

# Concerns and Coping of African-American Mothers After Youth Assault Requiring Emergency Medical Treatment

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**Objective** To explore maternal experience following youth assault occurring in the community. **Methods** A semistructured interview was used to elicit concerns and coping strategies among 35 African-American mothers whose children received emergency department (ED) treatment for assault-related injuries. Mothers also completed measures of violence exposure, trauma symptoms, social support, and youth functioning. **Results** The most common concerns involved family safety, maternal mental health, and youth externalizing behavior. Faith and social support were the most common coping strategies. High levels of distress were found, which were directly related to maternal violence exposure, relationships that required mothers to nurture others, and youth functioning. Distress was inversely related to relationships that provided guidance from others. **Conclusion** Distress is common among low-income African-American mothers of youth assault victims. To bolster youth recovery and to reduce the risk of future injury, ED staff should be knowledgeable regarding culturally sensitive resources to address maternal distress.

**Key words** ecological-transactional approach; maternal distress; youth violence.

There is growing consensus regarding the importance of addressing the mental health needs of youth presenting to emergency departments (EDs). Recommendations from a recent national conference encouraged ED staff to assist pediatric patients and their parents in dealing with distress following utilization of emergency medical services (Horowitz, Kassam-Adams, & Bergstein, 2001). Researchers also have suggested adding parental stress management components to interventions for youth who have been assaulted (Gorman-Smith & Tolan, 1998) or have sustained a traumatic brain injury (Max et al., 1998). The rationale for the parental focus stems from the recognition of ecological-transactional processes (Lynch & Cicchetti, 1998), in which factors at one level (e.g., youth traumatic experience) affect and are affected by factors at other levels (e.g., parental functioning). Given this framework, exploration of parental

experience following youth trauma is essential to develop appropriate interventions.

A common presenting problem in the ED receiving little attention from pediatric psychology is nonfamilial assault-related injuries. In 2002, just over 400,000 youth aged 10–19 were treated in EDs for such injuries (Centers for Disease Control and Prevention, 2002). African Americans, males, and individuals aged 15–24 are most likely to become victims of violent crime (Bureau of Justice Statistics, 1997), as are youth living in low-income neighborhoods (Buka, Stichick, Birdthistle, & Earls, 2001) and those exhibiting externalizing behaviors (Lynch & Cicchetti, 1998). Correlational studies indicate that this type of direct exposure to community violence is associated with various affective and behavioral difficulties (Buka et al., 2001). However, parental support appears to facilitate youth resiliency in some cases

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*Journal of Pediatric Psychology* 31(4) pp. 388–396, 2006

doi:10.1093/jpepsy/jsj057

Advance Access publication August 10, 2005

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(Buckner, Mezzacappa, & Beardslee, 2003; Ceballo, Ramirez, Hearn, & Maltese, 2003).

Not surprisingly, parental distress following youth trauma can be detrimental to youth. Studies have indicated that maternal emotional distress is the strongest predictor of youth distress among low-income youth exposed to community violence (Aisenberg, 2001; Linares et al., 2001). In addition, researchers have reported a direct relationship between maternal and youth diagnoses of posttraumatic stress disorder (PTSD) among various clinical samples including maltreated children (Famularo, Fenton, Kinscherff, Ayoub, & Barnum, 1994) and children of Holocaust survivors (Van Ijzendoorn, Bakermans-Kranenburg, & Sagi-Schwartz, 2003).

Despite the impact that parental factors have on youth functioning following exposure to community violence, little attention has been devoted to the experience of parents of assaulted youth. A few studies offer limited information from African-American mothers about life in violent neighborhoods. Maternal distress and concerns for family safety are featured prominently (Dubrow & Garbarino, 1989). African-American mothers of assault victims likely experience additional stressors related to socioeconomic pressures (McLoyd, 1998) and racism (Clark, Anderson, Clark, & Williams, 1999). They also may have their own history of violence exposure to consider. Dealing with the pervasive difficulties associated with these stressors may lead parents to feel overwhelmed by their own concerns and unable to provide the support that their children require (Cicchetti & Lynch, 1993; Dix, 1991). A child's assault also may contribute directly to parental distress, as other childhood traumas (e.g., life-threatening illnesses) have been associated with elevated rates of PTSD symptomatology among parents (Kazak et al., 2004).

