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The Psychosocial Needs of Adolescent Males Following Interpersonal Assault

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A B S T R A C T

Purpose: We examined the self-identified, postassault psychosocial needs of male adolescents to guide recovery and healing after being seen in an emergency department (ED) for a violence-related injury.
Methods: We analyzed deidentified data from 49 adolescent male adolescents who participated in a postdischarge case management program following a violence-related injury. Descriptive statistics summarized youths' demographic characteristics and self-identified needs and goals for postassault recovery.
Results: Most participants (80%) were treated for nonpenetrating 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 postinjury 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.

IMPLICATIONS AND CONTRIBUTION

This study examined the self-identified recovery needs of recently injured male adolescents. Findings highlight that youth self-identified multiple postassault 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 engage male youth in services.

Compared with female peers, adolescent males experience a greater burden of injuries from interpersonal violence [1]. Youth who have experienced interpersonal violence may require not only medical care but also ongoing psychosocial support to address the adverse sequelae of their injuries [2]. Engaging violently-injured young men in posthospital 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 postassault 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

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assault-injured male adolescents participating in a voluntary postdischarge 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 injury. 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, deidentified 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 [6]) were summarized. Child Post-Traumatic Stress Symptom Scale scores were dichotomized, with scores greater $\geq$ 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 postassault 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, as appropriate. Data were analyzed using SAS version 9.3 software (SAS Institute Inc., Cary, NC).

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 was referred by ED social workers and sought care for nonpenetrating 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 psychoeducational peer groups (Table 2). Nearly two thirds of youth (62.5%) identified mental health needs within 1 week of program initiation. Youth discharged from the ED were significantly more likely to identify safety needs compared with youth who were admitted ($p < .04$). 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 (interquartile range: 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).

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 and 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/nonpenetrating)	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

ADHD = attention deficit hyperactivity disorder; CPSS = Child Post-Traumatic Stress Symptom Scale; ED = emergency department; PTSD = Post-traumatic stress disorder; SD = standard deviation.

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

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 with prior studies [8,9]. By employing a