

## **Children and Violence in the Acute Medical Setting: A Search for Theological Understanding, Ritual, and Blessing**

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**Abstract:** Pastoral counselors care for many children and families whose lives are touched by violence. The majority of these encounters are in an outpatient office setting, where medical and neurological injuries are not as apparent as are the emergent insults and life-threatening physical and psychiatric situations seen in the pediatric hospital setting. Through a series of vignettes, this piece describes acute medical and psychiatric manifestations of violence sustained by children and families in a variety of circumstances. Pastoral counselors often find such case illustrations helpful in understanding the acute or emergent manifestations of violence they may not see in their offices, especially for aggression related to childhood neuropsychiatric conditions. Some basic theological reflections for caregivers of children affected by violence are offered, in addition to recent statistics at childhood violence, and risk and protective factors. A contemporary ritual analogous the Shema (Deut. 6:4-9) is woven throughout the piece as a reminder of the sacred calling of those who work with these children and their families.

**Keywords:** children, families, violence, pastoral care, emergency and medical settings

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I am an academic child and adolescent psychiatrist who has spent nearly thirty years caring and teaching others to care for children, adolescents, and their families in pediatric hospitals. I am also theologically trained, and have served as a clergywoman in a variety of ecclesial and non-ecclesial settings. By virtue of dual vocations and experience, my perspectives on childhood violence, its consequences on victims and their families, and consequent implications for pastoral care are admittedly different than many of my colleagues in both medicine and pastoral theology. Daily I encounter perplexing medical situations that are best understood as theological quandaries, and dilemmas of faith that present or are evoked in the context of physical illness and its intrinsic vulnerabilities. Over the years, violence has become a much greater factor in pediatric and child psychiatric settings than those disciplines could have predicted. The same is true for the field of pastoral care, charged with tending the spiritual and emotional fall-out and sequelae that outlast bruises and broken bones.

In my “day job” as a consultation liaison child psychiatrist, I typically see ill and traumatized children and their families immediately after a critical injury or event, assess them to better identify and define key issues, and make accurate, appropriate diagnoses in the medical and psychiatric terms that inform other professionals of information they need to know as they render care. Just as important as assessment and diagnosis is understanding the child in the context of his or her family, school, and extended communities of support so that I can make the best referrals for ongoing medical, psychiatric, and – if indicated – spiritual care, and pass along critical information gleaned in the midst of the crisis to caregivers who will come to know and work with the child and family over time. I certainly include pastoral counselors as valued colleagues who continue to minister long term to many of the children I meet during the hours, days, and occasionally, weeks in the inpatient medical setting.

Over the years I have had many pastors, chaplains, pastoral counselors, seminarians, clinical pastoral education (C.P.E.) students and other trainees of many backgrounds and theological viewpoints join me for periods of observation as I see pediatric patients and assess them from a biopsychosocial perspective, all the while mindful of the larger, very important, pastoral underpinnings of their unique, individual presentations. Though this experience does not answer all theological questions or clarify all pastoral care goals and objectives, many guests have stated it reminds them that the child who eventually reaches their offices and worship settings likely has witnessed and experienced physical and emotional trauma that cannot be appreciated fully by the pastoral care clinician meeting them in a time and space removed from traumatic event(s). Observing a child and family in a hospital bed who have been affected by violence fills in a gap in the continuum of care that pastoral caregivers often do not get to see but should understand if they are to have the most complete picture of the child's lived experience. Whether a day spent on my rotation helps sharpen the pastoral lens or adds more gust to theodicy whirlwinds like those in the Book of Job depends upon the situation, the child, and the theologian trying to make sense of things. Regardless, these are some stories and reflections – psychiatric, epidemiologic, and theological – I have been invited to share.

### **A day in the life of a pediatric consultation psychiatrist**

I arrive at my office in the children's hospital around 7:30 AM, lock away my purse, and turn on my computer. At the top of my list of new email messages for the morning are daily e-news updates I subscribe to from various professional societies – the American Academy of Child and Adolescent Psychiatry, the American Academy of Pediatrics, the American Psychiatric Association, and the American Medical Association. Hmmm .... a few blurbs about

accountable care and maintenance of board certifications requirements. I am up to date on those, so what's next? Oh, more news about violence – interpersonal, guns, knives, child abuse, date rape, bullying, and aggression associated with psychiatric illness and traumatic brain injuries. I'm really saturated with that stuff. I know it's important to know about, but I went to medical school to practice medicine and to seminary to study scripture and pastoral theology. Trying to keep up with and integrate all of that is more than I can handle on any given day, so all the violence and trauma updates can wait. Besides, there's probably not much that has changed since what I read yesterday, so I'll just move these to the "violence and trauma" folder and refer to them later if I need them.

