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Physical and Mental Health Outcomes in Juvenile Victimization Subclasses

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Abstract

Juvenile victimization has become a hot topic in the media, able to draw equal anger from liberals and conservatives. Previous research has shown that victims of abuse are more likely to display symptoms of depression and anxiety, have difficulty with emotional regulation, and have lower self-esteem. Research also shows that victims of abuse are more likely to experience abuse multiple types of abuse, as opposed to only experiencing one type. Interestingly, much research on juvenile victims has focused on one outcome at a time. Recent research on juvenile victimization has uncovered five abuse constellations. This study uncovers outcomes for individuals classified across the those constellations. This research has implications in policy, clinical application, and public health prevention and implementation.

Keywords: juvenile victimization, abuse, social support

Physical and Mental Health Outcomes in Juvenile Victimization Subclasses

Juvenile Victimization is a wide category encompassing a variety of childhood abuses in a variety of contexts. Victimization by caregivers, peers, and strangers are included, as is sexual, physical, and emotional abuse. While children have always been targets of violence, recent media attention has added increased scrutiny. Some studies estimate that as many as 66% of children experience some form of victimization (Ford, Elhai, Connor, & Frueh, 2010). Psychologists are studying juvenile victimization on many fronts including prevention, intervention, and post-trauma care. Some psychologists study perpetrators while others study survivors. Research has shown that survivors of victimization of one type are more likely to be victims of other types (e.g., physical abuse and emotional neglect; Finkelhor, Ormrod, Turner, & Hamby, 2005). Survivors of multiple victimization types are termed "polyvictims," often defined as someone who experiences four or more victimization types within a year (Finkelhor, Ormrod, & Turer, 2007). The current study assesses outcomes of specific juvenile victimization combinations.

Previous Research

Much of the previous victimization research has focused on one type of victimization at a time. In the late 1990s, researchers discovered that it is atypical for people to experience only one form of victimization (Finkelhor et al., 2005). Much research on polyvictimization focuses on adolescents and includes emotional dysregulation and social support as outcomes (Barnes, Howell, & Miller-Graff, 2016). A 2015 study from Spain investigated mental health outcomes for polyvictims in adolescents and confirmed that it is atypical for people to experience only one form of victimization (Soler, Forns, Kirchner, & Segura, 2015). Studies show that polyvictims display higher levels of trauma stress than controls or even victims of a single

type (Finkelhor et al., 2007). Finkelhor and Hamby set out to design a reliable measure to identify experiences of victimization to assist in intervention efforts. They developed the Juvenile Victimization Questionnaire in 2004 and it has been used in a multitude of studies including the present investigation.