Choice of coping strategy can influence distress levels as well. Use of faith-related strategies appears to be prevalent among African-Americans (Taylor, Mattis, & Chatters, 1999), but the evidence is inconclusive regarding whether the strategies are effective in reducing symptoms of distress. It also has been assumed that African American women have access to high levels of social support via the church and extended family (Henly, 1999; Wilson & Tolson, 1990). Social support has been found to buffer distress associated with a wide variety of concerns, including the loss of a child to a violent death (Murphy, Johnson, Chung, & Beaton, 2003) and PTSD symptomatology among traumatized adults (Ozer, Best, Lipsey, & Weiss, 2003). Some research suggests that although African-American women experience

long-lasting relationships, they often provide more support than they receive (Snowden, 2001; Thomas, Milburn, Brown, & Gary, 1988). This may put low-income African-American mothers at added risk for experiencing distress in the face of multiple stressors associated with youth community violence exposure, thus contributing to youth distress.

To facilitate the development of appropriate strategies that would enable ED staff and clinicians to help parents manage their distress, more attention should be devoted to the experience of parents following the assault of their children. The aim of this study was to focus on low-income African-American mothers whose children have been assaulted in the community. There is increasing recognition that it is important to take context into account when exploring stressors (Phelps, McCart, & Davies, 2002; Quittner, 1999). Therefore, the elicitation of concerns and coping strategies in this study was based on Goldfried and D'Zurilla's (1969) behavior analytic model, which emphasizes the identification of relevant difficulties experienced by members of a particular population to develop context-specific instruments that assess behavioral competence. It was hypothesized that mothers would report a wide range of concerns and high levels of distress. It was also expected that maternal distress would be directly related to maternal violence exposure and to youth psychosocial concerns, and inversely related to reliance on faith and social support for coping.

## Methods

### Participants

Participants in this convenience sample were 35 African-American mothers whose children (age range 10–18 years; 77% male) presented to the ED at Children's Hospital of Wisconsin (CHW) following an assault between November 1999 and May 2002. Injuries were caused by nonweapon assault (49%), gunshot wound (31%), blunt object assault (11%), and stabbing (9%). Injury Severity Scores (ISS; Baker, O'Neil, & Haddon, 1974) indicate that the majority of children were not seriously injured (Table 1). Time between injury and interview ranged from 10 to 104 weeks ( $M = 34.2$ ;  $SD = 24.5$ ). Mothers ranged in age from 27 to 51 years ( $M = 37.7$ ,  $SD = 5.7$ ). Thirty-four percent did not complete high school, 40% earned a high school diploma or general education diploma and 26% attended college. The majority (74%) were single parents, and all lived in low-income neighborhoods with median household incomes ranging from \$14,660 to 42,189 (U.S. Census Bureau, 2000).

**Table I.** Maternal Quantitative Results

Instrument	<i>N</i>	Range	<i>M</i>	<i>SD</i>	% Above clinical cut-offs
Distress					
TSI	34 <sup>a</sup>				
Scales ( <i>t</i> -scores)					
Depression		38–78	52.03	9.86	18
Anger/irritation		37–78	52.68	10.16	12
Anxious arousal		37–77	52.94	11.17	15
Intrusive experience		39–79	56.06	10.69	18
Dissociation		41–91	58.71	13.30	35
Defensive avoidance		38–76	59.35	11.06	35
Overall (raw scores)		6–138	59.59	32.12	
Violence exposure					
SAVE (raw scores)	35	41–101	60.29	12.75	
Social support					
SPS	35				
Scales (raw scores)					
Reassurance of worth		8–16	12.80	2.10	
Social integration		9–16	13.00	1.97	
Attachment		8–16	13.03	1.98	
Guidance		6–16	13.77	2.17	
Reliable alliance		4–16	13.46	2.62	
Opportunities to nurture		11–16	14.23	1.66	
Youth psychosocial functioning					
PSC (raw scores)	33 <sup>b</sup>	4–56	28.24	14.73	45
Injury severity					
ISS	30 <sup>c</sup>	1–36	6.47	8.85	

ISS, Injury Severity Score; SAVE, Screen for Adolescent Violence Exposure; SPS, Social Provisions Scale; TSI, Trauma Symptom Inventory; PSC, Pediatric Symptom Checklist.

<sup>a</sup>One mother's TSI was invalid because of an elevation on the Inconsistent Response Scale.

<sup>b</sup>Two mothers did not complete the PSC.

<sup>c</sup>Only 30 youth had been assigned an ISS.

