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Victimization in childhood: General and specific associations with physical health problems in young adulthood

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ABSTRACT

Objective: The goal of the current study was to examine the direct relationship between diverse types of childhood victimization and physical health problems in early adulthood, controlling for other common factors that contribute to physical health problems, including psychopathology and health risk behaviors. The associations between types of victimization (e.g., physical assault) and specific health problems (e.g., pain) were also examined.

Methods: 2500 Swedish young adults reported on their exposure to victimization in childhood and their current mental and physical health as adults.

Results: Using multiple regression, results indicated that the amount of childhood victimization was a significant predictor of health problems in adulthood, controlling for the significant negative effects of health risk behaviors and mental health problems on physical health. Logistic regressions indicated that physical assaults and sexual abuse were associated with all types of health problems assessed. Sleep problems were associated with almost all types of victimization history.

Conclusions: The long-term effects of childhood victimization on physical health in adulthood are serious and warrant significant attention. Primary care providers should include assessments of past victimization as one way of screening for health risk. Health providers should also consider multiple points of intervention that may help to reduce physical illness. For example, providing a mental health intervention or social service support related to victimization experiences may not only address these difficulties, but also more broadly impact physical health as well.

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Introduction

Victimization in childhood, including maltreatment, neglect, community crime, and witnessed/indirect violence, is relatively common [1,2] and has been linked to increased short and long term psychopathology [3–9]. In keeping with modern definitions of health [10], many research studies have begun to more deeply consider the associations between physical health, mental health, and the environmental correlates of each. In studies of individuals exposed to different forms of violence, crime, and neglect, the presence of mental health difficulties has been repeatedly associated with physical health problems. As examples, one study found that rates for asthma, allergies, gastrointestinal problems, headaches and cold/flu were higher for children who had symptoms of traumatic stress [11]. Other research identified a relationship between Posttraumatic Stress Disorder (PTSD) and Type 2 Diabetes [12].

Cross-sectional relationships between physical and mental health identified in past research have been generally strong, and both mental and physical health show relative stability over time. Mediating and reciprocal effects, however, have tended to be weaker and less consistent across models [13] and studies have suggested that mental health factors may both precede physical health problems and be exacerbated by them [14]. Further, the relationship between mental and physical health may be multiply determined by other social, environmental and behavioral factors. For example, childhood adversity has been related to several health risk behaviors, such as cigarette smoking and weight gain, which in turn have shown direct effects on inflammatory markers in the body, increasing vulnerability to infections and disease [15,16]. For this reason, cross-sectional data on mental and physical health, while being able to adequately control for concurrent associations, may not provide highly useful information about the processes underlying the concordance between mental and physical health over time.

Physiological research has provided important insight into some of the underlying processes explaining the association between mental

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and physical health. In the context of victimization, mental health problems, such as PTSD, are thought to relate to physical health difficulties due, in part, to disturbances in stress hormone regulation systems [17]. For example, when examining physical, sexual and emotional abuse together, studies found that these children displayed high cortisol during the day [18], especially in the afternoon [19], which is typically when cortisol levels should be at their lowest concentrations. Such variation in this established cortisol pattern was a marker of risk for poor health [20]. More recently, Kuhlman et al. [21] investigated relations between stress responses and exposure to physical abuse, emotional abuse, or non-intentional trauma. They found that non-intentional trauma was associated with elevated cortisol in the evening, physical abuse was associated with faster physiological reactivity to acute stress, and emotional abuse was associated with delayed recovery of cortisol following acute stress. This body of research suggests that dysregulation of physiological stress systems contributes to both over- and under-activation of systems that control inflammation and immune responses, which may make individuals more vulnerable to illness [17]. Other studies, however, found no link between PTSD and somatic symptom severity [22] or have found that children exhibiting more posttraumatic stress symptoms display fewer total health problems [23].

