



Review article

# Exposure to Violence and Victimization: Reflections on 25 Years of Research From the National Longitudinal Study of Adolescent to Adult Health



Jillian J. Turanovic, Ph.D.\*

College of Criminology and Criminal Justice, Florida State University, Tallahassee, Florida

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 A B S T R A C T

**Purpose:** Over the past 25 years, across a wide range of academic disciplines, the National Longitudinal Study of Adolescent to Adult Health has facilitated a wealth of research on the sources and consequences of victimization and exposure to violence (ETV). In this review, I reflect broadly on the knowledge gleaned from this impressive data source.

**Methods:** The review is situated within an integrated, multilevel framework that (1) emphasizes differential risks for ETV and victimization (at the individual, peer, school, family, and neighborhood levels), (2) allows for the dynamic study of violence exposures, (3) recognizes an overlap between multiple forms of victimization and ETV, (4) allows for the study of moderating factors and mediating mechanisms, and (5) allows for a wide array of developmental consequences to be identified.

**Results:** Major correlates and consequences of ETV and victimization in the data are described, along with mediators and moderators that influence the link between violence exposures and negative life outcomes.

**Discussion:** Gaps and challenges are discussed. Several directions for future research are put forth, including the need to further uncover the dynamic sources and consequences of victimization and ETV over the life course.

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 IMPLICATIONS AND CONTRIBUTIONS

This review focuses on what Add Health research has revealed regarding the multilevel sources and consequences of victimization and ETV over the life course. The unique design and richness of Add Health have facilitated both substantive and methodological advancements in the victimization literature.

Experiences with violence shape human development. A wealth of literature shows that being violently victimized, or witnessing serious violence, can carry many short-term and long-term harms. Problems such as substance abuse, poor health, criminal behavior, depressive symptoms, and low socioeconomic wellbeing disproportionately occur among adults who have been

victimized or witnessed serious violence earlier in their lives [1,2]. Especially during childhood or adolescence, these violence exposures can be traumatic, alter brain development, and compromise the ability to manage emotions and responses to stress over the life course [3,4].

Encounters with violence are not distributed evenly across the population but instead tend to be clustered among vulnerable groups that are already socially marginalized. Youth growing up in high crime communities, with lower levels of social support and weaker conventional social ties, for example, are at a greater risk for witnessing and becoming victims of serious violence [5]. Indeed, victimization has many complex sources at the individual, peer, family, and neighborhood levels. Further adding to this complexity, the risks and sources of

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\* Address correspondence to: Jillian J. Turanovic, Ph.D., College of Criminology and Criminal Justice, Florida State University, Tallahassee, Florida 32306.

E-mail address: [jturanovic@fsu.edu](mailto:jturanovic@fsu.edu).

victimization can vary by age and the consequences of violence, too, can change over time. Thus, an ecological, life course approach is necessary to best understand experiences with violence and their dynamic impacts [6].

Over the past 25 years, the National Longitudinal Study of Adolescent to Adult Health (Add Health) has spurred a wealth of research on victimization and exposure to violence (ETV). Few other data sources capture these phenomena across multiple developmental stages—from adolescence through early adulthood—or allow for longitudinal examinations of their causes and consequences across such a large and diverse population. The Add Health data are also unique in that victimization is captured in various forms—allowing for the study of general violence, sexual victimization, violence by intimate partners, and childhood abuse—and their connections to a range of health and social disparities.

Here, I provide a bird's eye view of Add Health research produced on the sources and consequences of victimization and ETV. This is not a comprehensive account of all research studies ever produced using the data but rather a high-level summary of key themes and advancements in Add Health victimization research. Consistent with the scope of the *Journal of Adolescent Health* special supplement, “Implications of Adolescence for Adult Well-Being: 25 Years of Add Health Research,” this thematic review focuses on what Add Health research on victimization and ETV has uncovered with respect to social contexts (e.g., neighborhoods, parents, peers), disparities (e.g., age, gender, race/ethnicity), and longitudinal/developmental patterns. The review also highlights the unique aspects of Add Health that contributed to substantive and methodological advancements in the literature.

In what follows, I discuss this research as part of an integrated multilevel framework. I review the correlates and consequences of ETV and victimization, describe mediators and moderators that influence the link between violence exposures and negative life outcomes, outline gaps and challenges, and put forth broad directions for future work using the Add Health data.