## Procedures

Following approval from the CHW institutional review board, the first author contacted the mothers of youth who had been treated in the ED for injuries stemming from nonfamilial assaults to solicit participation in this study. Ninety-seven percent of mothers contacted agreed to participate. Approximately one-half were recruited through Project Ujima, a violence intervention program based at CHW that offers psychosocial support services to the families of assaulted youth. The remaining mothers in this study had declined services from Project Ujima.

Researchers interviewed mothers in their homes, with interviews lasting between one and several hours. Interviews included a consent form and several self-report surveys, which were read aloud to mothers, along with a semistructured interview focusing on concerns since the assault. Mothers received a \$25 gift certificate to the store of their choice. The first author and three research assistants (RAs) conducted the interviews. RAs

received extensive training on interview and rapport-building skills and did not conduct interviews for this study until their performance in mock interviews was rated as satisfactory by the first author.

## Measures

### Qualitative Concerns

The aim of the semistructured interview was to elicit difficulties experienced by the mother since the youth's assault. The format of the interview was based on Goldfried and D'Zurilla's (1969) behavior analytic model. An extensive literature review and consultation with professionals working with low-income African-American families suggested the following domains to structure the interview: mother's emotional well-being, youth's emotional well-being, family conflicts, balancing responsibilities, social network, support services for the youth, youth academic performance, finances, and the legal system. At the conclusion of the interview, the researcher asked mothers how they coped with the

difficulties elicited. The semistructured interviews were audio taped and transcribed.

#### Screen for Adolescent Violence Exposure

The Screen for Adolescent Violence Exposure (SAVE) (Hastings & Kelley, 1997) assesses lifetime exposure to community violence. Respondents rate the frequency of 32 events on a five-point Likert scale from 1 (*never*) to 5 (*almost always*). Mothers in this study used the SAVE to describe their own violence exposure and did not complete six items that dealt with abuse experienced by children; internal consistency ( $\alpha$ ) for the remaining 26 items in this sample was .89. The SAVE was used to allow comparability with data collected from the assaulted youth (McCart, Davies, Phelps, Heuermann, & Melzer-Lange, in press). Because the instrument was developed with adolescents, no normative comparisons were made.

#### Trauma Symptom Inventory

The Trauma Symptom Inventory (TSI) (Briere, 1995) measures psychological distress by having respondents rate the frequency of trauma-related symptoms on a four-point Likert scale from 0 (*never*) to 3 (*often*). In this study, only the clinical scales assessing dysphoric mood (Anxious Arousal, Depression, and Anger/Irritability) and posttraumatic stress (Intrusive Experience, Defensive Avoidance, and Dissociation) were used, reducing the total number of questions from 100 to 57. Therefore only two of the three validity scales could be calculated (Inconsistent and Defensive responses). Internal consistency ( $\alpha$ ) for the clinical scales in this study were comparable to those reported by Briere (1995) and ranged from .87 to .91. Because the internal consistency ( $\alpha$ ) for all clinical items in this study was .97, an overall distress score also was calculated.

#### Social Provisions Scale

The Social Provisions Scale (SPS) (Cutrona & Russell, 1987) assesses perceived social support with respect to six factors: Attachment, Guidance, Opportunities to Nurture Others, Reassurance of Worth, Reliable Alliance, and Social Integration. Respondents rate their agreement with 24 statements on a four-point Likert scale from 1 (*strongly disagree*) to 4 (*strongly agree*). Internal consistency ( $\alpha$ ) for the factors in this study were comparable to those reported by Cutrona and Russell (1987) and ranged from .60 to .90. The standardization sample used in the development of the SPS was primarily Caucasian and highly educated, preventing meaningful normative comparisons in this study.

#### Pediatric Symptom Checklist

The Pediatric Symptom Checklist (PSC) (Jellinek, Murphy, & Burns, 1986) is a screening instrument that assesses a child's psychosocial functioning. Respondents rate the frequency of 35 behaviors exhibited by their children on a three-point Likert scale from 0 (*never*) to 2 (*often*). If the value of the summed responses is greater than 28, further psychological evaluation of the child is suggested. Internal consistency ( $\alpha$ ) for the PSC in this sample was .94. There is evidence to suggest that child ethnicity does not affect the validity of this instrument (Murphy & Jellinek, 1988).