Now what is that email marked urgent with a red exclamation point and a message saying "return acknowledgment when read"? It can't be time to review my hospital privileges again, can it? Oh well, I guess so. I have a little time now before I make rounds, so let's see what they have added to the list of requirements and check offs since I went through this the last time. Surprisingly little new has been added, but I do need to watch those mandatory staff training videos and take those after tests again. Let's see how many I can knock out before I have to start rounds.

The first training video opens with a basic and familiar mantra: '**Clean in and clean out**' is required upon exit and entering patient room regardless of whether you touch the patient or the patient's environment. This promotes good habits, reassures our patients and prepares you for any unanticipated activity that arises after room entry."

Thus begins the learning module *Annual Infection Control for Physicians* that all doctors are required to view. They also must pass the associated post-test to acquire and maintain their privileges at my institution. The "clean in and clean out" protocol is such a basic, common sense

behavior that it has always struck me as part amusing and part tragic that medical professionals must be forced to watch such an elementary slideshow on the topic, under the threat of disciplinary action and financial penalty. After all, how many times a day, a week, a year, a career do we all touch the pump of the antiseptic container at the doorway of a patient's room before entering to cleanse our hands, then repeat the process of touch, pump, and scrub again at the antiseptic jar companion container as we leave the same space? "Touch, pump, and scrub", or "clean in and clean out" - regardless of what one calls it, it is the most commonly performed sacred medical ritual in healthcare.

This pause at every doorway brings to mind the *mezuzah*, a small case affixed at an angle on the doorposts of Jewish homes. Inside the mezuzah is the *Shema*, Deuteronomy 6:4-9:

Hear, O Israel: The Lord is our God, the Lord alone. You shall love the Lord your God with all your heart, and with all your soul, and with all your might. Keep these words that I am commanding you today in your heart, Recite them to your children and talk about them when you are at home and when you are away, when you lie down and when you rise. Bind them as a sign on your hand, fix them as an emblem on your forehead, and write them on the doorposts of your house and on your gates.

Hebrews were to touch the mezuzah every time they passed through their doorways to remind them of God's commandment in the Shema.

I am struck by the odd similarities of the mezuzah and "Clean in and clean out" rituals. Though instituted centuries apart for vastly different reasons, both are at every entry and entrance by those who adhere to their particular custom, and both are done in a spirit of obedience with a greater good in mind - either obedience to God or as a sign of dedication or devotion to the health and well-being of patients on the other side of a hospital room doorway.

And at the heart of the Shema is this instruction: “***Recite them to your children and talk about them when you are at home and when you are away.***” Indeed, the care and nurture of children is of the utmost importance to people of faith, especially pastoral counselors. In recent years, I have striven to combine these practices as a spiritual discipline for myself, using the act of “touch, pump, and scrub”, or “clean in and clean out”, as a reminder to silently ask God’s blessing on the children who dwell in the room I enter and leave as a physician priest.

***Clean in and clean out – the Lord bless you and keep you.***

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**Let’s get to work**

Whoops, time has gotten away from me. I pause the video so I can return to it later, grab my list of new consults, and meet my team on the wards. No, wait a minute, my pager is going off – it’s the Emergency Department (ED) number. The phones are always busy down there this time in the morning, so I’ll just save time and walk on over to the ED.

I hit the automatic door opener at the ED entrance and grab a seat at the nursing station. The pediatric ED attending physician and the ED charge nurse see me logging on to a computer to review the medical information for the patient I have been asked to see. The nurse says, “We’re starting early for you today, doc. And this one is really sad, too. She’s way too cute and too young to need you, but we’re seeing them younger and younger like this. She’s the kind of kid that makes me ask my husband if I can retire early.” I ask the attending pediatrician if this child needs admission to a pediatric medical bed. “No, her physical injuries don’t need hospitalization. But I don’t think you are going to say the same about her mental status.” I walk over to meet the patient.

I pump the antiseptic bottle at the doorway as I enter the room and rub my hands. ***Clean in and clean out – the Lord bless you and keep you.***

*Charlotte is a twelve year old brought in to the ED last night by the police. She ran away last week from the apartment she shares with her mother and her mother's abusive, alcoholic boyfriend. Police found her staggering in a dangerous part of the city at midnight, battered, bruised and raped by three young men to whom a friend on the streets had introduced her a few days before. During the pelvic and forensic examinations in the wee hours of the morning, she mentioned to the ED nurse that her life was over, she might as well kill herself. The ED ordered a nursing student to stay with Charlotte in the ED bay until I could evaluate her first thing after I arrived at the hospital.*