Outcomes of Victimization

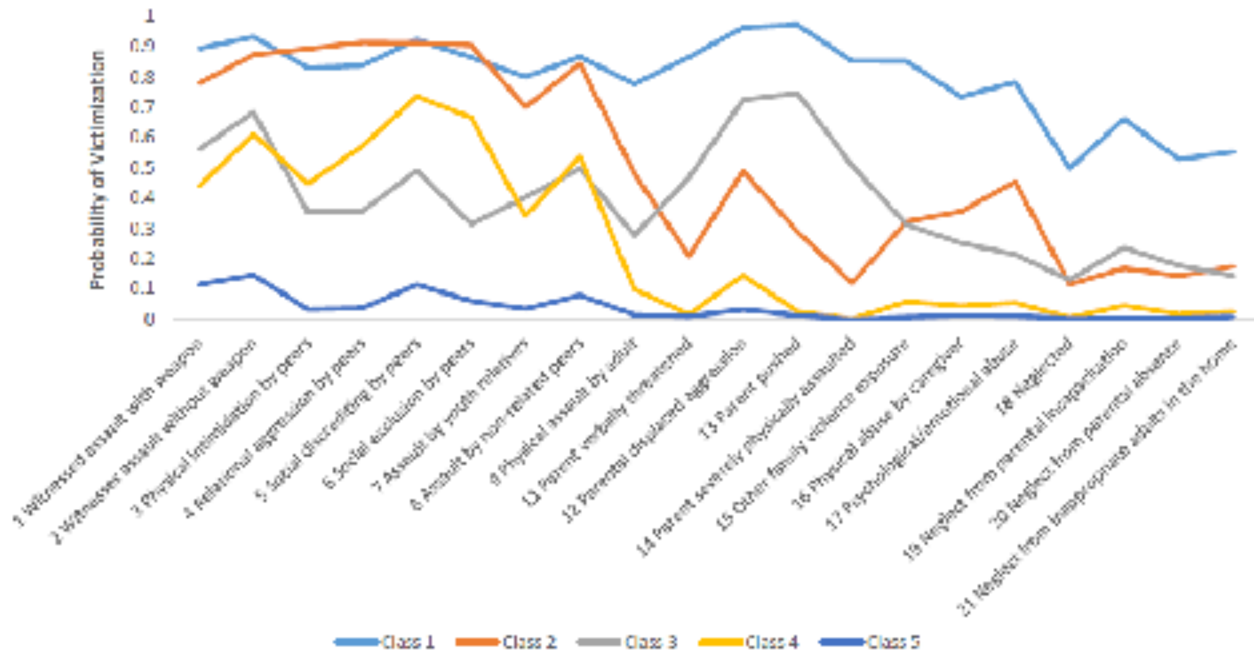
All victimizations are essentially connected (Hamby, Roberts, Taylor, Hagler, & Kaczkowski, in press). Focusing on single victimization incidents might lead researchers to miss key moderators of victimization outcomes. People who experience polyvictimization are prone to depression and anxiety (Cyr, Clement, & Chamberland, 2014), decreased sense of self-worth (Evans, 2003), emotional dysregulation, and other negative effects on mental health (Barnes et al., 2016). Cyr's study was unique in that it was the first to measure the effects of polyvictimization on mental health in Canada. Her findings indicate that depression and anxiety are the most common outcomes of negative childhood experiences, but these relations could be moderated by family status. Children from intact families fair better than children from single- or step-parent homes. An earlier study by Ford found similar results and also found that poly-victims were more likely to engage in delinquent behavior and have delinquent peers (Ford et al., 2010). These findings were confirmed by a 2011 study that found poly-victims had an elevated likelihood for future high risk behaviors (Begle et al., 2011). Evans's 2003 study found that high allostatic load on children, which included trauma and victimization, led to poor regulatory control, learned helplessness, poor cardiovascular and neuroendocrine health, as well as higher body mass index.

Barnes's findings are congruent with Cyr's in that both indicate forms of social support being moderating influences on the effects of poly-victimization (Barnes et al., 2016; Cyr et al., 2014). Barnes found that children with low social support fared less well than those with strong social support. This study suggests that juvenile poly-victims tend to have less social support available to them; furthermore, negative or traumatic childhood events lead to emotional dysregulation, which might further alienate potential sources of support. Finkelhor's 2007 longitudinal study suggests that polyvictimization, rather than individual victimizing events, is more predictive of trauma symptoms.

Classes

As previously reviewed, the Juvenile Victimization Questionnaire provides data on a variety of victimization types. Previous research uncovered cohesive subgroups of individuals in regard to their constellation of juvenile victimization experiences (Swartout, Hamby, Banyard, & Grych, in preparation). When analyzing the data, five constellations of abuse were discovered based on prevalence of different forms of peer victimization and victimization by adults and caregivers. As shown in figure 1, class 1 (11.8% of the sample) is highly likely to experience every form of victimization assessed. Class 2 (16.7%) is highly likely to experience peer victimization and has moderate likelihood to experience victimization from a caregiver. Class 3 (14.3%) is moderately likely to experience peer victimization and highly likely to experience victimization from a caregiver. Class 4 (31.4%) was moderately likely to experience peer victimization but unlikely to experience victimization from a caregiver. Class 5 (26.1%) was unlikely to experience any form of victimization assessed.