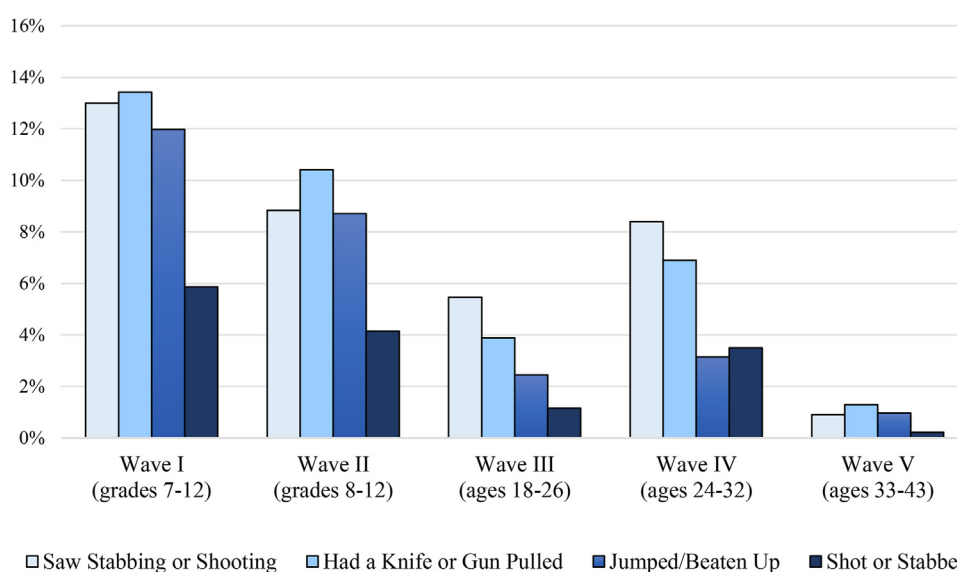
## Domains of violence

Before delving into the literature, it should first be clarified how ETV and victimization are typically captured in research using Add Health. ETV tends to refer to witnessing someone shoot or stab another person and general violent victimization can include being jumped or beaten up, shot or stabbed, threatened with a knife or a gun, and injured in a physical fight. Across all waves of Add Health data—from adolescence through early adulthood—ETV and forms of general violent victimization are measured in the past year. As seen in Figure 1, these experiences are relatively rare but are more common in adolescence than in adulthood. These violent encounters are also more prevalent among males and are often referred to as forms of “street violence” given their tendency to occur outside of the home, in the absence of guardianship [7,8].

Other forms of violent victimization such as sexual victimization, intimate partner violence (IPV)/dating violence victimization, childhood physical abuse, and childhood sexual abuse are also measured in Add Health at selected points in time. These forms of violence are unique in that females are over-represented as victims (especially for sexual and IPV victimization) and they occur more often in private residences than in public spaces. This review is inclusive of all forms of violent victimization and ETV captured in Add Health, although the bulk of the discussion (much like the bulk of the literature) focuses on general violent victimization.

## A multilevel framework for exposure to violence and victimization

One of the broadest and most interdisciplinary areas of research on human development concerns victimization. For decades, scholars across various fields—including public health, psychology, sociology, and criminology (to name a few)—have devoted considerable efforts to identifying the sources and consequences of victimization and ETV among youth and young



**Figure 1.** Prevalence of exposure to violence and victimization, Add Health respondents (Waves I–V). Note: Prevalence reflects exposure to violence or victimization in the past 12 months at each wave. Source: National Longitudinal Study of Adolescent to Adult Health (Add Health).

adults. And while numerous data sources have facilitated advancements in this literature, the cross-disciplinary contributions made from Add Health are unparalleled. The information gathered on schools, peer networks, family life, romantic relationships, and neighborhoods has allowed researchers to develop and test robust explanatory models. This is true even among subpopulations that are under-represented or difficult to evaluate in smaller studies (e.g., Native American, justice-involved, or immigrant youth).

To make sense of this large body of Add Health research, I situate my review within an integrated, multilevel framework [9–11], as presented in Figure 2. This framework as applied to the Add Health literature (1) emphasizes structural antecedents (e.g., structural inequality, concentrated disadvantage, social vulnerability) and differential risks at the individual, peer, school, and family levels, (2) allows for the dynamic study of violence exposures, including the timing and sequencing of experiences and their consequences over the life course, (3) recognizes an overlap between multiple forms of victimization and ETV, (4) allows for the study of moderating factors and mediating mechanisms in the relationship between violence exposures and outcomes, and (5) allows for a wide array of developmental consequences to be identified.