I introduce myself to Charlotte, a slight girl with thick wavy blonde hair, flawless skin, and sad gray eyes. Her mother is still her guardian. She should be on her way to the hospital now, but gave consent to the ED social worker over the phone so I can start my assessment, which in the clipped words of my charting reads like the outline to a tragic movie plot: "Abandoned by biological father, witness to mom's physical and emotional abuse by numerous men, left alone in a bedroom most weekends while mom entertained and used drugs in their apartment. Likes school and could probably get good grades if she tries, but no one else cares so why should she. Hears gunfire at night in her neighborhood, tried cigarettes for the first time when she was eight, has been smoking joints during the weekend and getting drunk on weekends for the last couple of years. No psychotic symptoms. Endorses all symptoms of depression, was going to kill herself a few weeks ago but 'chickened out'. Charlotte states that now that she's been raped, other people have just confirmed what she's known all along -- she's just a worthless whore and doesn't deserve to live. The question is not if she's going to kill herself, just when. If she goes back with her mom she knows where the pills and the knives are. Or she might walk out in the street in front of a truck. She just wants to die."

I give Charlotte the Axis I diagnoses of Major Depressive Disorder, Single Episode, Severe, without psychotic symptoms; Alcohol Abuse, rule out dependence; and Cannabis Abuse, rule out dependence. Further evaluation will be needed to determine if she meets criteria for post-traumatic stress disorder. The Diagnostic and Statistical Manual, the book of criteria used in the psychiatric diagnostic process, makes few distinctions between children and adults, especially in the areas of mood, substance use, and post-traumatic stress disorders. But the approach to a child injured, even damaged in situations beyond her control must be more than technically sound, informed by evidence-based practice, gentle, and compassionate – it must be pastoral, with *holy observation and holy listening*. This is even truer for the long term treatment of children affected by violence, treatment that is increasingly provided by pastoral counselors.

Charlotte's mother has arrived, I quickly confirm the main points of the history with her, and I need to head to the computer to complete the documentation. If I could, I'd really like to spend much more time with Charlotte and her mother, together and alone, to learn more about their lives, their loves, their relationships, their dreams, their strengths, what went wrong and when, and figure out long term strategies for treatment and care – body, mind, and spirit. Charlotte's life-story raises so many pressing theological questions. But this is a clear-cut inpatient psychiatric admission, and I have to get that process rolling and keep moving through my patient list.

I pump the antiseptic bottle at the doorway as I leave the room and rub my hands. *Clean in and clean out – the Lord bless you and keep you.*

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Next up is a child on the inpatient neurosurgery service, so I head back to the patient tower in the main part of the hospital. I pump the antiseptic bottle at the doorway as I enter the room and rub my hands. *Clean in and clean out – the Lord bless you and keep you.*

*Elijah is a six year old boy, one of a sibship of six children taken into the foster care system when his alcohol-, cannabis-, and cocaine- dependent parents were charged with neglecting and endangering their minor children. Elijah had always been aggressive with his siblings and peers in his Headstart program. However, due to the loving consistency of experienced foster parents, he had a good year in kindergarten, the aggression had faded almost totally away, and he was thriving academically. But shortly after he started first grade the aggression and irritability returned. He cried, felt remorseful, and said he did not want to hurt others, it just happened. Over the weekend he was brought to the hospital in status epilepticus. Head imaging studies revealed a large, cancerous tumor in the left front part of his brain.*

I had worked with the resident on the neurosurgery service before, so he knew the proper consent process and had already obtained permission from the county Department of Family and Children's Services for me to see Elijah. Before I could meet him however, I was pulled aside by the tearful foster mother. Even though the neurologists and neurosurgeons told her the tumor was not her fault and she could not have known he was ill before he had the seizure, she now felt so guilty about yelling at him for his recent aggression. He had broken a foster brother's nose two weeks ago and decapitated a rooster with a hoe spade. She should have known something was wrong, or at least different, because Elijah had really changed things around since he had come to live with her. He had become a good student, was helpful around the house, and was the most gentle with the chickens and milk cows of all the children she and her husband had ever fostered. How could God let this tumor happen to such a sweet boy who had already been

through so much abuse and neglect at the hands of his own biological parents? And what if he dies and the only happiness he's had is the months he's been with his foster family? Or even worse, what if he lives and the tumor turns him back into that mean, aggressive kid he was when they first took him into foster care?

I sit down by his bed to meet Elijah, a slender boy missing his two front teeth. He is groggy from medication, but not hallucinating, agitated, or delirious. I tell him I had stopped by briefly now to meet him before he goes to surgery. But I'll be back later and we'll become fairly well-acquainted during the time he's in the hospital after his operation. He gives me a high five, and says he knows he'll remember my name because his foster father has a Dell computer that he sometimes uses to play video games.