## Results

### Qualitative Data

Mothers reported 280 concerns ( $M = 8.1$ ,  $SD = 3.7$ ) and 65 coping strategies ( $M = 2.0$ ,  $SD = 0.8$ ) during the semistructured interview. Number of concerns was marginally related to youth injury severity possibly due to small sample size ( $r = -.34$ ,  $p = .06$ ) but was unrelated to time since the assault ( $r = .13$ ,  $p = .43$ ) or whether the family had accepted services from Project Ujima,  $t(33) = -.003$ ,  $p = .91$ . To identify types of concerns and coping strategies, the first author read all interview transcripts and recorded the critical element (a phrase or sentence) of each concern and coping strategy elicited. Maintaining the language used by the mothers, the author identified 66 types of concerns (e.g., child loses temper) and 33 types of coping responses (e.g., prayer). When appropriate, an individual concern was described by multiple concern types. A modified Delphi process (Jones & Hunter, 1995) provided a way of categorizing types of concerns and coping strategies that minimized the potential for idiosyncratic grouping. In this study, types of concerns and coping strategies were categorized into domains created by three psychology graduate students and a clinical psychologist, all of whom worked alone on the process. These individuals then came to a group consensus regarding the number and names of domains (Table II). The first author and a CHW ED physician subsequently categorized all concerns and coping strategies into these consensus domains. Inter-rater agreement was good for concerns ( $\kappa = .88$ ) and coping responses ( $\kappa = .96$ ).

Maternal concerns spanned the range of individual, family system, and community levels (Table II). Concerns at the individual level focused primarily on maternal affective reactions. Most prominent was chronic worry and/or depression, mentioned by 66% of mothers, as well as difficulty sleeping when their children were

**Table II.** Maternal Concerns

Level	Concern	% of mothers
Individual	Parental affective reaction (e.g., parent constantly worrying)	66
	Parental role strain (e.g., paying attention to child's needs interferes with parent's work)	46
Family	Youth aggression/acting out (e.g., child involved in verbal family fights)	63
	Financial concerns (e.g., bills)	40
	Youth internalizing symptoms (e.g., child shows no emotion/won't talk about assault)	37
	Youth academic concerns (e.g., child's poor school behavior/suspensions)	34
	Youth social/peer relations (e.g., peers serve as bad influence)	31
	Family stress (e.g., family members encourage child to retaliate)	31
	Medical treatment/physical concerns of youth (e.g., child's injury healing properly)	26
Community	Safety issues (e.g., threat of neighborhood violence)	89
	Systematic response (legal, school, and hospital) (e.g., inappropriate actions by police)	60

not home. In describing her anxiety, one mother said, "First you worry that [an assault] might happen. Then it happen[s], and then you worry it'll happen again. So it's like you constantly worry about this . . . you can't get rid of it, no matter what you do." Concerns regarding their child's aggressive behavior dominated family level concerns. Sixty-three percent of mothers were concerned with their child's anger, which was manifested in verbally and physically aggressive behavior. One mother, describing her son's proclivity for losing his temper since the assault, said, "As soon as he gets mad he just flies off the handle, you know, and it's so intense with him and so, it's kind of scary." Issues surrounding safety were the major concern located at the community level, as well as the most common concern reported overall. Eighty-nine percent of mothers described being worried about the safety of their family, given widespread community violence and the visibility of guns in their neighborhoods. "The streets are, they're not like when I was growing up," said one mother. "People, they carry guns, and all that shooting, you know . . . I stay at home. I very seldom go anywhere now."

Maternal coping strategies were categorized into five domains: Religion/Faith, Social Support, Distraction/Relaxation, Focus on Parenting, and Mental Health/Self Improvement. The most common strategy was to rely on faith, as reported by 51% of mothers, which involved prayer and belief in God. Mothers described their faith as being helpful because it provides relief, especially when coping with events beyond their control. One mother said, "I don't worry about a lot of things . . . because I was brought up [around] a lot of violence . . . and I have learnt over the years to block it out and just turn it over to the Lord." Social support was another common strategy for dealing with concerns. One-third of mothers reported relying on various forms

of support from family members and friends, which involved the provision of tangible assistance and having someone available to listen. "The people that I talk to is like understanding, so they understand what I'm going through," said one mother. "They done been through it, relate to what I'm saying."

Twenty-seven percent of mothers said that to deal with their concerns they focus on their children, which involves close monitoring or activities such as anger management instruction. Twenty-four percent reported using various activities (e.g., working on puzzles and gardening) to distract themselves. Many advocated keeping busy because "then I don't have to worry that much about [my child]." Fifteen percent said that they have relied on mental health services or self-help books. One mother said that the books were useful because they described "the same thing that you're going through now, and . . . they tell about what they do . . . They might take a walk, go take a bath . . . light a candle, whatever, and I kind of steal their ideas."

