



A daily calendar analysis of substance use and dating violence among high risk urban youth[☆]

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ABSTRACT

Background: Dating violence (DV) among youth is an important public health problem. This study examined reasons for physical DV and the association between substance use and youth DV using daily calendar-based analyses among at-risk urban youth.

Methods: Patients (aged 14–24) presenting to an urban Emergency Department (ED) for a violent injury and a proportionally selected comparison sample of non-violently injured youth who screened positive for substance use in the past 6 months ($n=599$) were enrolled in this study. Multi-level, multinomial regressions were conducted using daily-level substance use data from Time Line Follow Back (TLFB) responses and physical DV data that were obtained by coding Time Line Follow Back – Aggression Module responses for the 30 days prior to visiting the ED.

Results: The two most commonly reported reasons for physical dating aggression and victimization, across sexes, were “jealousy/rumors” or “angry/bad mood.” Multi-level multinomial regression models, adjusting for clustering within individual participants, showed that among females, cocaine use and sedative/opiate use were associated with severe dating victimization and alcohol use was associated with severe dating aggression.

Conclusions: Use of TLFB data offers a unique opportunity to understand daily-level factors associated with specific incidents of DV in more detail. This study provides novel data regarding reasons for DV and the relationship between daily substance use and DV among urban youth, with alcohol, cocaine, and sedative/opiate use being associated with various types of DV. ED based DV interventions should be tailored to address youths’ reasons for DV as well as reducing their substance use.

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1. Introduction

Adolescent physical dating violence (DV, aggression and victimization) is a significant public health concern with one in ten adolescents reporting past year dating victimization (CDC, 2009) and two in ten reporting aggression (Rothman et al., 2010). Youth DV has been associated with substance use and adult intimate

partner violence (Erickson et al., 2010; Silverman et al., 2001; Whiteside et al., 2009). It is critical to understand the motivations for DV and the role of substance use in order to develop interventions.

Previous research has examined physical dating victimization or aggression alone limiting our understanding of potential differences in factors (e.g., motivations for conflicts, substance use) related to youth DV (Foshee et al., 2011; Temple and Freeman, 2011). In one study that examined victimization and aggression, almost half of those experiencing DV (49.7%) report aggression by both partners, termed reciprocal violence (Whitaker et al., 2007). Although some research show no gender differences in substance use and DV (Boden et al., 2012), others find higher rates of physical dating aggression among females than males (Carroll et al., 2011; Ranney and Mello, 2011), some show that males report more severe

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physical aggression than females (Archer, 2000) and that females are at increased risk for injury (Chermack et al., 2010; Walton et al., 2007). Few researchers have examined motivations for physical dating aggression and victimization, which could differ by sex among youth and may provide critical information for intervention development. Hettrich and O'Leary (2007) found that the primary reasons for physical dating aggression among college females were anger or poor communication. In contrast, Foshee et al. (2007) found that the primary reason for physical dating aggression among females was responding "to violence perpetrated by the boyfriend," whereas males reported aggression in self-defense and dating victimization due to jealousy or anger over their infidelity. Although this study provides important findings, they only assessed the first and most severe incidents.

A key correlate of physical dating victimization and aggression is substance use (Erickson et al., 2010; Whiteside et al., 2009). Prior studies have been limited by examining aggregate substance use and violence patterns (e.g., past year frequency) which cannot elucidate the relationship between substance use and specific incidents of youth physical dating aggression and victimization (Temple and Freeman, 2011; Testa et al., 2011). Further, studies examining physical dating aggression and victimization have been limited by examining alcohol alone (Reyes et al., 2011) or drugs collapsed across classes (Erickson et al., 2010). Among adults, daily calendar data showed that alcohol and other drug use were associated with incidents of violence (Chermack and Blow, 2002; Chermack et al., 2010). Findings from adult studies vary by drug, with acute alcohol and cocaine use associated with increased risk of aggression, some evidence of a link between heroin use and aggression, but no association between marijuana use and aggression (Chermack and Blow, 2002; Chermack et al., 2010). Among adolescents, one study found that daily alcohol use was associated with dating aggression and victimization for males and females (Rothman et al., 2012b). However, this study did not examine other drugs. Consequently, data regarding daily associations between substance use and adolescent DV is needed.

For youth who do not attend school regularly, the Emergency Department (ED) may be uniquely suited to address DV. One in 4 adolescents lacks a primary care physician (McCormick and Stoto, 2000), making the ED an important point of contact for adolescents (Bernstein et al., 2009; Pitts et al., 2008). Further, rates of DV among female youth are higher in ED than in national samples (e.g., 28–37%; Erickson et al., 2010; Walton et al., 2009). Before implementing DV interventions in the ED, additional data is needed.