I speak with the neurosurgery nurse practitioner off to the side of the room away from Elijah. She has come in to help prepare Elijah and his foster mom for today's surgery. My provisional diagnosis is the very vague Mood Disorder Secondary to a General Medical Condition (brain mass). There are no indications for a psychotropic medication at this time, but I'll follow closely after surgery and throughout the hospitalization. We'll just have to see over time what effects the tumor and possible chemotherapy and radiation might have on his cognitive functioning, mood, and level of aggression.

I pump the antiseptic bottle at the doorway as I leave the room and rub my hands. *Clean in and clean out – the Lord bless you and keep you.*

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Next stop – the inpatient floor for general adolescent medical admissions.

I pump the antiseptic bottle at the next doorway as I enter the room and rub my hands. *Clean in and clean out – the Lord bless you and keep you.*

*Tom is a sixteen year old young man brought to the hospital ED after attacking the high school nurse and assistant principal with no known provocation. His parents are devastated not only by this incident, but by several other changes over the past year. Tom has gone from a straight-A, two sport athlete and disciplined musician to failing three subjects, skipping practices, and dropping band. He secludes himself in his room, will not shower for days on end, staring up at the ceiling and carryings on conversations with imaginary people. A week earlier, Tom shoved his brother down a flight of stairs because he thought the younger boy was selling Tom's trade secrets to the Taliban.*

Tom was sleeping when I arrived. But it was hard won sleep after severe agitation requiring five hospital security guards to keep him from attacking his nurse and parents after he was transferred to the inpatient psychiatry floor from the ED, plus an additional two nurses to give him an antipsychotic injection to target his acute psychotic symptoms. I meet with his beleaguered, devastated parents. The information they provide, including family history and the details of his recent functional decline, is consistent with the likelihood of a schizophrenic prodrome, or the general downward spiral of functioning in nearly all domains of life often seen in the several months to years before an adolescent or young adult meets full criteria for the diagnosis of the crippling psychotic disorder called schizophrenia. I tell them about the blood work and head imaging I am going to recommend to make sure there is not an underlying medical reason for Tom's mental status changes. However, assuming the head imaging and the lab studies return and do not reveal any significant medical issues, Tom will need to be transferred to the nearest adolescent inpatient psychiatry unit that accepts their insurance for treatment and stabilization of this acute psychotic illness. Tom's mother sobs into her husband's shoulder. His father just shakes his head, "I figured as much. We have to do what we have to do

to keep the rest of the family safe and to keep Tom safe from himself. He can't keep attacking us. This is all new to us but you've done this many times before. We're gonna have to trust you to help us to do the best we can for our son."

Tom's preliminary Axis I diagnosis is Psychotic Disorder Not Otherwise Specified, rule out Schizophreniform Disorder.

I pump the antiseptic bottle at the doorway as I leave the room and rub my hands. ***Clean in and clean out – the Lord bless you and keep you.***

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I check my list of new consults again. Next stop – the pediatric intensive care unit.

I pump the antiseptic bottle at the doorway as I enter the room and rub my hands. ***Clean in and clean out – the Lord bless you and keep you.***

*Allison is a 10 year old girl admitted to the pediatric intensive care unit after a life-threatening overdose of multiple over-the-counter medications she found in her mother's medicine cabinet. The overdose was bad enough, but the self-inflicted gunshot wound through the back of her mouth was the exclamation point to the suicide attempt. Miraculously, the bullet went through a tonsil and out the side of her neck, creating a bloody mess but missing vital structures. In the weeks leading up to the attempt, she had been teased and bullied mercilessly at school for being overweight. Instead of walking away and ignoring the teasing and shoving like she usually did, a few days ago Allison could not take the bullying anymore and punched one of her peers in the face and broke her nose. (Ouch! That's the second broken nose I've heard about today!) Allison became despondent when she was expelled from school, went home, and tried to kill herself.*

Allison's parents had been without sleep for at least 36 hours straight. With some assurance that she was going to survive and they would be called if anything changed, they left the hospital to go home just a few minutes before I arrived. Allison was sedated and resting now. Just like Charlotte and Tom, Allison's disposition was a given – inpatient psychiatric hospitalization after medical clearance. I'll need to come back and meet with her parents for additional information, but I anticipate her Axis I diagnosis will be something in the depressive disorder family.

Bullying has become a serious problem. Sometimes it seems that most of the children and adolescents I have cared for in the last decade have been bullied, are bullies, or are both victims and perpetrators of bullying. If bullies could spend a few days with me in the ED, the intensive care unit, on the medical floors, and in the nightmare of involuntary hospitalization of the suicidal and homicidal kids they prey upon, would they change their behaviors? Sometimes I wonder.