### Multilevel causes and correlates

Across different fields of study, a variety of theoretical perspectives have been put forth to explain victimization and ETV. In some fields, lifestyle and opportunity perspectives are dominant, which view victimization in terms of the convergence in time and space of a motivated offender, a suitable target, and the absence of capable guardianship [12]. Research in this tradition tends to focus on the behaviors, traits, and community characteristics that shape risky activity patterns and differential exposures to violence over time [13]. Other perspectives view victimization and ETV not as the product of risky activities but rather vulnerability factors that are often beyond a person's control [14]. These tend to represent non-normative characteristics that place individuals at risk of victimization through being shunned, stigmatized, or marginalized, including intellectual, social, and physiological impairments [14]. Over the life course,

and within a developmental ecological framework, risks for victimization and ETV are thought to be shaped by a complex interplay between social contexts, lifestyle-opportunity factors, and vulnerability factors [9–11]. Here, I draw collectively from these broader opportunity and vulnerability perspectives to better understand, in a multilevel context, what Add Health research conveys about the sources of individuals' risks for victimization and ETV from adolescence through early adulthood. This research will be discussed in terms of individual factors; peer, school, and family factors; and neighborhood factors.

### Individual factors

At the individual level, Add Health research shows that a range of characteristics shape vulnerability to victimization and ETV. Beyond gender and age, few correlates of victimization over the life course are as salient as involvement in crime or deviance. Across all ages, males and individuals who engage in “risky lifestyles”—such as offending, problem drinking, drug use, and gun carrying—are more likely to be victims or witnesses of street violence [5,12,13]. These patterns are typically explained from a lifestyle-opportunity perspective, whereby those who participate in activities that regularly expose them to “high risk times, places, and people” are more likely to be in situations where violence happens [12].

Age plays into this for a few reasons, largely because deviant behaviors peak during the adolescent years alongside risks of victimization. Self-control has also been integrated into the lifestyle framework, since individuals with poor self-control are at a greater risk of engaging in deviant lifestyles and finding themselves in unsafe situations [13]. In Add Health, the links between self-control, risky lifestyles, and victimization have been found to hold true in adolescence and early adulthood, for both males and females, even after accounting for gendered, early life experiences [13]. Although the lifestyle perspective tends to be less applicable to sexual victimization and IPV—forms of victimization that can be better explained by gendered power and control dynamics—Add Health research verifies that deviant behaviors and low self-control are correlated with these experiences [15].

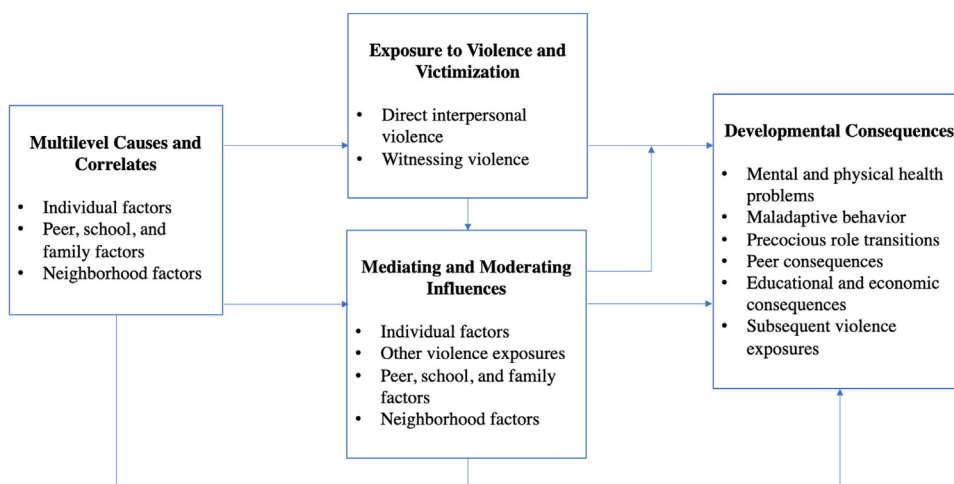


Figure 2. Multilevel framework for exposure to violence and victimization.

