

## Gender Differences in the Effects of Community Violence on Mental Health Outcomes in a Sample of Low-Income Youth Receiving Psychiatric Care

*Community violence exposure (CVE) represents a serious public health problem for youth. This study extends research in this area by examining how gender, type of violence (e.g. direct vs. indirect), and relationship to victims affects mental health outcomes in high poverty urban contexts in the U.S.*

Javdani, S., Abdul-Adil, J., Suarez, L., Nichols, S. R., & Farmer, A. D. (2014). Gender differences in the effects of community violence on mental health outcomes in a sample of low-income youth receiving psychiatric care. *American Journal of Community Psychology*, 53(3-4), 235-248.

### Summary and Commentary by Jenny Fauci, MA, Department of Counseling Psychology, Boston College

#### Introduction:

- What do we know about community violence?
  - CVE—direct or indirect exposure to deliberate acts of violence at home, school, or in one’s community— is 30x higher in US than other industrialized countries
  - Community violence represents a significant risk factor for U.S. youth, particularly in high poverty contexts where exposure is higher
  - Community violence accords mental health risks across the lifespan, including PTSD and traumatic stress
- What are the different types of community violence?
  - Direct violence: individual is a victim or voluntary engaged (e.g. fighting)
    - Consistently related to negative mental health outcomes
    - Most research relies on single-informant reporting; this study will ask both youth and caregivers about violence
  - Indirect violence: individual witnesses or hears about violence
    - Less research explores indirect violence, including relationships to victim; however, it is critical in high-poverty settings where indirect exposure to violence is higher
    - Indirect violence can affect youth through “vicarious trauma”— cognitive and interpersonal changes that represent posttraumatic symptoms
- Examining Gender: What are the gaps?
  - Scarce research has explored how gender moderates the relationship between community violence and mental health outcomes
  - Limited research has suggested some gender specific pathways to trauma-related symptoms:
    - Higher externalizing behaviors for girls who witness violence, perhaps because of the impact on relational experience
    - Higher anxiety for boys who witness violence, perhaps due to the greater experience of threat (i.e. “that could be me”)
- Research Questions

- What is the relationship between direct (e.g., being a victim) and indirect (e.g., knowing about or being a witness) community violence and mental health symptoms (internalizing, externalizing, & posttraumatic stress disorder—PTSD)?
- Are there differences in mental health outcomes based on exposure to indirect violence against a stranger or familiar person?
- Are there gender differences in mental health outcomes based on exposure?
- Hypotheses
  1. Direct violence will be related to higher mental health symptoms than indirect violence for both boys and girls
  2. Indirect violence against a familiar will be a higher risk factor for girls; indirect against stranger higher risk for boys

### Method:

- Sample was recruited through invitation to all families in an outpatient clinic in Chicago for disruptive behavior after their initial intake appointment
- Child and caregiver consent obtained
- Families compensated \$30 for participation

### Measures

- Child Mental Health: (1) *Child Behavior Checklist* (CBCL), by caregiver; (2) *Youth Self-Report* (YSR), by youth.
  - Internalizing subscale (anxiety, depression)
  - Externalizing subscale (aggression, rule-breaking)
  - PTSD subscale (post-traumatic symptoms)
- Community Violence Exposure: Parent and child versions of the *Child Report of Exposure to Violence* (CREV), including:
  - Direct victimization (direct)
  - Violence that is witnessed (indirect)-stranger & familiar
  - Violence that is heard about (indirect)-stranger & familiar
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- Participants
  - Total sample, n= 306 youth + one caregiver
  - Age range: 6-17 years old (M = 10 years, 8 months); half (48%) between 6 and 10 years
  - African American (80.2 %) Hispanic/Latino/a (9.5 %)
  - 78 % boys (typical for disruptive behavior samples)
  - High poverty: 80% families reporting receipt of public aid
  - Family status: 46% of caregivers married or living with a partner, 27% single, 19% divorced or separated, and 7 % widowed.
  - No demographic differences between genders, except girls were slightly older

### Results

- Analysis
  - Three hierarchical multiple regression analyses were conducted
  - Outcomes: Internalizing symptoms, Externalizing symptoms, and PTSD symptoms
  - Explanatory variables: gender (M/F) and community violence (5 subscales—direct, witness-stranger, witness-familiar, hear-stranger, hear-familiar)
  - Sample-based mean imputation was used to account for missing data

