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Original article

Patterns of Partner and Nonpartner Violence Among High-Risk Youth

Justin E. Heinze, Ph.D. [a,b,c,*], Patrick M. Carter, M.D. [b,c,d], Quyen Ngo, Ph.D. [c,d,e], Marc A. Zimmerman, Ph.D. [a,b,c], Maureen A. Walton, Ph.D. [b,c,f], and Rebecca M. Cunningham, M.D. [a,b,c,d,g]

[a] *Department of Health Behavior & Health Education, University of Michigan School of Public Health, Ann Arbor, Michigan*
[b] *Youth Violence Prevention Center, University of Michigan School of Public Health, Ann Arbor, Michigan*
[c] *University of Michigan Injury Center, University of Michigan School of Medicine, Ann Arbor, Michigan*
[d] *Department of Emergency Medicine, University of Michigan School of Medicine, Ann Arbor, Michigan*
[e] *Institute for Research on Women and Gender, University of Michigan, Ann Arbor, Michigan*
[f] *University of Michigan Addiction Center, Department of Psychiatry, University of Michigan School of Medicine, Ann Arbor, Michigan*
[g] *Department of Emergency Medicine, Hurley Medical Center, Flint, Michigan*

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A B S T R A C T

Purpose: Perpetration of violent behavior begins to increase in adolescence and peaks in young adulthood (e.g., age 18–29) before decreasing by the early 30s. Considerable variability in reported perpetration, targets, and severity of violence suggests youth may change their violent behavior patterns over time.
Methods: We use latent transition analysis to describe profiles of violent behavior against partners and nonpartners in an at-risk sample of young adults (N = 599; 59% male; 61% African-American) over a period of 2 years.
Results: A four-class solution provided the best fit to the data, with classes corresponding to (1) nonviolent behavior (48.3% of the sample); (2) violent only toward nonpartners (22.3%); (3) violent only toward partners (16.0%); and (4) violent toward nonpartners and partners (13.4%). Participants' sex, race, age, previous violent injury, antisocial behavior, alcohol dependence, and possession of firearms were associated with baseline class membership.
Conclusions: Implications for prevention are discussed.

IMPLICATIONS AND CONTRIBUTION

It is critical to consider multiple types of violence because they co-occur less frequently, with violent perpetrators typically focusing their violence on either peers or partners. Prevention strategies may be more effective if they focus on the type of violence instead of its severity.

Violence is the second leading cause of death for U.S. youth (14–24 years old), with an annual economic burden in billions of dollars [1,2]. Exposure to high rates of youth violence, including both partner and nonpartner violence, is associated with multiple long-term consequences, including mental distress, post-traumatic stress disorder, aggression, substance use, delinquency, and re-occurring violence involvement [3]. Substance-using youth under the age of 25 are among the most at risk of witnessing, experiencing, and perpetrating violence, with males, ethnic minorities, and urban residents more likely to be involved in violence compared with females, whites, and rural populations [4]. Violent behavior begins to increase in adolescence and peaks in emerging adults (e.g., age 18–29) before decreasing in full adulthood [5]. Considerable variability in reported perpetration, type of violence (i.e., nonpartner vs. partner), and severity of violence, however, suggests youth may change their patterns of violent behavior over time [6].

Conflicts of Interest: The authors have no conflicts of interest to disclose.

* Address correspondence to: Justin E. Heinze, Ph.D., Department of Health Behavior & Health Education, University of Michigan School of Public Health, 1415 Washington Heights, 3790A SPH I, Ann Arbor, MI 48109.
E-mail address: jheinze@umich.edu (J.E. Heinze).

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Researchers distinguish between violence directed at nonpartners (e.g., peers, coworkers, strangers) and violence directed toward partners (e.g., boy/girlfriend, fiancée, spouse), with negative consequences for both victims and aggressors [7,8]. Nonpartner and partner violence may share common antecedents, including a history of family violence or deviant behavior [9], suggesting that perpetrators of one type of violence may perpetrate both and that a focus on one form of violent behavior may overlook important connections among them. Ozer et al., for example, found that males who were violent toward nonpartners were more likely to also be violent toward a partner [7]. In younger adolescent samples, bullying and sexual harassment were correlated [10]. Fang and Corso posited a link between early exposure to violence and later partner violence (intimate partner violence [IPV]) perpetration through experiences of nonpartner violence perpetration that suggests a potential progression of behavior from exposure to violence as an adolescent to IPV as an emerging young adult [11]. These findings are consistent with the Cycle of Violence hypothesis, whereby earlier exposure to direct victimization or structural violence encourages the development of behavioral scripts for perpetrating violence as a means of communicating or solving conflict [12]. Yet, whether youth change patterns—regarding both the victim(s) and the severity—of their violent behavior remains largely unknown in the current literature.