Furthermore, the richness of Add Health has facilitated a better understanding of vulnerability factors for victimization, including the influences of physical disabilities, cognitive and intellectual deficits, and early puberty. For instance, studies find that females with physical disabilities are at a heightened risk of forced sex [16], and that, in general, intellectual deficits and learning disabilities are associated with greater odds of violent victimization [17,18]. Individuals with mobility limitations or cognitive disabilities are also found to face higher risks being victimized [19], possibly because they are less able to defend themselves against violence or abuse or because they are perceived as less likely to recognize and report maltreatment. In terms of early puberty, Add Health studies suggest that such youth face heightened risks for victimization as they enter more “adult-like” social settings prior to developing the “adult-like” skills needed to keep themselves safe in precarious situations [20]. Early puberty can even be a source of distress that triggers emotional volatility, relationship toxicity, physical conflicts, and victimization [21].

Over the life course, the Add Health literature also confirms that there are pronounced race differences in victimization and ETV. It has been found that Black persons are more likely to follow increasing trajectories of violent victimization over time [22] and that both Black and Hispanic persons confront persistent risks of IPV victimization in adolescence and early adulthood [23]. These patterns are notable given that persons of color already face heightened risks for health disparities tied to social inequality and structural racism [24] and repeated incidents of violent victimization can worsen these issues [5,22]. Racial and ethnic differences in risks for victimization and ETV will be revisited below in the discussion of neighborhood factors given the disparate community contexts in which persons of color are more likely to reside [25–27].

#### *Peer, school, and family factors*

Add Health research also emphasizes that individuals' ties to peers, school, and family can affect risks of victimization and ETV over the life course. During adolescence, delinquent peer associations are important for understanding youths' susceptibility to violence. From a lifestyle perspective, delinquent peers are thought to increase victimization through exposure to potential offenders in settings conducive to violence—such as where youth are fighting, drinking, using drugs, or engaging in petty crimes [13]. But it is not simply the presence or absence of delinquent peers that can affect victimization; rather, it matters whether one is embedded within a dense network of delinquent youth.

Consequently, the Add Health peer network data have been important for advancing this body of work. As Schreck et al. [28] found, membership in dense delinquent peer groups can “trap individuals in contexts in which it is more likely that violence will be targeted at them.” This is also true of gendered violence, as females who are more centrally located within deviant peer groups are more likely to experience sexual victimization [29]. Research has also focused on peer status differentials in schools that shape youths' vulnerability to victimization and ETV. Some studies suggest that violently victimized youth are more on the fringes, with fewer friends and brittle relationships that are difficult to sustain over time [30]. These patterns are somewhat unique to victimization given that youth who perpetrate violence and other forms of delinquency have been found, in

some circumstances, to occupy more privileged positions in their school networks [31].

Beyond peer hierarchies, Add Health researchers have demonstrated that other school-related factors can structure risks for victimization. Youth who are more attached to school have been found to have lower risks of victimization and ETV [32,33] given that they are more invested in schoolwork and tend to avoid deviant peers and other risky activities [34]. Schools have also been found to differ in terms of their overall levels of student connectedness, student substance use, and socioeconomic advantage, which can directly and indirectly influence victimization and ETV [35,36]. Also, depending on the types of schools that they attend, students may face greater or lower risks of being victimized. As one study found, girls from disadvantaged family backgrounds faced greater risks of dating violence victimization within socioeconomically advantaged schools [37].

Furthermore, families have enduring influences on victimization and ETV that extend into adulthood. Add Health research shows that, in adolescence, youth who reside in households where the family context is characterized by closeness and understanding tend to be safer from violence [38]. Positive family attachments during the teen years have also been linked to reduced risks of violent victimization in emerging adulthood [2]. These longitudinal associations can be explained through cumulative continuity, where youth with more social advantages and protective factors early in life may continue to benefit from them over time [6].

#### *Neighborhood factors*

Although individual, peer, school, and family factors are important, these do not operate in a social vacuum. Instead, peer, school, and family influences are shaped by neighborhood processes that set the stage for violence to unfold. The salience of neighborhood social context is well established in the Add Health literature and recognized in early theories of victimization [12]. For example, lifestyle patterns are thought to manifest as individual-level and group-level adaptations to role expectations and aspects of the social structure. People learn attitudes and behaviors in response to their social environment, and once learned, they are incorporated into their daily activities. As such, community conditions are thought to influence violent attitudes and beliefs, limit the extent to which individuals can avoid coming into contact with risky people and places, and shape opportunities for both legitimate and illegal avenues of employment [27,39]. With fewer viable options to make a living, residents in disadvantaged communities may be more likely to adopt certain risky lifestyles—such as stealing and selling stolen property or dealing drugs—which can increase risks of victimization [12].