### Quantitative Data

Mothers reported high levels of distress on the TSI (Table 1). Just over half (53%) were elevated on at least one clinical scale ( $M = 2.5$ ;  $SD = 1.9$ ). Percent elevated on each scale ranged from 12 (anger/irritability) to 35% (defensive avoidance and dissociation), which are well above the 2.5% associated with the normative sample. Distress level, as assessed by the overall score on the TSI, was not significantly related to youth injury severity ( $r = -.21$ ,  $p = .27$ ), time since the assault ( $r = -.22$ ,  $p = .21$ ), or reliance on faith-related coping as reported during the semistructured interview,  $t(32) = -.68$ ,  $p = .50$ . However, distress level was significantly related to maternal level of violence exposure as assessed by the SAVE ( $r = .53$ ,  $p = .001$ ). Distress also was significantly

higher among mothers who had accepted Project Ujima services compared with those who had declined,  $t(32) = 2.8$ ,  $p = .009$ , and among mothers who reported relying on social support to cope with concerns,  $t(32) = 2.20$ ,  $p = .035$ . Multiple regression was conducted to examine the relationship between distress level and aspects of social support as assessed by the SPS. The Guidance and Opportunity to Nurture Others scales explained a significant portion of the variance in distress (adjusted  $R^2 = .47$ ,  $F = 15.37$ ,  $p = .0001$ ). Standardized regression coefficients indicated that although relationships providing guidance to the mother were associated with lower levels of distress ( $\alpha = -.75$ ), those requiring the mother to provide nurturance were associated with higher levels ( $\alpha = .30$ ).

Mothers reported high levels of behavioral problems among their assaulted children on the PSC (Table I). Multiple regression was conducted to examine the relationship between those problems and aspects of maternal distress as assessed by the TSI. The Dissociation ( $\alpha = .48$ ) and Intrusive Experience ( $\alpha = .36$ ) scales explained a significant portion of the variance in maternal rating of the child (adjusted  $R^2 = .55$ ,  $F = 20.85$ ,  $p = .0001$ ), with both aspects of distress directly associated with youth behavioral problems. There also was a significant relationship between the presence of maternal emotional concerns, as reported during the semistructured interview, and maternal rating of youth psychosocial concerns on the PSC,  $t(32) = 2.06$ ,  $p = .048$ . Specifically, mothers who characterized their own emotional difficulties as a concern rated their children as displaying significantly greater levels of behavioral problems than mothers who reported no emotional concerns.

## Discussion

This sample of low-income African-American mothers whose children received ED attention following an assault reported concerns at all ecological levels. The most common concerns involved family safety and youth aggressive behavior, consistent with previous research involving low-income African-American families dealing with community violence (e.g., Dubrow & Garbarino, 1989; Schwab-Stone et al., 1999). Mothers also reported experiencing high levels of distress, which were unrelated to various aspects of the assault but directly related to maternal level of violence exposure. Most notable were the avoidant tendencies and emotional blunting associated with category C symptoms of PTSD (American Psychiatric Association, 2000). Similar findings have been shown among African-American

women with a history of childhood trauma (e.g., Banyard, Williams, & Siegel, 2001). In this study, levels of dissociation and intrusive experience among mothers predicted over half of the variance associated with maternal rating of youth psychosocial difficulties. There are several possible explanations for this relationship. It could be that maternal distress affects perception of youth functioning. Another possibility is that mothers experiencing PTSD symptoms have difficulty providing support and emotional availability to their children following an assault, which serves as a risk factor for subsequent youth functioning. On the other hand, youth difficulties may lead to or exacerbate maternal distress. Unfortunately, the cross-sectional nature of this study limits the extent to which transactional processes between mother and child can be identified. However, preliminary analysis of distress reported by the youth revealed a significant interaction between youth perception of safety and maternal distress (McCart et al., 2004). Specifically, for youth who did not report safety concerns, their levels of PTSD symptomatology were low regardless of maternal distress level. However, for youth who did report safety concerns, their distress was low if maternal distress was low but increased substantially in the presence of maternal distress. Researchers have suggested that there is a relationship between youth distress and perceptions of safety (e.g., Weaver & Clum, 1995), but the transactional relationships among maternal and youth characteristics require further attention.