I pump the antiseptic bottle at the doorway as I leave the room and rub my hands. *Clean in and clean out – the Lord bless you and keep you.*

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The fifth patient on my list is on the pediatric bone marrow transplant unit. I put on a gown and mask, then I pump the antiseptic bottle at the doorway as I enter the room and rub my hands. *Clean in and clean out – the Lord bless you and keep you.*

*Timothy is a seven year old with attention deficit hyperactivity disorder who has developed a severe form of leukemia. He has been hospitalized several times to receive chemotherapy, but the progression of his malignancy and the associated genetics pointed to bone marrow transplant as the treatment of choice. Staff wants psychiatry to be involved because*

*Timothy's father continues to use corporal punishment despite physicians' instructions that the boy should not be spanked or physically jolted at all during the transplant process due to the risks of severe bleeding and bruising. Timothy's mother and father are very reluctant to change their parenting style, citing scriptural references to support their belief that "losing Timothy's soul to sin" by withholding physical discipline is much worse than any temporary physical setbacks that he might sustain from appropriate consequences for his impulsive, mischievous behaviors. The oncology team feels obligated to report the parents to the county family and social services department, creating an awkward situation because Timothy is dependent upon the same team for treatment of his leukemia.*

Timothy is sleeping right now. The combination of severe nausea and pain from mouth ulcers – both consequences of chemotherapy – kept him awake most of the night. His parents are at an older sibling's school to deal with her recent academic and behavior problems. These sibling problems may be different from those faced by Timothy himself, but can be just as devastating as the childhood cancer itself when all attention and resources are heaped on the "identified patient", or the child in the hospital. I review the medical record again, and learn that the attending physicians, nursing supervisor, chaplains, the child advocacy team, and social workers have all seen the child and family separately. They all have weighed in on what they think should be done, but I see no evidence that all the professionals have conversed with each other in the same room about the similarities and differences in their opinions and recommendations, let alone how to implement them and engage the family in a way conducive to current and future healthy functioning. Yes, from the staffing observations, history, and family quotes in the medical record, county services must be notified and indeed one of the social workers plans to call today. However, even in 2014 not everything can be done by a phone call

to the county or on the computer in the electronic medical record. Sometimes staff members still must meet and talk in person. I need to recommend a multidisciplinary meeting as soon as possible where observations can be shared in person and staff can express their concerns and differences of opinion in an appropriate setting, thus enabling them to still provide the best quality care despite their feelings toward his parents (and dare we say even the family's church or faith community?) supporting continued physical punishment of this very ill little boy.

I pump the antiseptic bottle at the doorway as I leave the room and rub my hands. ***Clean in and clean out – the Lord bless you and keep you.***

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There is one last child to see before my first meeting of the day.

I pump the antiseptic bottle at the doorway as I enter the room and rub my hands. ***Clean in and clean out – the Lord bless you and keep you.***

*Jason is a five year old nonverbal boy with severe autism. His behaviors have worsened considerably in the last six months, especially self-injurious head banging and more recently, unpredictable incidents of aggression directed at caregivers and property. Psychotropic medications have not been particularly helpful for stabilizing his mood, and have contributed to a weight gain of over twenty five pounds in the last year. His father abandoned the family when Jason was a young child, and mother gave up custody to the county a year ago after Jason broke her leg and she sustained a concussion during a severe behavioral incident. The medical floor is consulting psychiatry for suggestions about how to handle Jason's behaviors there, should he become upset, and for our input into Jason's placement needs after discharge. The social worker has just learned that the current foster parents refuse to take him back after this hospitalization, and he failed three foster home placements before this one – all due to aggressive behaviors. He*

*is in the hospital right now because he ran into traffic and sustained a severe fractured leg when struck by a car. The combination of pain, agitation, and the side effects of the six different psychiatric medications he has been taking – in addition to being in a strange setting with unfamiliar caregivers – are going to make his surgery and post-operative care extremely challenging for everyone involved, especially Jason.*

I speak with the primary nurse and the constant attendant before I enter the room. Jason has just fallen asleep now, too, the sedative effects of his regular medications plus a couple of extra doses of medication for agitation finally kicking in. I am sure he must be worn out by struggling in restraints earlier in the morning. I check his vital signs, observe his respirations, and do a visual inspection of his head, neck and extremities to make sure there have been no undocumented lumps, bumps, or bruises. I review his medical record to make sure all appropriate blood work to monitor his psychiatric medications has been ordered, as well as an electrocardiogram. I suggest that they take his vital signs more frequently, record what and how much he eats, drinks, and eliminates. I am very concerned that he has been over-medicated for months and that has actually been making his agitation worse. However, even if I could correct the polypharmacy, it would not be safe to do that quickly. I must examine him when he is awake and get additional history before I can make a recommendation for medication changes. I will need to come back at random times over the next day or so to get a better sense of his mental status and behaviors. In the meantime, I leave recommendations about general communication and behavioral management strategies helpful when caring for children with developmental disabilities, especially those with autism.