Racial and ethnic differences in victimization and ETV are explicitly linked to these structural problems. In major U.S. cities, neighborhoods with high concentrations of Black residents have been described as “divergent social worlds” marked by extreme levels of poverty that are often unparalleled in White neighborhoods [25]. Intertwined with these economic problems are high rates of family disruption, incarceration, unemployment, poor educational opportunities, and limited access to quality health-care [26,27]. Add Health research has reinforced that violence is a product of individual and family disadvantages that are rooted in community structural problems [40] and that race differences in serious violence primarily reflect the differential exposure of

Black youth to disadvantaged community contexts [41]. The experience of being victimized or witnessing violence has also been found to be one of the most important mechanisms linking neighborhood contexts and race/ethnicity to violent crime [43].

Despite these findings, the literature on victimization and ETV remains skewed toward individual level factors and the Add Health contextual data are underused. More research linking macrostructural and micro contexts is needed. Neighborhood contexts can operate as structural constraints that shape the sources and consequences of victimization, and research must continue to examine the complex pathways through which neighborhood characteristics, race/ethnicity, and exposures to crime and violence are interconnected over the life course [43].

### Developmental consequences

One of the most valuable features of Add Health is that it allows for the consequences of violence to be examined across several decades of life. Indeed, few events are thought to be as disruptive to healthy development as witnessing or being the victim of serious violence [1–4]. Encounters with violence can be frightening, disruptive, and unexpected, and negative effects can linger long after the incident itself [5–8]. Even if there are no physical injuries sustained, in the aftermath of violence, victims often feel confused, afraid, and angry, and they suffer emotionally and psychologically. For some victims, these symptoms lessen over time, but for others, they crystallize into more serious and long-term problems. Several developmental perspectives have been put forth to explain the impacts of violence on the life course, including stress proliferation, risk amplification, and cumulative disadvantage models [6,11,42]. Drawing from these various theoretical perspectives, the Add Health research produced on the consequences of victimization and ETV on the life course will be discussed in terms of mental and physical health problems, maladaptive behavior, precocious role transitions, peer consequences, educational and economic consequences, and subsequent violent exposures.

#### *Mental and physical health problems*

In terms of mental health consequences, victims of crime and those who witness serious violence are thought to suffer in the short-term and long-term. Add Health studies have shown that IPV victimization increases depressive symptoms [44], as does exposure to community violence for Black youth [45]. Youth violent victimization and ETV have also been associated with suicidality in adolescence and early adulthood [2,46,47]. Victimization has even been found to alter youths' survival expectations and lead them to overestimate their risks of dying early. Add Health research shows that victims of childhood physical abuse are less likely to expect to survive to 35 years of age and that adolescent violent victimization and IPV can marginally reduce survival expectations [48]. This “unrealistic fatalism” is troubling in light of its established links to developmental deficits [48].

Beyond mental health consequences, experiences with trauma and violence can also “get under the skin” in ways that affect physical health. Serious and chronic ETV can lead to dysfunction in the brain and physiological stress systems, which in turn, increase risks for physical illness [49]. Add Health studies have revealed that violent victimization is linked to multiple health consequences over the life course, including poor general

health, hospital visits, and subclinical/somatic symptoms (e.g., increased cold or flu-like symptoms, fevers, night sweats, nausea, vomiting, stomach aches, cold sweats, dizziness, and headaches). These patterns hold true for general violent victimization, IPV victimization, and sexual violence [22,50,51].

#### *Maladaptive behavior*

On top of mental and physical health issues, ETV and victimization can spur the onset of maladaptive behaviors. In response to victimization, individuals may act out with violence and aggression (e.g., through means of retaliation or “blowing off steam”), self-medicate their emotional distress using drugs and alcohol, or engage in other types of risky behaviors. The “victim-offender overlap” has been long established in the literature, whereby victimization is linked to future involvement in crime [6,22,30]. Research using Add Health has further confirmed that victimization and ETV are correlated with various forms of crime and analogous behaviors [2,52], and specifically that violent victimization has both acute and enduring effects on violent crime over the life course [53].