Despite the high levels of distress and multiple concerns found in this study, few mothers relied on mental health services. This is consistent with prior findings (Chow, Jaffee, & Snowden, 2003) and underlies the need for examination of the barriers to accessing mental health services for this population. Mothers did report relying on social support to cope with concerns, but the relationship between social support and distress was complicated. Specifically, relationships providing guidance were associated with lower levels of distress, whereas those requiring mothers to nurture others were associated with higher levels of distress. In addition, mothers who reported relying on social support also reported higher levels of distress, as did mothers who accepted Project Ujima services following the assault of their child. Although extended family support has been shown to be beneficial for single African-American mothers and their children (Wilson & Tolson, 1990), it may be that mothers who rely on support do so because they are experiencing high levels of distress. A majority of mothers in this study also reported relying on faith-related strategies, replicating results from a national survey

of African Americans (Ellison & Taylor, 1996). No relationship was found between the use of faith and symptoms of distress, but future research should examine the use of faith in more depth, given its importance to this population.

There are several limitations associated with this study. First, without a control group it is difficult to conclude whether mothers of assaulted youth have different experiences than other mothers in the same neighborhoods. The authors currently are conducting a study to compare maternal experience among samples of low-income African-American families whose children have presented to CHW for assault-related injuries and for acute illness. Research suggests that there may be overlap among the experience of these mothers, in that McAdoo (1995) also reported high levels of distress and a variety of concerns among a large random sample of urban African-American mothers.

A second limitation is whether these results can be generalized. The focus on African-American mothers is important, given that African-American youth are disproportionately exposed to community violence (Buka et al., 2001) and living in families headed by single mothers (Fields, 2003). Nonetheless, future research should consider the experience of fathers and families of other ethnic and racial groups. In addition, it would be preferable to use representative sampling and to consider the influence of various factors on parental functioning (e.g., time between youth assault and interview, youth age and gender). For example, time likely serves as a confound, although it was unrelated to level of maternal distress in this study, suggesting that stressors other than youth assault are contributing to maternal distress. However, because particular concerns are undoubtedly related to time since the assault (i.e., worried about the child's injury healing), further research is needed to examine the longitudinal nature of maternal concerns.

A final limitation involves the use of surveys that have not been normed on African-American women, underscoring the lack of well-developed instruments aimed at African-American women and the need to better involve this population in research. Results from this study comprise the first step of the behavior analytic model (Goldfried & D'Zurilla, 1969), which culminates in the development of a context-specific instrument for assessing coping among members of a particular population. The first author currently is examining how a second sample of mothers hypothetically would cope with the most common concerns elicited in this study. After responses are rated for effectiveness, an instrument

will be created that includes relevant difficulties experienced by low-income African-American mothers whose children have been assaulted, along with potential coping responses rated for effectiveness. Such an instrument could be used to appropriately target and evaluate interventions.

### **Clinical Implications**

The results of this study have implications for the recommendation that more attention be devoted in the ED to managing parental distress, assessing risk factors associated with PTSD, and providing mental health referrals when needed (Horowitz et al., 2001). Among low-income African-American mothers of assault victims, relationships that provide guidance, and individuals who appear to understand the mothers' situations, are related to lower levels of distress. Being familiar with the concerns of this population may help to build legitimacy for ED staff, thus making recommendations about ways to manage youth distress, mental health referrals, and social service options more palatable. Research among hospitalized youth has indicated that providing mothers with information regarding how to manage youth distress is helpful for both mothers and youth (Melnik & Feinstein, 2001). Accordingly, in working with the families of assault victims during home visits following the ED visit, Project Ujima staff provides psycho-education that normalizes youth response to trauma and emphasizes the importance of parental support. Because of maternal disinclination to engage with traditional mental health services, Project Ujima also provides referrals to alternative sources of support (e.g., culturally sensitive and/or in-home therapy).

Given the relationship between maternal symptoms of PTSD and child psychosocial difficulties, a brief screen administered in the ED also would be helpful to initially identify distressed mothers. The screening tool for early predictors of PTSD (Winston, Kassam-Adams, Garcia-Espana, Ittenbach, & Cnaan, 2003) identifies youth and parents who are at risk for developing symptoms of PTSD following youth trauma. However, because it focuses on factors specifically related to the youth trauma, it may be beneficial to augment with a few questions about maternal trauma history for this population, thus recognizing the likelihood that factors other than the severity of the youth's injury are related to maternal distress and, in turn, to youth resiliency following the trauma.

*Received January 5, 2004; revisions received July 21, 2004 and December 9, 2004; accepted December 13, 2004*

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