis of job, parent's own life experiences, or some other unrecognized family variable. This may also be true for inpatients that report drug-related problems. While one possible explanation for the increased drug-related difficulties among inpatients exposed to community violence is that drugs use may serve as a means for coping with unpredictable, chronic forms of threat and lack of safety. Another possible explanation is that the patient's drug use or drug-seeking behavior may place them in contexts where community violence is more prevalent—thus increasing their rate of exposure. Again, due to the cross-sectional and correlational nature of this study, we cannot infer the direction of effect. Longitudinal studies would help to clarify the temporal sequence which specific behavior patterns, such as aggression or drug use, occur.

While it is beyond the scope of this paper to resolve the type of "chicken and egg" dilemma caused by cross-sectional research designs, it is clearly evident that violence exposure, violence victimization, and violence perpetration are significantly associated with one another in this psychiatrically hospitalized sample of adolescents. The frequency with which these experiences co-occur for inpatients deserves careful clinical consideration and treatment planning. Similarly, the high percentage of patients who have access to firearms within their homes, and who have used weapons in an assault, is alarming-and should cause concern for those treating adolescents, considering the fact that most adolescents referred for inpatient hospitalization are the result of acute suicide or homicide risk.

Several strengths and limitations of this study are also worth noting. Our selection process resulted in a relatively large study group of psychiatrically hospitalized adolescents. The study group was nearly consecutive in nature with primarily gross psychotic or cognitively impaired patients resulting in exclusion. Thus, our sample is perhaps generalizable to other general adolescent inpatient facilities. Our two study groups (inpatients with and without a history of community violence exposure) were ascertained from the same overall sample, thus eliminating a variety of selection and sampling confounds.[45] Moreover, we note that the two study groups did not differ in important demographic features (i.e., age, gender, and ethnicity) or in regard to level of depression.

Our findings however, may be potentially limited by our reliance on patient self-report. The validity of self-reports in adolescents must be con-

sidered cautiously. A number of potential biases range from negative mood states to more interpersonal biases stemming from individual response styles. Conversely, it is arguable that self-report questionnaires may make disclosure of sensitive or embarrassing material easier for adolescents. Many of the instruments here have undergone previous psychometric and validity checks against other assessment methods, and computer administration methods have previously been empirically found to be useful for assessing sensitive topics such as depression and suicidality.[46,47] In addition, our reliance on self-report data as the sole means of data and clinical material limits the scope and understanding of our subjects as patients and as people. Future studies would benefit from including additional sources of patient data such as structured diagnostic interviews, life-event assessments, family history data, and psychophysiologic laboratory data. Finally, studies, which assess variables such as proximity to violence and severity of violence, are also needed to better understand the impact and violence exposure and the subsequent development of internalizing and externalizing psychopathology.

In conclusion, community violence exposure appears to be a potentially prevalent problem for psychiatrically hospitalized adolescents that is associated with serious psychological and behavioral symptomatology. We propose that violence exposure significantly increases one's risk for psychopathology and the development of aggressive behaviors among vulnerable, exposed youth. Specifically, traumatization via an exposure to community violence may serve as one important determinant in the development of mixed internalizing and externalizing psychopathology for some adolescents. It is also possible that, at least for some other cases, family variables or the presence of behavior disorder and substance abuse may increase risk taking behavior and the likelihood of being exposed to violence.

The extent to which inpatients report having been exposed to serious community violence as well as having been the direct victim and perpetrator of violence underscores the need for clinicians to thoroughly assess inpatients for violence exposure histories. Similarly, inpatient programs that treat adolescents should integrate methods of coping with community violence and trauma as part of an overall treatment plan.

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