#### *Precocious role transitions*

Youth ETV and victimization can also force a premature end to adolescence through precocious (“off-time”) exits from teenage roles and entry into adult roles. Add Health research has helped to illuminate that, although normative transitions into adulthood are a healthy part of the aging process, non-normative early exits from adolescence are not—and these tend to represent provoked adaptations to traumatic circumstances [7]. Precocious exits brought on by victimization and ETV can include running away from home, dropping out of school, accelerated entry into dating, early sexual behaviors, early parenthood, and early coresidential unions [54–56]—all of which may lead to worsened life outcomes. Early experiences with victimization can additionally result in subjective weathering—feelings of “wear and tear” or accelerated aging—that stem from the process of being forced into adult life too soon (i.e., adultification). For example, IPV exposure in adolescence has been found to increase the risk of early parenthood and the failure to graduate high school, culminating in subjective weathering and depressive symptoms in emerging adulthood [57].

#### *Peer consequences*

In terms of peer consequences, adolescent victimization is thought to carry a stigma among peers that results in avoidance and social exclusion [30]. The Add Health peer network data have been useful in identifying, during the teen years, how victimization negatively affects friendships and victims' social standing within peer groups. Such research has shown that violent victimization leads to friendship losses (i.e., decreases in the total number of friends), especially for females and youth who exhibit depressive symptoms [58], and that violent sexual victimization is tied to decreases in popularity and centrality within female friendship networks [59]. Considering that strong quality friendships can carry a range of social, emotional, and mental health benefits throughout adolescence, victims of violence may lack sources of peer support that can help them positively cope with their experiences. Without such supports, the



consequences of victimization may be further magnified into adulthood.

#### *Educational and economic consequences*

Over the course of development, victimization and ETV also affect socioeconomic attainments, such as lower educational achievement and financial hardship. These costs can stem from “chain effects” in the life course—whereby violence sets in motion a sequence of events that give rise to later economic problems [60]. For youth, the most immediate socioeconomic consequence of victimization is a diminished investment in education. The psychosocial toll of being victimized—on mental health, behaviors, and friendships—can correspond with disengagement from school, poorer grades, and school dropout, and can lower occupational status and earnings in adulthood [6,60]. Even later in the life course, the stress of violence exposure may prompt time off from work or compromise job performance, which can disrupt income and job stability. Add Health studies have shown that multiple forms of violent victimization, in adolescence and adulthood, can reduce educational attainment, increase financial hardship, and lower subjective socioeconomic status [1,61].

#### *Subsequent violence exposures*

Given the various social, behavioral, health, and psychological consequences of victimization and ETV, it is not surprising that being victimized once can increase the chances of being victimized again. Early childhood experiences with violence, for example, can result in the development of maladaptive coping responses that increase victimization later in life [62]. Add Health studies show that physical maltreatment in childhood heightens the odds of IPV victimization for women [63] and that adolescents exposed to violent crime have an increased risk of partner violence in adolescence and victimization in adulthood [64]. Although theoretical debates have persisted about whether repeat victimization is the product of “state dependent” (i.e., dynamic) or “population heterogeneity” (i.e., stable) processes [23,65], there is general consensus that victimization has the potential to alter one’s life circumstances in ways that increase vulnerability to subsequent violence exposures, independent of time-stable factors [66].

#### **Mediating and moderating influences**

Clearly, victimization and ETV can inflict a wide array of harms over the life course. That said, not everyone is equally as likely to suffer the same consequences to the same degree. There are both mediating and moderating influences that can help explain the underlying processes and variation in these relationships. Mediators are the intervening mechanisms that account for the link between victimization or ETV and particular life outcomes. These factors change in response to a stimulus (i.e., victimization), and in turn, influence the outcome of interest. Alternatively, moderators are those factors that either weaken or amplify the impacts of victimization or ETV on people’s lives (e.g., characteristics of individuals, families, and communities). Given the diversity of the Add Health data, a wide range of both mediators and moderators have been identified, although there has been more of an emphasis on moderators than mediators in the literature. Following the multilevel

framework, these mediators and moderators are discussed in terms of individual factors; other violent exposures; family, school, and peer factors; and neighborhood factors.

#### *Individual factors*

At the individual level, the impacts of victimization and ETV can vary across demographic groups. One of the most widely discussed moderators in Add Health research is sex, whereby males and females can be impacted differently by violence. Gender differences in socialization, support and coping resources, and emotional reactivity can potentially explain these patterns [67]. For example, a study by Exner-Cortens et al. [52] found that after dating violence victimization, both males and females faced increased suicidality and further IPV victimization, but females were more likely to drink heavily and suffer depressive symptoms, while males were more likely to engage in antisocial behavior. The link between adolescent violent victimization and adult sexual IPV perpetration has also been found to vary by sex, where the relationship tends to be stronger for women [68].