This study fills an important gap in the literature by providing data regarding reasons for physical dating aggression and victimization among females and males, and by examining daily associations between incidents of DV aggression and victimization severity and substance use. We expect similar findings for aggression and victimization with substance use given the reciprocal nature of DV (Rothman et al., 2011; Testa et al., 2011). We hypothesized that:

1. Alcohol, cocaine, and sedative/opiate use will be more likely on days in which DV occurred than on days without DV. The association between alcohol, cocaine, and aggression is well established among adults (Chermack and Blow, 2002; Chermack et al., 2010; Chermack and Giancola, 1997). Although findings for sedative/opiate use are more mixed, we believe that they will be associated with DV based on prior adult experimental and daily-calendar studies (Ben-Porath and Taylor, 2002; Weisman et al., 1998).
2. Marijuana use will *not* be more likely on days with DV than on days without DV. Although several studies have found an association between aggregate marijuana use (e.g., Rothman et al., 2010; Moore et al., 2008), in experimental and daily-calendar

studies, there was no evidence of an association between marijuana use and violence (Chermack et al., 2010; Myerscough and Taylor, 1985).

3. The associations between substance use and DV will be similar for males and females based on prior studies using aggregate data (Boden et al., 2012); however, the reasons for DV will differ by sex.

2. Methods

2.1. Procedures

This paper presents data from a longitudinal, observational study examining substance use among youth treated in an urban ED (The Flint Youth Injury Study). Participants were recruited at Hurley Medical Center (HMC), a Level 1 Trauma Center in Flint, MI (December 2009 to September 2011). Protocols were approved by the University of Michigan and HMC Institutional Review Boards. A National Institute of Health Certificate of Confidentiality was obtained. This study was designed to oversample youth (14–24 years) presenting to the ED for violent injury (i.e., assault-related) and reporting past 6-month substance use. Patients completed screening and surveys during their ED visit. However, those with violent injuries too severe to participate in the ED were recruited if they stabilized in the hospital within 72 h. Based on the age block (14–17, 18–20, 21–24) and sex (male/female) of enrolled youth presenting with violent injury, a proportionally selected comparison group was sampled of youth who presented for non-assault-related complaints (e.g., abdominal pain, fever) and reported past 6 month substance use. Comparison youth were approached based on triage time, to mirror the proportion of participants in each age/sex group of violently injured participants.

Patients were approached by research assistants to participate in a screening survey to determine eligibility. Patients presenting to the ED for an acute sexual assault, child abuse, or suicidal ideation or attempt, were excluded. Upon written consent/assent from the patient (and parent/guardian if age <18), participants self-administered a computerized screening survey (~25 min) and chose a \$1.00 gift (i.e., cards and lotion). Participants completed the surveys in treatment spaces without others present, in order to ensure confidentiality. Screened participants in the violently injured and comparison group reporting past 6 month substance use on the ASSIST (i.e., marijuana, cocaine, prescription stimulant opiates, or sedatives/sleeping pills, methamphetamine, inhalants, hallucinogens, street opiates; World Health Organization ASSIST Working Group, 2002) were enrolled in the longitudinal study and completed a baseline assessment (~90 min; \$20 remuneration), and a urine drug screen (\$5) and oral HIV testing (\$5; not reported here). The baseline interview included self-administered and research assistant administered portions (e.g., Time Line Follow Back (TLFB) interview). Our IRB did not allow for collection of additional data from refusals without written informed consent.

2.2. Measurement

2.2.1. Substance use. Drug and alcohol use for the 30 days prior to ED visit were assessed using the TLFB semi-structured interview (Sobell et al., 1979), for the purpose of obtaining detailed, reliable and valid quantitative data about frequency of daily substance use (Maisto et al., 1979; Sobell et al., 1979, 1988). Use of alcohol, illicit drugs (e.g., cocaine, inhalants, heroin), and non-medical use (i.e., to get high, taking someone else's, taking more than prescribed) of prescription drugs (e.g., sedatives, opiates, stimulants) over a specified interval (e.g., 30–180 days) was assessed with the TLFB utilizing monthly calendars beginning on the day of the assessment and working backwards (Sobell et al., 1979). Data from the semi-structured interviews were coded for quantitative analysis.

2.2.2. Dating violence. The TLFB-Aggression Module (TLFB-AM), developed to be used with the TLFB, assessed detailed characteristics of incidents of physical violence in the past 30 days (Chermack and Blow, 2002; Chermack et al., 2006). Following the TLFB for substance use, the TLFB-AM was administered. Again, using monthly calendars and beginning on the day of assessment and working backwards, participants were asked to identify specific dates in which they experienced interpersonal conflict (e.g., physical violence) (Chermack et al., 2010). For each of the conflict incidents, participants were asked about the setting (e.g., home, bars, work, "the streets,"), substance use before or during the conflict (e.g., alcohol, cocaine), and their relationship with the other person (e.g., spouse, girlfriend/boyfriend, friend, stranger, co-worker). Next, participants were given a list of behaviors adapted from the physical assault and injury scales of the Conflict Tactics Scales-2 (CTS-2; Straus et al., 1996) and asked to identify which acts occurred with "your current or ex-boyfriend/girlfriend, dating partner, or fiancée," and who committed the act. The other CTS scales (e.g., sexual assault) were not included due to time limitations. Severity of aggression or victimization was coded: moderate (pushed, grabbed or shoved, slapped) and severe (beat up, hit with a hard object, used a knife or gun), consistent with CTS-2 categories. Participants reporting moderate and severe behaviors were placed into the "severe" category.

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