Looking now at this sleeping, overweight youth, the mother within me imagines what he looked and acted like when he was a baby and young toddler, when his own mother could just



sweep him up to keep him safe and prevent him from wandering off into trouble and danger. Even violent kids - regardless of the type of violence, its underlying causes, and who they have hurt – look tranquil and cherubic when they are sleeping.

I pump the antiseptic bottle at the doorway as I leave the room and rub my hands. *Clean in and clean out – the Lord bless you and keep you.*

### **Theological musings and the hospital elevator**

Jason’s room is on the twelfth floor of the patient tower and my meeting is in a different part of the hospital, so I leave his room and head toward the elevator. If I had any influence with Infection Control, I’d put antiseptic bottles at the elevator doors. After seeing what gets on and off hospital elevators over the years, that is where I would want to live if I was a virus or microbial pathogen! I cannot “clean in and clean out”, but I have a twelve floor ride down to ponder my morning from a theological point of view.

I was raised in a tradition that teaches that all of life’s challenges can be summarized and addressed effectively by time-tested, tragedy-tested memory verses from the Bible. While leaving behind that particular hermeneutical lens, as child of my upbringing, I search my cognitive memory banks for verses that fit and can give comfort to what I saw this morning. But I will need more time and space before I’ll be able to come up with any warm, fuzzy verses to dampen the aggression, the anger, the accoutrements of violence that are part of these patients’ lives. Instead, I despair with the psalmist:

“Out of the depths I cry to you, O Lord. Lord, hear my voice!” (Psalm 130:1-2a)

“Why, O Lord, do you stand far off? Why do you hide yourself in times of trouble?”  
(Psalm 10:1)

Indeed, as a caregiver of children affected by violence, I ask, “Where is God in all this violence”? Where is God in all of this suffering, and why does it go on and on and on? It’s not like this morning is unique in my professional life. For years now I have seen and heard the effects of violence from my patients in emergency rooms, regular hospital rooms, the intensive care units, and the outpatient clinics of several medical centers. It happens in the cities, and it happens in the small towns and the rural areas served by these facilities. Violence does not discriminate based on race, educational achievement, gender, religion, sexuality, or socioeconomic status.

I make a mental note to go back and reread the Book of Lamentations with Kathleen O’Connor’s *Lamentations and the Tears of the World* nearby. Though Lamentations depicts the aftermath of the Babylonian invasion of Jerusalem in the 6<sup>th</sup> century B.C.E. and is set in the context of war, the emotions of the remnant trying to survive in Jerusalem are similar to what my patients and their families feel in diverse manifestations of violence – physical and emotional pain, hopelessness, and anger and despair that God has permitted atrocities to happen and abandoned them to deal with the suffering alone (O’Connor, 2002). Yes, it would be great if I could jump straight into scriptural passages of divine justice and comfort, but sometimes as a care provider to children I must acknowledge that sometimes I am in the same place as many of my patients and their loved ones, struggling with the devastation and horror of the violence I see. I must claim the power of biblical lament and supplication to absorb the spiritual, emotional, and physical aftershocks of the unleashed evil, whether perpetrated by self or others, or the evil of illness that robs peaceable thoughts and behaviors.

Okay, the elevator is stopping at the eighth floor. My second theological thought involves ethics. I remember reading a section in Richard Hays’ *The Moral Vision of the New*

*Testament* (1996) in which he discusses his interpretation of Elisabeth Schussler Fiorenza's position on violence. The gist for Hays is that Schussler Fiorenza does not spend time pondering the why's and other theological fine points of violence. In her written treatments of violence, primarily against women, she assumes its existence as a fact in the lives of so many. She then focuses on how to survive it and denounce it in ways that are healing and cathartic for its victims, in addition to diminishing the occurrence and severity of the unspeakable acts. Hays notes:

It is evident that she (Schussler Fiorenza) deplores violence, but she makes no argument against it on the basis of biblical warrants. Rather the experiences of those who have suffered violence is taken as a sufficient testimony of its evil. (Hays, 1996, p. 273)

The fact that I remember this particular observation by Hays about a feminist theologian's take on violence while riding in an elevator twenty years later confirms two things for me. The first is that my theological leanings are definitely much more practical than philosophical and abstract. The second is that evil is evil, violence is evil, and the proof that violence is evil is evident and obvious in the lives of my patients and how they came to be hospitalized. If I could take Hays and Schussler Fiorenza on rounds with me today, the ethicist, the feminist theologian, and the psychiatrist would all agree that human violence is evil. But while the theologies of evil and sin are important to understand, pastoral counselors must accept Schussler Fiorenza's observation that sufferings of the children from violence are proof enough of evil, and then turn to the care of those suffering as the result of that evil.