Race, ethnicity, and immigrant status, too, have been considered as moderators in the Add Health literature, given the diverse cultural, social, and historical contexts that condition how people cope with and respond to violence. The impacts of IPV victimization on later drug use have been found to vary by race, where these associations exist for White and Latina women but not for Black women [69]. Other Add Health research shows that immigrant populations are more resilient to the impacts of violence, finding that adolescent violent victimization is unrelated to negative health, psychological, or behavioral outcomes for immigrants in early adulthood [70]. This resiliency may be attributed to immigrants’ higher levels of cultural capital, supportive familial ties, and strong coping skills.

In terms of mediating processes, Add Health research has made strides to examine factors that explain the link between childhood victimization and negative outcomes in adolescence and early adulthood. Studies show that, among females, childhood sexual abuse negatively impacts the formation of adolescent social bonds (e.g., maternal and school bonds and religiosity) and these bonds fully mediate the effect of childhood sexual abuse on adolescent delinquency [71]. Involvement in risky lifestyles and maladaptive coping behaviors (e.g., skipping school, sneaking out, engaging in violent and nonviolent delinquency) have also been found to mediate the effects of childhood maltreatment on adolescent victimization [62].

Still, Add Health studies that test mediating pathways between victimization/ETV and life outcomes are rare and more of this work is needed. This is not an issue with Add Health research per se but rather a reflection of the limited focus on mediating processes in the victimization literature more broadly [66]. A typical approach is to correlate victimization with an outcome, control for confounding variables, and then determine if the victimization effect remains in a multivariable regression model. If it does, it is often assumed that whatever speculated (yet unmeasured) causal process is, in fact, responsible for that relationship [66]. This approach leaves much to be desired. The longitudinal design of Add Health allows for temporal sequencing to be established between measurable predictors, mediators, and outcomes, and more research should use the data to identify the mechanisms that link victimization to its consequences.

### *Other violent exposures*

A related line of work examines how previous or recurring exposures to violence either mitigate or compound the effects of additional violence on the life course. For individuals who have suffered abuse or victimization in the past, it is possible that subsequent victimization has an even stronger impact on life outcomes through processes of cumulative disadvantage. From this perspective, subsequent victimization may serve to worsen the lives of individuals who, because of their prior exposures to violence, already have depleted coping resources and lack the support needed to recover from added traumas [61]. For example, Farrell and Zimmerman [72] found that the effects of ETV on offending were strongest when individuals were exposed to multiple episodes of multiple types of violence (polyvictimization).

A competing set of findings, though, indicate that the consequences of victimization are more pronounced for individuals who have not experienced violence before in their lives [8,73]. These results are more consistent with the idea that victimization is most detrimental when it is rare, singular, and unexpected rather than when it is a more common occurrence [61]. It is possible that repeated exposures to violence have a diminished impact on life outcomes once adversities hit a ceiling or a certain point of depletion, consistent with processes of disadvantage saturation [61]. Questions remain, however, about whether these patterns vary by age and whether at a certain point in the life course, subsequent violence exposures become more or less consequential.

### *Peer, school, and family factors*

Beyond individual level factors, there are various peer, school, and family factors that are known to moderate the link between victimization or ETV and life outcomes. With respect to peers, Add Health research suggests that delinquent friends can amplify the effects of victimization on delinquency, substance use, and violence by encouraging deviant coping (e.g., retaliation, coping with drugs and alcohol) and violent victimization can sever friendships in ways that make individuals more vulnerable to be victimized again or suffer other consequences [30,58]. Add Health research has also revealed that the peer group context can help explain why victimization and ETV are linked to violent behavior later in life. In terms of mediating processes, it has been found that vicarious victimization (i.e., the violent victimization of a close friend in adolescence) is linked to increased violence within one's peer group, which increases the risk of violent offending in early adulthood [74].

Scholars have also explored how positive social attachments to parents and to school can buffer the impacts of violence on youth development. These social attachments are thought to serve as sources of support and provide prosocial coping resources to help youth overcome their experiences in more healthy and positive ways. Add Health studies show that having strong, quality relationships with parents and connections to school can reduce the effects of adolescent violent victimization on a range of outcomes [75,76] and that family attachments can be particularly protective for young female victims of violence in preventing the development of low self-esteem, suicide ideation, and risky sexual behavior in adulthood [2].