Despite some discrepancies regarding the relationship between mental health problems and physical illness after childhood victimization, there has been growing evidence of a direct link between victimization in childhood and physical health problems in both the immediate aftermath of such adverse events [11,23,24] and over the life course [22,25]. Two large-scale studies of adverse childhood experiences (including rejection, abuse, harsh parenting, violence against the mother, parental substance abuse, mental illness and suicide) linked cumulative exposure to adversity to physical health problems in adulthood. The Dunedin Multidisciplinary Health and Development Study took place in New Zealand and showed that 33% of the sample was exposed to maltreatment as a child, which greatly increased the odds (1:181) of having a physical health problem in adulthood [26]. A second large-sample study by Felitti and colleagues, the Adverse Childhood Experience (ACE) study, assessed 7 categories of childhood experiences including violence and abuse, with 50% reporting at least one ACE and 25% reporting two or more ACEs [27]. Here, there was a dose–response relationship between the number of ACEs and physical health risks as an adult. Such physical health problems exceed direct injuries sustained from the violent event and include greater numbers of somatic complaints and symptom severity, e.g., headaches, chest pain, and nausea [22], as well as arthritis and cardiovascular disease [25]. Further, a history of childhood victimization has been found to increase the risk of mortality and has been associated with obesity [2,25,26,28]. Exposure to violent events and serious life stressors has also been linked to increased visits to the doctor and nights spent in the hospital [29]. A history of victimization has also been connected to a number of health risk behaviors, such as excessive drinking, alcohol or drug misuse, risky sexual behavior, and becoming a teen parent [1,2,5,28].

Despite emerging evidence for the link between victimization in childhood and later physical health problems, few studies have examined a broad range of adverse events (as in McCall-Hosenfield et al.'s work [22]) and even fewer have assessed how varying histories of childhood exposure are differentially related to specific health problems in adulthood (as in Afifi et al.'s work [25]). Further, while many studies have taken into consideration sociodemographic effects on health, only a small number adjust for the contribution of mental health problems to physical health after exposure to adversity (as in Gawronski et al.'s work [29]). As such, the examination of associations between victimization types and specific physical health problems and the assessment of the contribution of number of victimizations to these health problems (controlling for the role of mental health) represents a significant and unique contribution to this growing literature.

The first objective of the current study, therefore, was to evaluate the association between types of childhood victimization and specific

physical health problems in early adulthood. Based on previous research, it was expected that childhood victimization would be associated with the total number of physical health problems in early adulthood, but relationships between specific types of victimization and physical health problems were regarded as exploratory. The second study objective was to examine the association between the total amount of victimization in childhood and total physical health problems, controlling for other factors commonly associated with physical health problems in victimized populations (i.e., mental health problems, health risk behaviors). It was hypothesized that the amount of victimization in childhood would be uniquely associated with the total number of physical health problems, beyond expected significant relationships between health risk behaviors, mental health, and physical health.

Methods

Participants

Participants were randomly selected from the Swedish national inhabitant register based on proportional draws from different geographic regions. A total of 20,827 individuals with a registered telephone number were drawn from the register. Of these, 4455 individuals could be reached and agreed to participate in the study. However, 1955 were not included because an interview appointment could not be made, the participant did not arrive for the interview, or the participant changed his/her mind about participation. The sample thus included 2500 young adults (52.6% female) between the ages of 20 and 24 ($M = 22.1$, $SD = 1.38$). At the time of interview, 69.4% of participants were employed, 58.3% of participants were enrolled in college, and 47% were financed by study assistance. Participants responded to an extensive battery of questionnaires regarding childhood exposure to violence and current psychosocial functioning. To investigate whether the non-participants differed from the participants, 30 randomly chosen non-participating men and women were asked a few questions from the interview/questionnaire through a telephone interview and were then compared with the total sample of 2500 participants [1]. The analyses showed no significant differences between non-participants and participants in level of education, subjective well-being, prevalence of psychiatric diagnoses, alcohol risk use, criminality, or physical victimization.

Procedure

All study procedures were evaluated and approved by the ethics committee in Uppsala, Sweden to ensure protection of human subjects. Selected participants were contacted by telephone and given information about the study. If willing to participate, they were scheduled for an interview at a time and location of their choosing. Interviews were conducted by trained employees of a Swedish survey company. Basic demographic information was obtained using a brief interview (5–10 min). Participants then completed a survey questionnaire electronically, which assessed their history of violence exposure and current psychosocial functioning. This self-report survey took approximately one hour to complete, and after completion, participants received a voucher for 400 Swedish Kronor (approximately 60 USD) as compensation for their time. Referral information for local mental health resources was provided during the post-survey de-briefing.

Measures

Demographics

Demographic information was collected during a brief face-to-face interview and included information about the participant's sex and age.

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