HHS Public Access

Author manuscript

J Adolesc Health. Author manuscript; available in PMC 2018 August 01.

Published in final edited form as:

J Adolesc Health. 2017 August ; 61(2): 262–265. doi:10.1016/j.jadohealth.2017.02.022.

The Psychosocial Needs of Adolescent Males Following Interpersonal Assault

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Abstract

Purpose—We examined the self-identified, post-assault psychosocial needs of male adolescents in order to guide recovery and healing after being seen in an Emergency Department (ED) for a violence-related injury.

Methods—We analyzed de-identified data from 49 adolescent male youth who participated in a post-discharge case management program following a violence-related injury. Descriptive statistics summarized youths' demographic characteristics and self-identified needs and goals for post-assault recovery.

Results—Most participants (80%) were treated for non-penetrating injuries and discharged from the ED (76%). Nearly two-thirds of youth reported clinically significant traumatic stress symptoms and 89% self-identified mental health needs following injury. Legal and educational needs were also commonly identified.

Conclusions—Despite experiencing minor physical injuries, assault-injured youth report clinically significant traumatic stress symptoms and recognize post-injury mental health needs. Results suggest that youth-focused, early intervention services, particularly related to mental health, are acceptable and desired by youth soon after a violent injury.

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Keywords

adolescent; mental health; male; crime victim; violence; health service needs

Compared to female peers, adolescent males experience a greater burden of injuries from interpersonal violence [1]. Youth who have experienced interpersonal violence may require medical care, but also on-going psychosocial support to address the adverse sequelae of their injuries [2]. Engaging violently-injured young men in post-hospital services may help to improve mental health outcomes and reduce the likelihood of injury recidivism [3]. Community-focused case management following violent injury provides support to assault-injured youth and is recognized as an important violence prevention tool [4].

Limited data exist regarding the diversity and frequency of adolescent males' self-identified post-assault needs. As male youth are less likely than female adolescents to seek help or receive mental health care [5], understanding male adolescents' perceived needs may inform services to overcome these barriers. The present study explores the self-identified recovery needs of assault-injured male adolescents participating in a voluntary post-discharge case management program. Recognizing the needs of male youth following violent injury provides a novel opportunity to examine the alignment of goals with available services and programs to promote successful healing and recovery.

METHODS

This retrospective study utilized data from a violence intervention program at a large, urban children's hospital. Eligible youth were between 8 and 18 years old, resided within city limits, and sought care at this hospital's Emergency Department (ED) or Trauma Unit for any injury resulting from an interpersonal assault, which was not attributable to child abuse, sexual assault, or self-inflicted injuries. Eligible youth were referred by hospital social workers and participation was voluntary. Analyses were limited to male youth who agreed to receive services between January 2012 and August 2016. Because we analyzed existing, de-identified data, this study was deemed exempt by the hospital's Institutional Review Board.

Demographic, injury, and psychosocial variables, including youth-reported traumatic stress symptoms (Child Post-Traumatic Stress Symptom Scale (CPSS) [6]) were summarized. CPSS scores were dichotomized, with scores greater ≥11 reflecting clinically significant traumatic stress symptoms. In partnership with program staff, youth identified goals, both at the time of program intake, as well as throughout the course of post-assault case management.. Goals were discrete and measurable objectives related to 14 need domains shown in Table 2. We reported, without prioritization, frequencies and percentages of all need domains and goals identified by participants. We compared the proportion of youth reporting each need domain by discharge status (admitted vs. discharged from ED) using Fisher's exact tests. For continuous variables, we calculated means and standard deviations or medians and interquartile ranges (IQR), as appropriate. Data were analyzed using SAS (Version 9.3).

RESULTS

Between January 2012 and August 2016, 49 male youth enrolled in the program. Table 1 summarizes the demographic, injury, and psychosocial characteristics of youth at program intake. The majority of youth were referred by ED social workers and sought care for non-penetrating injuries. Consistent with racial demographics of our ED patients, most program participants were Black. Most youth were between the ages of 12 and 17 years (88.8%, Range: 8–17 years), 75.5% were discharged directly from the ED, and slightly more than half previously received mental health care. At intake, 63.4% of youth reported clinically significant traumatic stress symptoms.

Four youth withdrew or were lost from contact before program intake. Among the remaining 45 participants, the majority identified between one and three need domains, with most identifying mental health needs (88.9%) and more than half reporting needing legal support, education, or psycho-educational peer groups (Table 2). Nearly two-thirds of youth (62.5%) identified mental health needs within one week of program initiation. Youth discharged from the ED were significantly more likely to identify safety needs compared to youth who were admitted ($p<0.04$). Youth could identify multiple need domains, as well as multiple goals within each domain (examples in Table 2). Youth identified a median of five goals (IQR: 4–11) across the need domains; one “outlier” youth with 83 goals had medical complications, prolonging participation. Participants identified the highest number of goals within the domains of child protection, medical, legal, and basic needs assistance (e.g. food, clothing, and housing).

