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RESEARCH ARTICLE

Violence-Related Disparities Experienced by Black Youth and Young Adults: Opportunities for Prevention

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Introduction: The purpose of this study is to characterize violence-related disparities experienced by young blacks in the U.S. Reducing violence experienced by blacks, particularly youth, who are at substantially higher risk, is essential to improving the health of blacks in the U.S.

Methods: Data from four independent data sets for youth and adults were analyzed to examine rates of homicide, assault, injury from a physical fight, bullying victimization, and missing school because of safety concerns for non-Hispanic blacks and whites aged 10−34 years between 2010 and 2015. Disparities in adverse childhood experiences (e.g., exposure to violence and household challenges) and physical/mental health outcomes in adulthood were examined. Data were analyzed in 2017.

Results: Black adolescents and young adults are at higher risk for the most physically harmful forms of violence (e.g., homicides, fights with injuries, aggravated assaults) compared with whites. In addition, black adults reported exposure to a higher number of adverse childhood experiences than whites. These adverse childhood experiences were positively associated with increased odds of self-reported coronary heart disease, fair or poor physical health, experiencing frequent mental distress, heavy drinking, and current smoking.

Conclusions: Disproportionate exposure to violence for blacks may contribute to disparities in physical injury and long-term mental and physical health. Understanding the violence experiences of this age group and the social contexts surrounding these experiences can help improve health for blacks in the U.S. Communities can benefit from the existing evidence about policies and programs that effectively reduce violence and its health and social consequences.

INTRODUCTION

In the report, *A Nation Free of Disparities in Health and Healthcare*, the HHS highlights the disproportionate burden of mortality experienced by some racial and ethnic groups, including black Americans.[1] Homicide is a leading cause of death for black Americans of all ages.[2] Non-Hispanic black Americans (hereafter "blacks") consistently experience the highest homicide rates among racial/ethnic subgroups, with rates far exceeding non-Hispanic whites (hereafter "whites").[3,4] Young blacks are at particularly high risk for homicide. The homicide rate for blacks aged 10−34 years was 2.6 times higher than the rate for blacks aged 35 years and older in 2015.[5] In addition to age-related risks, disparities in homicide rates between blacks and whites have persisted over time. For example in 2000, for people aged 10−34 years, homicide rates were more than 11 times higher for blacks than whites (i.e., 35.9 per 100,000 for blacks and 3.1 per 100,000 for whites).[5] In 2015, the homicide rate for blacks aged

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10–34 years (37.5 per 100,000) was 13 times the rate for whites (2.9 per 100,000).[5]

Reasons for disparities in violence between blacks and whites are understood.[6] Minority populations are disproportionately exposed to conditions such as concentrated poverty, racism, limited educational and occupational opportunities, and other aspects of social and economic disadvantage contributing to violence.[7] These conditions provide context for disproportionate rates of homicide and nonfatal violence experienced by blacks, particularly among young males.[8,9] These disparities are sustained, in part, due to the persistence of unfavorable social conditions,[10] and because exposure to childhood trauma and adversity is associated with increased risk for victimization and perpetration of violence, both within one's lifetime and across generations.[11,12]

Less established and understood is the contribution of violence exposure to racial and ethnic disparities in a range of mental and physical health problems. Aside from immediate physical consequences of violence, stress and trauma in the form of victimization have the potential to set individuals on negative health trajectories with lasting consequences.[13] Violence exposure is associated with increased risk of mental health problems, risky health-related behaviors (e.g., alcohol abuse, sexual risk-taking), chronic disease (e.g., coronary heart disease, diabetes), delinquency, and premature mortality.[14,15] Evidence for causal relationships between early exposure to violence, especially child maltreatment, and health outcomes is emerging.[16,17] This literature suggests racial and ethnic disparities in violence may be linked to other prominent health disparities.

Violence also exacts enormous and disproportionate social and economic costs in minority communities.[18] These include medical, educational, and justice system costs, reduced labor market productivity, decreased property values, and disruption of community services.[19–22] Thus, preventing violence exposure and intervening when violence has occurred has implications for the health and prosperity of racial and ethnic minority communities.

The purpose of this study is to update the literature on racial disparities in violence between black and white youth using data sources capturing different severity levels in violent outcomes (e.g., homicide versus assault). This paper also seeks to extend understanding of the impact of these disparities by examining associations between disparities in childhood adversity (e.g., child maltreatment) and adult health conditions. The results provide a basis for discussing available evidence for prevention that may be important for reducing these disparities.

METHODS

Study Sample

This study examined racial disparities in violent victimization across a range of violent behaviors, and health consequences associated with violence exposure during childhood by black youth and young adults aged 10–34 years.[5,8] Rates of violence were stratified by sex, age, and race. Rate ratios (RRs) of population-based rates were calculated to show the magnitude of disparities between blacks and whites. Four independent, cross-sectional data sets were analyzed. Data were analyzed in years 2017–2018.

Measures

Data from the National Vital Statistics System (NVSS) for 2015 were analyzed to examine leading causes of death using the Web-based Injury Statistics Query and Reporting System (WISQARS). Death certificate data from NVSS and population estimates from the U.S. Census Bureau were used to calculate homicide rates by sex, race, and age using the Centers for Disease Control and Prevention Wide-ranging Online Data for Epidemiologic Research (WONDER).[5,23] RRs with 95% CIs were calculated to compare homicide rates by race.

Data from the National Crime Victimization Survey (NCVS) from 2010 to 2015 for non-Hispanic blacks (n=469) and non-Hispanic whites (n=2,163) aged 12–34 years were used to calculate pooled rates of aggravated assault (i.e., attack or attempted attack with a weapon, regardless of whether an injury occurred, and an attack without a weapon when serious injury results) and simple assault (i.e., not causing a serious injury).[24] NCVS is a self-report survey administered to individuals aged ≥12 years from a nationally representative sample of U.S. households. Sample data are weighted to be representative of people aged ≥12 years. Established procedures were used to calculate 95% CIs for each estimate.[24]

Data from the Youth Risk Behavior Surveillance System (YRBSS) for 2015 were used to calculate the prevalence of being physically injured in a fight, bullying on school property in the past year, and students' reports of missing school in the past month because they felt too unsafe to go among 15,624 high schoolers. The YRBSS includes a nationally representative sample of U.S. high school students (grades nine to 12). Weighted prevalence estimates, 95% CIs, and pairwise comparisons of black and white students were generated using the Youth Online analysis tool.[25]

Data from NVSS, NCVS, and YRBSS were used to show RRs of black and white experiences of violence over time. RRs of homicide, aggravated assault, and missing school because of safety concerns were calculated for years 1995–2015.

Data from the Adverse Childhood Experiences (ACE) module of the Behavioral Risk Factor Surveillance System (BRFSS) 2011–2012 were analyzed to examine the average number of ACEs experienced and associations with health conditions. BRFSS is an annual, cross-sectional telephone survey of non-institutionalized adults aged ≥18 years.[26–28] The ACE module consists of 11 items assessing exposure to eight adversities including child abuse (physical, emotional, and sexual) and household challenges (parental divorce/separation, domestic violence, substance abuse by a household member, a household member incarcerated, or living with a household member who attempted suicide, was depressed, or mentally ill) experienced prior to age 18 years.