Figure 1. Classes



Current Study

The current study is a secondary data analysis concerned with the constellations of individuals discussed above. Although much of the previous research on juvenile victimization focuses on profiles of victims or a specific outcome, this study investigates subgroups of victims along with a variety of possible outcomes. We know that polyvictimization leads to depression and anxiety, emotional dysregulation, and lower self-esteem. Based on recent research findings that uncovered five classes regarding juvenile victimization experiences, do these five constellations of juvenile victimization experiences differ in regard to participants' outcomes experienced as adults?

Methods

Participants

As part of a larger survey on personal growth and self-efficacy, 2565 individuals from largely rural areas of Southern U.S states participated in the study. Participants ranged in age from 11-70 years old (M=29.3 years; SD=12.3 years), and 63% were female. Forty-seven percent of participants worked at least part-time outside the home, and 61% reported no education beyond the high school/GED level. The sample was largely drawn from rural regions, with 23.2% of participants living in a rural area with a population of less than 2,500, 35.5% living in a small town with a population of 2,500 to 20,000, and 18.7% living in a town with a population of 20,000 to 100,000. For total household income in 2012, 39% of participants reported less than $20,000 per year; 36% reported between $20,000 and $50,000 per year; 25% reported more than $50,000. Most participants were White, non-Hispanic (75 %), 12% were Black/African American, 7% were Hispanic or Latinx, 4% were multiple races, 1% were American Indian or Alaska Native, 0.4% were Asian, and .5% were Native Hawaiian or Pacific Islander.

Measures

The LifePaths Measurement Index was a survey project conducted in Appalachia. The project covered a variety of domains, from assets and resources to interpersonal behaviors, adversities to personal strengths. A total of forty-seven different measures were used to complete the Index. All surveys used a four-point Likert-type scale for consistency of responses.

The Juvenile Victimization Questionnaire-Key Domains Short Form was adapted from Finkelhor, Hamby, Turner, & Ormrod's 2005 measure, as well as Hamby et al.'s 2011 work. A pilot study was run on the adaptations, which focused on peer and community victimization,

caregiver maltreatment, and exposure to domestic violence. The final version used in the Life Paths survey consisted of 21 questions with nine potential follow-up questions regarding the nature of the victimization. Sample questions included "At any time in your life, in real life, did you SEE anyone get attacked or hit on purpose WITH a stick, rock, gun, knife, or something that would hurt? Somewhere like at home, at school, at a store, in a car, on the street, or anywhere else" and "When you were a child, did you get scared or feel really bad because grown-ups called you names, said mean things to you, or said they didn't want you?"

To assess outcomes, six measures were used. Spiritual Well-Being: The Awe Index was developed by Hamby, Grych, and Banyard in 2013. To test its validity, a pilot study was conducted from the same population as the main sample used in the Life Paths project. The survey consisted of five questions pertaining to the participant's sense of spiritual connections, either religion or connectedness to nature. Sample questions include "My relationship with God gives me a sense of inner peace" and "I feel a sense of well-being from being in touch with forces that are bigger than me."

The Alcohol Use Disorders Identification Test (AUDIT) – Short Form was adapted from Babor, de la Fuente, Saunders, & Grant's 1992 10-question survey. The adapted measure consists of five questions about the participant's alcohol usage intensity and frequency of use. Sample questions include "How often do you have a drink containing alcohol" and "Has a relative, friend, or doctor or another health professional ever expressed concern about your drinking or suggested you cut down?"

The Health Related Quality of Life was adapted from the Healthy Days Measure, which was developed by the Centers for Disease Control. The five question adapted measure was tested

in a pilot study and contained questions regarding pain and other physical or psychological limitations participants might have experienced in the past 30 days. Sample questions include "During the past 30 days, how many days was your physical health, which includes physical illness and injury, not good" and "During the past 30 days, for about how many days did PAIN make it hard for you to do your usual activities, such as self-care, school/work, or recreation?"