And sometimes violence begets more violence and more evil, and so much of that second- and third- generation violence comes in and out of these hospital doors, too. I think back to a particular metropolitan area where I practiced in the past. The police found it was easier and

involved much less paperwork to take all adolescents to the children's hospital emergency room for a psychiatric evaluation than to the police station when they were called to neighborhood disturbances, street fights, or domestic disturbances. It was then my responsibility to assess the youth and determine whether or not the presenting problem was due to an underlying psychiatric problem, and if so, was it serious enough to require immediate hospitalization or regular outpatient follow-up? If I determined psychiatric hospitalization was not indicated, the officers either took the child to the police station or let them go home.

Most of the violent and aggressive kids I evaluated there were themselves physically, emotionally, and sexually abused from very young ages. Bullying was the norm, and as they grew their choice was to bully others or continue to be victimized themselves. Just by living in certain zip codes and neighborhoods, it was virtually predetermined that their health care was inferior, their living conditions crowded and substandard, their nutrition quite poor, their safety always precarious, their supervision and nurturance by responsible adults lacking, and their education underfunded and often neglected. To witness, be the victim of, and/or perpetrate violence seemed like a given for so many. As a Christian and as a clinician in that setting, I had to focus on the one adolescent in the room with me, the one whose personal story I was hearing and the one brought to me to see at that time in that space. Yes, occasionally I received follow-up that a diagnosis or referral I made eventually made a difference, or that a parent was encouraged to not give up when a physician in the ED spent some extra time and seemed to genuinely care about the entire household – not just the youth in the hospital gown. But the immensity of the issue, of violence begetting violence, of the inability of a historically privileged, Christian society to keep violence from escalating in so many settings and becoming an accepted part of children's lives weighs heavily upon me. From my conversations with pastoral caregivers

carrying caseloads consisting of many children dealing with violence-laden environments, I know the same to be true for them as well. Supervision and meeting with professional peer groups are vital support structures for pastoral counselors dealing with the burdens of childhood violence they hear about in their ministries and clinical work.

I have to imagine that these sample vignettes of aggression and violence from urban emergency departments and the pediatric medical world would have interested liberation theologian Robert McAfee Brown. Brown (1973) was adamant that religion should not be quarantined to the private world, to be only a matter between one's heart and God. Faith is not exclusively a private matter, for individuals of faith have a God-given mandate to live, work, and address the sin and evil in the external world of politics and institutions as well. He published *Religion and Violence* in 1973, referring to the "slum environments" of impoverished cities and chastising privileged modern societies worldwide for failing to appreciate the fact that adverse circumstances such as poverty, violence, and other depravities victimize and perpetrate violence against those who must live in it and are often powerless to escape or change it. **Brown writes,**

We must acknowledge ... that the structure of institutions of our society contain within themselves elements that do violate the personhood of many of those within... It is not enough to say that violent acts such as mugging, rape, or robbery take place in a slum environment. The point is that the slum environment, the structure of the slum itself, works violence against those who live within it .... They are denied the possibility of achieving full personhood, since living in the slum means that they will probably not get the health care to which human beings are entitled; their children will almost surely go to inferior schools; because of inferior schooling their children will almost certainly have inferior jobs; as a result, they too will have to go to inferior schools – and the vicious

cycle will be repeated in each generation. All of this adds up to “violation of personhood” and is a clear example of structural violence. (Brown, 1973, pp. 35-36)

Oh, that I had the opportunity to share one of my hospital work days with Dr. Brown and hear his thoughts about violence and our lives in community in this time and place!

The elevator slows to a stop and I head back to my office.

### **The facts about violence and children**

As was seen on morning rounds, child maltreatment increases both the incidence of psychic pain of the abused and the possibility that he or she will mistreat or abuse others. According to statistics from the **Centers for Disease Control National Center for Injury Prevention, the Division of Violence Prevention (CDC NCIPC DVP)**, 1,560 children died in the U.S. in 2010 from abuse and neglect, and 695,000 children were victims of maltreatment. In addition to the bruises, fractures, burns and other injuries, abuse adversely affects brain development and the immune system. Abuse also predisposes its victims to depression, substance abuse, obesity, eating disorders, sexual acting out, smoking, and suicide (**CDC NCIPC DVP**, 2012a). What cannot be over-emphasized, however, is the fact that abuse and neglect is one of the greatest risk factors for violence later in later childhood, adolescence, and adulthood.

Youth violence is all too common in the United States. It includes slapping, hitting, shooting, stabbing, and bullying, and a child or adolescent can be a victim, a perpetrator, or a witness. Violence is the second leading cause of death for those between the ages of 15 and 24.

Other relevant statistics include (AACAP, 2011; **CDC NCIPC DVP, 2012b, 2012c**):

- In 2010, 4,828 adolescents between the ages of 10 and 24 were homicide victims – that is an average of 13 every day.