DISCUSSION

Youth identified a vast need for mental health care in the aftermath of violent injury. Adolescent males experience a disproportionally high burden of interpersonal victimization, as well as exposure to additional forms of violence, which are associated with poor mental health [7]. Although most youth were discharged from the ED following minor injuries, many reported clinically significant traumatic stress symptoms and nearly all reported a mental health need, despite nearly half of the youth having never received mental health care. Youth identified multiple discrete recovery goals, indicating openness to support following violent injury, representing a critical moment for teaching and intervention [4].

A greater proportion of youth self-identified mental health needs as compared to prior studies [8, 9]. By employing a trauma-informed approach, whereby youth are empowered with voice and choice [10], goals are likely more relevant and sensitive to youths’ needs. Many youth reported legal and educational needs, highlighting the urgency of support across diverse areas of their lives following assault injury. Further, youth discharged from the ED were more likely to identify safety needs than youth admitted for inpatient care, emphasizing the need for safety planning. Since the violence intervention program addresses multiple youth-identified goals simultaneously, program staff can provide trauma-informed advocacy and expertise within multiple youth-serving systems.

These results may not generalize to all settings, given our sample of male youth who voluntarily participated in a single hospital-based violence intervention program. However, the majority of violence intervention programs like ours nationally, provide services to demographically similar populations. Future research is needed to examine the needs of other programs' participants, as well as female youth.

Study results suggest that male adolescents self-identify a diverse range of post-injury needs. Despite limited prior utilization of mental health services, youth articulated a desire for mental health support. Providing youth with access to trauma-informed case management following violent injury may reduce the burden of post-victimization mental health morbidity, improve outcomes across multiple domains of youth functioning, and reduce the likelihood for future injury.

Acknowledgments

We are deeply grateful to the youth who have participated in the Violence Intervention Program and honestly and openly shared their goals and needs with Violence Intervention Program staff. We would like to acknowledge the tremendous efforts of VIP team members: Ayana Bradshaw, MPH; Danielle Centeno, MA; Caroline Menapace, MSW; Brooke Paskewich, PsyD; and Jody Thigpen, MSW.

Funding Sources: Dr. Culyba received support from the National Institutes of Health (NIH), Eunice Kennedy Shriver National Institute of Child Health and Human Development, grant F32 HD084028. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH. There were no other specific grants from funding agencies in the public, commercial, and not-for-profit sectors.

Abbreviations

ED	Emergency Department
CPSS	Child Post-Traumatic Stress Symptom Scale
IQR	Interquartile ranges
ADHD	Attention Deficit Hyperactivity Disorder
PTSD	Post-Traumatic Stress Disorder
SD	Standard Deviation

References

1. National Adolescent Health Information Center. A Health Profile of Adolescent and Young Adult Males. San Francisco, CA: University of California, San Francisco; 2005.
2. Cunningham R, Knox L, Fein J, et al. Before and after the trauma bay: the prevention of violent injury among youth. Ann Emerg Med. 2009; 53(4):490–500. [PubMed: 19162376]
3. Carter PM, Walton MA, Roehler DR, et al. Firearm violence among high-risk emergency department youth after an assault injury. Pediatrics. 2015; 135(5):805–15. DOI: 10.1542/peds.2014-3572 [PubMed: 25847808]
4. Purtle J, Dicker R, Cooper C, et al. Hospital-based violence intervention programs save lives and money. J Trauma Acute Care Surg. 2013; 75(2):331–3. DOI: 10.1097/TA.0b013e318294f518 [PubMed: 23887566]
5. Thomas JF, Temple JR, Perez N, Rupp R. Ethnic and gender disparities in needed adolescent mental health care. J Health Care Poor Underserved. 2011; 22(1):101–10. DOI: 10.1353/hpu.2011.0029 [PubMed: 21317509]

6. Foa EB, Johnson KM, Feeny NC, Treadwell KR. The child PTSD Symptom Scale: a preliminary examination of its psychometric properties. J Clin Child Psychol. 2001; 30(3):376–84. DOI: 10.1207/S15374424JCCP3003_9 [PubMed: 11501254]

7. Finkelhor D, Ormrod RK, Turner HA. Poly-victimization: a neglected component in child victimization. Child Abuse Negl. 2007; 31(1):7–26. DOI: 10.1016/j.chiabu.2006.06.008 [PubMed: 17224181]

