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Adolescent exposure to violence and adult physical and mental health problems

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ABSTRACT

Evidence on the relationship of adolescent exposure to violence (AEV) with adult physical and mental health problems is limited, with studies often focusing on earlier childhood rather than adolescence, and also on short term rather than long term outcomes. Information specifically on the relationship of AEV to seeking help for mental health problems in adulthood from either formal sources such as mental health professionals or informal sources such as friends and clergy is even more difficult to find. The present study investigates how adolescent exposure to violence (AEV), in the form of parental physical abuse, witnessing parental violence, and exposure to violence in the neighborhood, are related to self-reported adult physical problems and seeking formal or informal assistance with mental health, controlling for more general adolescent violent victimization and for self-reports and parent reports of mental health problems in adolescence. This study adds to the literature on AEV and adult physical problems, and provides a rare look at the relationship of AEV to adult help-seeking for mental health problems. The results suggest that AEV is associated with mental health problems in adolescence for both females and males, that for females AEV is related to physical problems and to seeking help for mental health problems in adulthood, but for males the only significant relationship involves inconsistent reports of witnessing parental violence and adult physical problems.

Introduction

There is an extensive literature on the relationship of childhood and adolescent exposure to violence on subsequent mental health problems (see for example the reviews by Acosta, Albus, Reynolds, Spriggs, & Weist, 2001; Buka, Stichick, Birdthistle, & Earls, 2001; Gewirtz & Edleson, 2007; Kendall-Tackett, 2013; Lynch, 2003; Ruback & Thompson, 2001; Widom, 2014), and a much more limited literature on the relationship of childhood and adolescent exposure to violence on subsequent physical health problems (see for example the reviews in Kendall-Tackett, 2013; Ruback & Thompson, 2001; Widom, 2014; and see also Bonomi, Cannon, Anderson, Rivara, & Thompson, 2008; Springer, 2009; Springer, Sheridan, Kuo, & Carnes, 2007). Several limitations, however, affect nearly all of this research. First, this research often relies on samples that are small in size and/or limited to clinical samples of individuals who have experienced certain types of exposure to violence, or to predominantly

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urban, minority ethnicity, lower socioeconomic status samples, without comparison samples (Gewirtz & Edleson, 2007; Heyman & Slep, 2002; Lynch, 2003; Margolin & Gordis, 2000). In particular, studies involving national probability samples representative of the general population are rare (Rebellon & Van Gundy, 2005); an important exception is the National Study of Children's Exposure to Violence (NATSCEV; see Finkelhor, Turner, Ormrod, & Hamby, 2009; Finkelhor, Turner, Ormrod, Hamby, & Kracke, 2009). Second, studies of adolescents, as opposed to younger children, are particularly rare, and many studies make no distinction between adolescent and earlier childhood exposure to violence (Menard, Weiss, Franzese, & Covey, 2014; for exceptions to this general pattern, see Ireland, Smith, & Thornberry, 2002; Thornberry, Ireland, & Smith, 2001). Kitzmann, Gaylord, Holt, and Kenny (2003) conducted a meta-analysis of 118 studies on child exposure to domestic violence and found that only 10 utilized adolescent samples. Third, some studies have failed to distinguish between directly experiencing violence (as a perpetrator or a victim) from broader exposure to violence such as witnessing violence in the family or awareness of violence in the neighborhood (Acosta et al., 2001; Gewirtz & Edleson, 2007). Fourth, several reviews of the literature have indicated the rarity of and the need for longitudinal studies (e.g., see also Gewirtz & Edleson, 2007; Widom, 2014). Kitzmann et al. (2003) found that only 6% (7 studies) of the 118 studies they reviewed utilized longitudinal data sets. Even in existing longitudinal studies, individuals are often followed only into adolescence (e.g., Ehrensaft et al., 2003) or young adulthood (e.g., Yates, Dodds, Sroufe, & Egeland, 2003), neglecting longer term consequences of adolescent and childhood exposure to violence (Gewirtz & Edleson, 2007; Margolin & Gordis, 2000, 2004).

The present study examines the relationship of adolescent exposure to violence (hereafter AEV) to three adult outcomes: professional mental health service utilization, more general seeking assistance with mental health problems (which may include informal as well as professional sources of mental health assistance), and physical health, more specifically functional limitation. AEV is used here, as in Covey, Menard, and Franzese (2013), Eitle and Turner (2002), Finkelhor, Turner, Ormrod, and Hamby (2009), Finkelhor, Turner, Ormrod, Hamby, and Kracke (2009), and Menard et al. (2014), as a general term encompassing direct physical abuse, witnessing parental violence, and perceptions of neighborhood violence, as different and specific forms of the broader concept of exposure to violence. (An even broader term used in the literature is "maltreatment" which encompasses not only physical abuse or exposure to violence, but also neglect). Weaknesses in past research are addressed, first by examining a national probability sample (as opposed to a local or clinical sample) of over 1,000 total respondents. Second, we distinguish among direct victimization (physical abuse) and more general exposure to violence (witnessing parental violence and neighborhood violence). Third, we measure exposure to violence in adolescence and mental and physical health outcomes in middle adulthood, adding to our knowledge of both of these otherwise underrepresented age ranges. Fourth, we not only examine bivariate correlations but also include the different measures of AEV in the same analyses and consider their separate relationships to adult mental and physical health problems. Fifth, we control for prior violent victimization other than physical abuse, to allow for the possibility that violent victimization in general may be a risk factor for subsequent mental and physical health problems. We control as well for other potential confounding influences, including gender (by analyzing the data separately for females and males), ethnicity, urban–suburban–rural residence, and socioeconomic status. Separate analysis for females is necessary because past research suggests that they respond differently, with males more likely than females to engage in externalizing behaviors such as aggression and females more likely than males to engage in internalizing behaviors such as depression in response to exposure to violence (Gewirtz & Edleson, 2007; Herrenkohl, Sousa, Tajima, Herrenkohl, & Moylan, 2008; Widom, 1989).

Theoretical Perspective

Considerable attention is now being placed on theories and therapeutic interventions which emphasize the important role trauma plays in increasing risk for a variety of adverse medical, social, and psychological consequences. A neurobiological approach to understanding the critical role trauma plays in shaping lives has been proposed by Perry (2001); see also Anda et al. (2006) and Perry (2003). Anda et al. and Perry conclude that the impact of traumatic events and experiences, such as exposure to violence, on brain functioning leads to increased risk for mental health problems, anti-social behaviors, victimization, and other negative life consequences. Some of these responses are acute and others are long-term. Responses to traumatic events individually vary and often are acute, but recollections of some traumatic events, such as physical abuse, are stored deep in the memory and may surface with environmental cues that remind the individual of the previous trauma. Thus, we might expect youth subjected to violent trauma during adolescence to have recurrent episodes of lasting effects (symptoms), such as mental health problems, drug use, violent behaviors, and other problems.

Although this study is not a formal test of Perry's propositions, the design of this study fits well with much of his conceptual framework. Following his framework and the research of Anda et al., the more the adolescent is exposed to trauma, in this case witnessing domestic violence, being physically abused, and being exposed to neighborhood violence, the greater the likelihood we would observe long-term and potentially permanent changes in the social, behavioral, medical and psychological functioning of the individual, at least when measured during different spans of time up to middle adulthood. More specifically, we hypothesize that those adolescents exposed to traumatic events would self-report physical health problems and mental health problems, with greater frequency than those not reporting exposure. In addition, as noted above, we expect to find significant differences between male and female responses to trauma. In particular, Perry (2001) suggests that females are more likely than males to retreat and disassociate and males are more likely to become more aroused and active in events.