- Of those 4,828 murdered youth, 86% (4,171) were males and 14% (657) were females.
- Homicide is the leading cause of death for African Americans, the second cause of death for Hispanic youth, and the third leading cause of death for American Indians and Alaska Natives.
- In 2011, more than 707,000 youth had physical assault injuries treated in emergency rooms (~ 1,938 a day).
- Youth murders and assault injuries produce \$16 billion in medical and work loss costs.

There are numerous **risk factors** for childhood violence, including (AACAP, 2011; CDC, 2011):

#### Individual Risk Factors -

- History of early aggressive behaviors
- History of abuse or violent victimization
- Attention deficit hyperactivity disorder and learning disorders
- Tobacco, alcohol, drug abuse
- Below average intelligence
- Past treatment for psychiatric or emotional concerns
- Poor academic performance, lack of interest in academics

#### Family Risk Factors -

- Excessively strict or authoritarian childrearing attitudes
- Harsh, lax, or inconsistent disciplinary practices
- Low parental education and income
- Low parental involvement

- Poor family functioning
- Poor monitoring and supervision of children
- Parental substance abuse and criminality

Peer and social risk factors –

- Gang involvement or association with delinquent peers
- Rejection by peers
- Lack of involvement in typical activities for age

Community risk factors –

- Low levels of community involvement, limited interest by churches, service and philanthropic organizations
- Limited employment and economic opportunities
- Increased transiency
- Poverty
- Socially disorganized neighborhoods

When pastoral psychotherapists uncover one or more of the above risk factors, they should be alert to the potential that violence is indeed a concerning part in a child and family's lives.

On the other hand, **protective factors** can buffer youth from becoming involved in violent or risky situations. These include (AACAP, 2011; CDC, 2011):

- Above average intelligence
- High grade point average
- Religiosity



- Family connectedness and/or connectedness to adults outside the family
- The ability of the youth to discuss problems with parents
- Shared time and activities with parents
- Involvement in social or sanctioned extracurricular activities
- Consistent presence of a parent at one or more of the following times: upon awakening, arriving home from school, at the evening meal, or bedtime

In addition to risk and protective factors regarding child maltreatment and youth violence in general, pastoral counselors must make it a point to stay current with news headlines and matters related to violence in the larger society. Recent events in Connecticut, Colorado, and so many other places in the United States have highlighted the problems associated with children, youth and firearms in this country. Clergy and pastoral counselors tend not to like talking about firearms, knives, bows and arrows, explosives, and other objects associated with violence. However, it cannot be assumed that religiously oriented care providers and those who gravitate to them for care share the same views on the ownership and use of weapons. This is one area in which pastoral counselors may need to look to other guilds and how they address potentially delicate or controversial issues. The American Academy of Child and Adolescent Psychiatry recommends that if guns are kept, they should be unloaded and locked in a secure location known only to the parents or guardians. Guns and ammunition should be locked and stored in separate locations. When cleaning or handling a gun, it should be in the adult's view at all times and never left unattended (AACAP, 2008).

Other “hot topics” relevant to clinical work, with research in process and evidence-based practices in development, are bullying and cyber-bullying. What I call “old-fashioned bullying” – insults, cruel teasing, threats, and physical aggression – still exists and is quite common. What

seems to have changed is that it is occurring at younger ages, increasingly among siblings, is being perpetrated in a burgeoning number of new digital and social media, and more and more adults accept it as a new norm or rite of passage from childhood to adolescence and adulthood. Pastoral counselors working with children and other victims of violence must rise to the challenge of staying current with new cultural trends, especially those that can be misused or adapted for purposes potentially destructive and damaging to children in vulnerable situations and those already struggling with and affected by violence.

### **Final thoughts**

Violence. It is just a common, crippling, and deadly as any microbial pathogen, but sadly, no antiseptics, antibiotics, or sterile procedures exist to eradicate it. As a physician, a child and adolescent psychiatrist who works in a children's medical center, it is too often the constant, reliable evil in my day. In recent years, it seems as if most of my *clean ins and clean outs* are to prepare my heart, hands, and mind to hear and work with victims affected by violence. The presence of a ritual, "medical Shema" reminds me that children are at the center of God's promises to us and that we as adults and pastoral caregivers are charged to convey God's grace and care to the extent that we can, wherever and whenever we can. This is especially true when we work with children who have witnessed and experienced violence as victims, and those who act violently toward themselves, others, and property. I share these vignettes, reflections, and basic facts about childhood violence to enhance interdisciplinary conversation among colleagues also caring for children affected by violence. May you, too, find a scripture verse, a mantra, or sacred ritual to lighten the weight on your souls and open you to be vessels of care as you enter rooms of children and leave bearing their burdens and offering them back to God.

**Clean in and clean out – the Lord bless you and keep you.**

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