The Posttraumatic Growth Index was developed by Tedeschi & Calhoun in 1996. The measure was adapted and tested with a pilot study by the Life Paths team. The adapted scale contained nine questions pertaining to the nature and subjective level of each participant's optimisim based on behavior from the last year. Sample questions include "I changed my priorities about what is important in life" and "I have a greater sense of closeness with others."

A Subjective Well-Being scale was adapted from a variety of sources by the Life Paths team (Battista & Almond in 1973; Diener, Emmons, Larsen, & Griffin in 1985; Pavot & Diener in 1993; Pearlin & Schooler in 1978; Rosenberg, 1965; Turner et al., 2012) The finalized thirteen questions measure the participant's self-report of their current state and optimism about the future. Sample questions include "In most ways my life is close to my ideal" and "When I look at my life, I feel I have really worked to accomplish something."

Procedures

Participants were recruited through word of mouth and a local email list for classifieds advertisements. All participants and close informants were given a $40 Wal-Mart gift card for their participation. A subset of participants were asked to bring "someone who knew them well" to act as a close informant; 47% of informants were family members, 39% were friends, and 13% were spouses. Participants and close informants each completed a computer-assisted self-

interview (CASI) using The Survey System software. Participants answered questions about themselves; close informants answered an abbreviated questionnaire about their "study partner."

Results

A majority (85.2%) of the sample reported experiencing at least one type of either direct or indirect juvenile victimization, with an average of 6.4 (*SD*=5.1) separate juvenile victimization experiences. Incidence rates for the specific victimizations assessed ranged from 10.5% for neglect by adults to 59.8% for witnessing an assault that did not involve a weapon. Descriptive statistics of the distal outcome variables are presented in Table 1.

Table 1. Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Subjective Well-Being	2037	-9	10	-.24	1.878
Mental Health	2090	2	1	.03	1.021
Post-Traumatic Growth	2076	-8	3	-.40	2.058
Healthy Days	2077	-4	6	-.05	1.044
Spirituality	1979	-3	1	.01	.999
Alcohol	2032	-1	4	.10	1.012

As shown in Table 2, mean differences in subjective well-being were significant in all but two constellation comparisons. Class one compared to class two and also to class five had very large negative mean differences, -.69 and -.62, respectively. Class one and class five are vastly different in their victimization experiences, so this is not surprising (see Figure 1). Class two is only slightly different from class one, having a relatively lower risk of victimization by caregiv-

er. Levels of subjective well-being significantly differed between class one and classes three and four, though less extremely. Also significant were the differences between classes three and four compared to class five. There were positive mean differences between class two compared to classes three and four. Most interestingly, class two and class five appeared to have little difference in subjective well-being. Class three and four also had similar levels of subjective well-being, but this is hardly surprising given their similarities in victimization experiences.

	Subjective Well - Being	**General Mental Health**	**Post-Traumatic Growth**	**Healthy Days**	**Awe Index**	**Alcohol Use**
Overall test	115.89***	594.26***	17.01***	139.65***	17.33***	80.49***
Class 1 vs Class 2	-0.69***	-0.81***	-0.16*	-0.76***	-0.28***	0.26***
Class 1 vs Class 3	-0.41***	-0.68***	-0.01	-0.60***	-0.25***	0.04
Class 1 vs Class 4	-0.30***	-0.20***	-0.08	-0.41***	-0.25***	0.04
Class 1 vs Class 5	-0.62***	-1.25***	0.04	-0.80***	-0.26***	0.48***
Class 2 vs Class 3	0.28***	0.14*	0.15*	0.16***	0.03	-0.13*
Class 2 vs Class 4	0.39***	0.61***	0.08	0.36***	0.04	-0.23***
Class 2 vs Class 5	0.07	-0.44***	0.20***	-0.04	0.02	0.21***
Class 3 vs Class 4	0.12	0.48***	-0.06	0.20**	0.01	-0.09
Class 3 vs Class 5	-0.21***	-0.57***	0.05	-0.20***	-0.01	0.35***

	Subjective Well - Being	**General Mental Health**	**Post-Traumatic Growth**	**Healthy Days**	**Awe Index**	**Alcohol Use**
Class 4 vs Class 5	-0.32***	-1.05***	0.12	-0.39***	-0.02	0.44***

Table 2 Mean Differences

Note: p**<.005**

Average levels of general mental health significantly differed between classes one compared to all the other classes, especially between classes one and five. Class two had positive mean differences compared with classes three and four, but was significantly lower than class five. Class three had a positive significant difference compared to class four, but was lower than class five. Class four had much lower than class five.