- No significant differences found on demographic or descriptive data between participants with missing and non-missing data
- What were the general trends across variables?
  - Mental Health:
    - No differences in overall mental health outcomes between boys and girls
    - Parents report higher internalizing symptoms; youth report higher externalizing symptoms
  - Community Violence:
    - According to youth report, no gender differences in CVE
    - Parents perceive that boys witness more stranger violence; youth report that girls do
    - Boys vs. parents report more exposure to reported violence against familiars, and witnessed against stranger
- What did their analyses reveal about the relationship between CVE and mental health outcomes, including gender differences?
  - Direct Exposure to Violence
    - Being a direct victim of violence significantly and positively associated with all outcomes—higher externalizing symptoms, internalizing symptoms, and PTSD symptoms—for both boys and girls.
  - Indirect Exposure
    - For girls vs. boys, hearing about violence against a familiar is more strongly associated with all outcomes— higher externalizing symptoms, internalizing symptoms, and PTSD symptoms.
    - When using only the parent report of CVE, gender no longer moderates the relationship between PTSD and witnessing violence against a familiar
  - Discrepancy between parent and child reports: Should be noted as research is applied and continued

## Applications and Comments by Reviewer

- What did this study offer?
  - Confirms findings that direct victimization is similarly detrimental across genders, including in high poverty
  - Extends research by demonstrating that indirect violence differentially affects girls vs. boys
- Why the gender difference? *Family care-giving roles and gender expectations for girls*—which increase through adolescence—may explain heightened impact of indirect violence against *familiars*, considering:
  - Disruption to identity and role development
  - Threats to safety and safety of loved ones
  - Vicarious trauma and stress
- What are the assessment & treatment implications?
  - Expand definition of violence—including indirect and direct CVE, particularly in high poverty settings
  - Attend to the complexity of violence across genders—including an assessment of relationship to victim (e.g., familiar vs. stranger) and any associated meanings—perhaps particularly when working with young women

- Attend to cumulative traumas; the disruption of safety, power; and coping as part of treatment
- Incorporate ecological approach to health for youth in poverty, including resilience focused interventions, family-based approaches, and social supports
- Limitations
  - Conducted in high risk, outpatient sample: Generalizable to youth identified with behavioral problems
  - Relatively more boys vs. girls in the sample: Additional research on girls' experiences is needed

### Practitioner Implications: Vivien Sun, MD, UCSF Benioff Children's Hospital, San Francisco, CA

- **New information:** There is a growing body of research investigating how toxic stress (e.g., neglect) in youth—including witnessing and being a victim of violence (CVE)—leads to increased risk for poor mental and physical health in adulthood. This study adds further nuance to the established relationship between CVE and mental health risks, suggesting how individual factors such as gender and relationship to victims adjust a youth's risk for a variety of poor mental health outcomes.
- **Implications for screening:** Given the detrimental effects of community violence on mental health, it is important to screen for community violence in primary care and identify higher risk patients early. The *American Academy of Pediatrics* recommends universal screening for youth safety and violence in routine primary care visits. Optimal screening would be conducted:
  - Within a private setting (with parents outside the room) and would be preceded by establishing the limits of confidentiality.
  - Through a validated tool (e.g., Child Report of Exposure to Violence-CREV). However, with many competing screenings needing to be performed in a short visit, it may suffice to simply screen with an open-ended normalizing question, e.g. "Many teens I see are dealing with violence in their homes or communities, so I now ask all my teens about it. Have you experienced violence in your life?"
  - From a comprehensive trauma-informed approach by all staff and providers. This includes building emotional safety (e.g. being transparent about questions and procedures) and avoiding re-traumatizing (e.g. using patient/client's language).
- **Developing interventions:** In addition to offering universal screening and providing a trauma-informed approach, it is important to consider the following responses, services, and pathways for intervention:
  - Highlight and leverage resilience and positive supports in child's life (e.g., strengths, relationships, family supports)
  - Provide information for youth and families with multiple sources of toxic stress, given the demonstrated graded risk of adverse childhood

experiences on poor health outcomes. Information should be pre-prepared and readily accessible at time of visit.

- Offer appropriate and timely treatment, as well as early referral and supports for exposure to violence (e.g., community-based programs; individual, group, or family treatment options). Collaborate with other health services to provide continuity and access.