8. Zun LS, Rosen JM. Psychosocial needs of young persons who are victims of interpersonal violence. Pediatr Emerg Care. 2003; 19(1):15–9. [PubMed: 12592107]

9. Bohnert KM, Walton MA, Ranney M, et al. Understanding the service needs of assault-injured, drug-using youth presenting for care in an urban emergency department. Addict Behav. 2015; 41:97–105. DOI: 10.1016/j.addbeh.2014.09.019 [PubMed: 25452051]

10. Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2014. HHS Publication No. (SMA) 14–4884

Implications and Contribution

This study examined the self-identified recovery needs of recently injured male adolescents. Findings highlight that youth self-identified multiple post-assault needs, which overwhelmingly included support in accessing mental health care. Early, trauma-informed interventions, which provide youth with voice in their recovery, may help overcome barriers to engaging male youth in services.

Table 1

Descriptive Summary of Male Violence Intervention Program Participants (N=49)

Characteristic	N	%
Age at Injury, Mean (SD)	14.2 (2.1)	
Race		
Black	44	89.8
White	2	4.1
Other or More than One Race	3	6.1
Hispanic	3	6.1
Referral Source: ED	39	79.6
Referral Source: Trauma Unit	10	20.4
Grade in School at Injury		
Not currently attending school	2	4.1
Elementary school (grades 4 & 5)	5	10.2
Middle school (grades 6–8)	9	18.4
High school (grades 9–12)	26	53.1
Missing grade data	7	14.3
Mechanism of Injury		
Assault (Blunt Trauma/Non-penetrating)	39	79.6
Gun Shot Wound	5	10.2
Stab Wound	5	10.2
ED Disposition: Discharged	37	75.5
ED Disposition: Admitted	12	24.5
Previous violence-related injury (n=37)	11	29.7
Fight in school or community in prior year (n=35)	19	54.3
Previously received mental health care (n=41)	22	53.7
ADHD (n=22)[a]	10	45.5
Anger (n=22)[a]	7	31.8
PTSD/trauma-symptoms (n=22)[a]	6	27.3
Depression (n=22)[a]	4	18.2
Intellectual disability (n=22)[a]	1	4.5
Not specified (n=22)[a]	3	13.6
Clinically Significant CPSS Score	26	63.4

[a]Reasons cited by participants for receiving mental health care prior to program participation. Categories are not mutually exclusive and reflect self-reported reasons for treatment, not necessarily the clinical diagnosis provided by a clinician.

Table 2

Descriptive Summary of Male Participants' Identified Needs and Goals (N=45)

Need Domain	Examples of Youth Identified Goals	Youth Reporting Need		Median Number of Goals Within Domain	Interquartile Range
		N	%		
Mental Health	• Refer to therapy • Refer for psychiatric evaluation • Suicide safety planning	40	88.9	1.0	1–2
Legal	• Court accompaniment • Assist youth in navigating legal system • Obtain police report	27	60.0	2.0	1–2
Education/School	• Support school transfer • Assist with securing homebound services • Care coordination with school	26	57.8	1.5	1–2
Psycho-educational groups	• Attend at least five group sessions	25	55.6	1.0	1–2
Employment	• Assist youth with application for summer employment • Assist youth with obtaining working papers • File victim's compensation for lost wages	21	46.7	1.0	1–2
Medical	• Refer youth to primary care • File victim's compensation for medical costs • Accompany youth to medical visit	18	40.0	2.0	1–3
Safety	• Address peer relationships in school/community • Make child protection report • Support family in psychiatric admission process	18	40.0	1.0	1–2
Basic Needs Assistance [a]	• Obtain clothing for youth/family • Obtain food for youth/family • Provide family with housing and utility resources	15	33.3	2.0	1–4

Need Domain	Examples of Youth Identified Goals		Youth Reporting Need		Median Number of Goals Within Domain	Interquartile Range
			N	%		
Parent Training	•	Refer family to parent support program	7	15.6	1.0	1
Substance Use Treatment	•	Support youth through treatment	4	8.9	1.5	1–4.5
	•	Refer youth to inpatient substance use treatment				
	•	Care coordination with treatment program				
Public Income/Social Security Income	•	Support family in applying for nutrition assistance program	4	8.9	1.5	1–2.5
	•	Support family in application for social security income				
Health Insurance	•	Assist family in application for medical assistance	3	6.7	1.0	1–2
	•	Assist family in application for private insurance				
Extracurricular Activities	•	Refer youth to summer camp	3	6.7	1.0	1
	•	Refer youth to after-school activities				
Child Protection	•	Assist family in navigating child protection legal system	2	4.4	2.5	2–3
	•	Care coordination with child protection staff				

[a]This domain addresses needs related to housing, food, clothing, and other basic needs.