All classes appeared to have similar levels of Post-Traumatic Growth. The largest significant difference was class two versus class five, with a .20 mean difference. Other significant differences were between classes one versus two (-.16) and classes two versus three (.15). Class four versus class five had a mean difference of .12

Most groups also had marked differences in reported Healthy Days. Class one had large significant mean differences with all classes. The only insignificant mean difference for class two was compared to class five. Classes three and four also had significant mean differences with each other and with class five.

Class one had significant negative mean differences with all other classes on the Awe Index. All other classes were remarkably similar to each other, though classes three and four had insignificant negative mean differences when compared with class five.

There were a wide variety of significant mean differences between the classes in Alcohol Use. Insignificant differences existed between class one versus class three, class one versus class four, and an insignificant difference between class three and four. A small significant difference was noted between class two and class three, and the largest difference existed between class one and class five.

Discussion

This study demonstrates a wide variety of consequential outcomes of juvenile victimization experiences. Alcohol use seemed to be relatively consistent for victimized constellations, which was expected. The AWE Index results appear to indicate a base religiosity that would be expected in the Bible Belt. The Healthy Days measurement produced a wide variety of responses. Post-Traumatic Growth levels among the constellations of victimization were relatively similar, which is unsurprising given that most participants live in the same or similar communities, therefore with similar options for recovery and therapy.

The most surprising result of the study is the similarity between class two and five on the subjective well-being measure. Class 2 is highly likely to experience peer victimization and has moderate likelihood to experience victimization from a caregiver. Class 5 was unlikely to experience any form of victimization assessed. Despite very different victimization experiences, there appears to be some moderating force with class two's victimization that is comparable to a characteristic of class five. Given the negative mean difference between the classes in general mental

health, it is likely to be an external force. The similarities between classes three and four were also expected, but the positive difference in general mental health is worthy of future investigation. Barnes's (2016) and Cyr's (2014) research may indicate that social support buffers against negative outcomes of the victimization experience, though class two is likely to experiences peer victimization. Class two is not likely to experience victimization from a caregiver, though, so perhaps the social support they receive at home or in another context moderates the victimization experiences.

The Life Paths Assessment Project is very comprehensive and unique in that the researchers recruited a predominantly rural sample. Limitations still exist. The project did not account for any sexual victimization among minors, which may have changed not only victimization profiles but also these findings. Perhaps urban centers with denser populations and different crime rates would produce different results as well. Perhaps with the different recreational activities and access to resources might affect post-traumatic growth or healthy days.

Future studies should include a larger urban representation. Combined with assessment of juvenile sexual victimization among all participants, this could help provide a more clear picture of these outcomes for both rural and urban populations. Future studies using these constellations of victimization should further investigate the differences in general mental health between classes three and four.

One implication from this study is that the present geographic area of study contains generations of children who are victimized, living in close proximity to each other with reduced resources comparable to urban environments. There is great potential for a perpetual cycle of abuse, particularly given the prevalence of substance use confirmed by the study. Psychologists

of all disciplines should work to enhance existing services in the region as well as support public policy initiatives aimed at introducing new services. Clinicians should incorporate these findings into their existing treatment plans, helping patients find creative outlets for trauma recovery. Industrial/Organizational psychologists can incorporate these findings in their strategic planning, adding resources to alcohol treatment and healthy work/life integration plans. As these findings have profound implications for public health, community psychologists can assist in the study and implementation of improved initiatives towards treatment and prevention.

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