We examine patterns of violent behavior with nonpartners and partners over time in a sample of high-risk (history of drug use, variable victimization) youth seeking care in an urban Emergency Department (ED). We also examine predictors of these violent behavior profiles. Profiling patterns of violent behavior and their predictors can inform focused and tailored intervention strategies to mitigate violence from those most at risk of perpetration [13]. Researchers who studied developmental trajectories of violence have often used small samples, cross-sectional or multiwave data with relatively long intervals between waves, considered just one domain of violent behavior (e.g., IPV), or limited measures of violence perpetration [14,15]. Our study builds on this work by including a sample that incorporates a longitudinal design with five measurement occasions over 2 years and measures both nonpartner and partner violence. This longitudinal approach allows us to examine how youth change their pattern of violent behavior during a period of development when youth are creating schemas for intimate relationships [16], adjusting to independence, work- and school-related stressors, but may also lack the cognitive and emotional inhibition to control aggressive behavior [17].

Methods

Data used in this study were collected as part of the Flint Youth Injury Study [3,18], a 2-year prospective cohort study examining violence outcomes among a consecutively obtained sample of assault-injured youth (aged 14–24 years) with past 6-month drug use (assault injured group [AIG]; n = 349) and a proportionally sampled (by age and gender) comparison group (control group [CG]; n = 250) of nonassaulted, drug-using youth. The study was conducted in the ED at Hurley Medical Center (HMC) in Flint, Michigan. HMC is the region's only level 1 trauma center. The study population reflected the broader demographic characteristics of Flint, Michigan (~50%–60% African-American) [19], which has violent crime and poverty rates that are comparable with other urban settings.

Study population and recruitment

Youth seeking ED care for assault and reporting past 6-month drug use, and a proportionally sampled comparison group presenting for other non–assault-related reasons and reporting past 6-month drug use were eligible for the study. Assaults were any intentional injury caused by another person and was assessed by a research assistant (RA) at the time of the interview. Exclusion criteria included ED presentations for acute sexual assault, child maltreatment, suicidal ideation or attempt, or a medical condition preventing consent (e.g., altered mental status, schizophrenia). Youth under 18 years old without a parent/guardian present were also excluded. Recruitment proceeded 7 days per week, excluding holidays, with trained RAs recruiting 21 hours (5 A.M.–2 A.M.) on Tuesday and Wednesday and 24 hours a day Thursday through Monday. Enrollment was from December 2, 2009, through September 30, 2011.

Study procedures

Study procedures were approved by UM and HMC Institutional Review Boards; a National Institutes of Health Certificate of Confidentiality was obtained. After an initial review of the presenting medical problem (i.e., chief complaint), RAs approached assault-injured patients in ED waiting or treatment areas. Following written consent (assent with parental consent if <18 years old) participants self-administered a computerized screening survey [18] to assess study eligibility. Assault-injured youth reporting past 6-month drug use or nonmedical use of prescription drugs on the National Institute on Drug Abuse Alcohol Smoking and Substance Involvement Screening Test (NIDA ASSIST) were eligible for the study [20]. Unstable patients with trauma (e.g., unconscious patients who were intubated and on a ventilator) were recruited after hospital admission if they stabilized within 72 hours. The control group (nonassaulted, drug-using youth) was recruited in parallel to limit seasonal and temporal variation, and was enrolled to ensure balance by sex and age. For example, after a 21-year-old assault-injured woman, reporting past 6-month drug use, was recruited into the study, RAs would recruit the next female in the 20–22-year-old age group that arrived in the ED for a nonassault injury and screen positive for past 6-month drug use. Youth enrolling in the longitudinal study completed an ~90-minute baseline survey, including both a self-administered and an RA-structured interview. Surveys were administered privately and were paused for medical evaluations and procedures to avoid interfering with care. In-person follow-up assessments were completed in the ED or a community setting (e.g., library, jail) at 6, 12, 18, and 24 months. Remuneration for study participation included $1 for screening, $20 for the baseline surveys, and $35, $40, $40, and $50 at each sequential follow-up.

Measures

Nonpartner and partner violence. Violent behaviors toward nonpartners and partners were measured using 13 physical assault items from the Conflict Tactics Scale-2 [21]. The frequency of moderate (e.g., slapped, pushed/shoved) and severe (e.g., threatened/used a knife/firearm) violence behaviors over the past 6 months were measured separately for partners (e.g., girlfriend/boyfriend, husband/wife) and nonpartners (e.g., peers, friends, strangers, police). Response scales ranged from 0 (never) to 6 (≥20 times),