School factors may also interact with parent factors to buffer adolescents from the effects of ETV. Brookmeyer et al. [75] found

that when youth perceive high levels of connectedness to both their schools and their parents, the effects of ETV on violent behavior are mitigated. However, when students lack feelings of school connectedness, parent connectedness is no longer protective [75]. The effects of victimization on offending have additionally been found to vary across school contexts and tend to be stronger in nonurban rather than urban schools [77]. These findings further emphasize that school effects cannot be considered in a vacuum, but rather they are best understood alongside familial and community influences within an overlapping, ecological framework.

### *Neighborhood factors*

Just as neighborhood contexts shape risks for victimization, they also condition the consequences that victimization has on people's lives. Disadvantaged structural conditions can limit access to prosocial coping resources, victim services, and social support [5,6,39]. Community contexts can also exacerbate the effects of victimization on future violence through the proliferation of a retaliatory honor culture that thrives in disadvantaged settings [27,78]. For some populations and forms of ETV, Add Health research reveals that the impacts of victimization are worse in disadvantaged areas and that in such contexts, coerced sexual victimization increases involvement in future property crime [79]. Even so, some show the opposite pattern, where the effects of victimization are more pronounced in less disadvantaged environments [79,80]. Such findings can be viewed through the lens of a stress inoculation or social push framework, in which the effects of victimization are diluted in more disadvantaged environments where there are typically more stressors to contend with [61]. Given these mixed patterns in the literature, there is much more to explore with respect to how neighborhood factors condition the effects of victimization and ETV on life outcomes.

### **Gaps and challenges**

Despite the wealth of knowledge produced from Add Health on victimization and ETV, several methodological challenges remain. For one, it is difficult to say that the life course impacts of violence are causal—that is, that encounters with violence are a true source of negative life outcomes, beyond the influences of other adversities, stressors, and risk factors. Due to data limitations, researchers are often unable to account statistically for various confounders that may render the relationship between victimization and adverse outcomes spurious. Victimization and ETV have many complex sources at the individual, family, peer, and neighborhood levels that can rarely all be considered in a single study. Making things even more challenging, youth who encounter violence are likely to have been subjected to multiple forms of disadvantage, maltreatment, and abuse in their lives [81]. The large gaps of time between waves of Add Health data also mean that dynamic life circumstances and additional experiences with violence can go unmeasured for several years. Problems of endogeneity and selection bias thus tend to “loom large” in this literature [5].

Second, in Add Health, much remains unclear about the situations and contexts under which violence unfolds. With the notable exceptions of IPV victimization and childhood abuse, it is unknown who perpetrated the violence or what their relationship was to the victim. The victim-offender relationship can have

implications for the severity of consequences experienced, where the socioemotional toll of victimization can be amplified if the perpetrator was someone known or loved to the victim—such as a family member, friend, or acquaintance—instead of a stranger [82]. The locales of violence are also not recorded and thus it cannot be determined whether victimization was experienced at school, at home, on the street, in the workplace, or in a neighborhood that the respondent does not live in. This can hamper the ability to identify with greater precision the contextual sources of victimization and ETV. Furthermore, victimization is measured without details on aggravating factors or defensive behaviors, which can have implications for understanding the situational risks and consequences of victimization.

Third, information is lacking on how individuals subjectively interpret and process their encounters with violence. Even when experiencing similar forms of victimization, individuals can perceive these events quite differently in terms of magnitude, severity, and injustice. For example, those who view violence as legitimate, routine, or as an acceptable way to settle disputes may not perceive these events to be as acutely traumatic [61,83]. Without direct assessments of how individuals feel about their victimization or ETV, it may be difficult to identify the causal processes that link these events to negative life outcomes. Of course, these various gaps and challenges are not unique to Add Health but rather to victimization research generally. Notwithstanding these issues, Add Health remains an incredible resource for understanding the developmental antecedents and consequences of victimization and ETV from adolescence through adulthood.

## Conclusion and Future Directions

Even after 25 years of Add Health research, there remain many opportunities to advance the literature. Although the possibilities are vast with these data, there are some key avenues for future work to prioritize. First, researchers can further leverage the panel-based design of Add Health to examine a within-person change and dynamic patterns of ETV and victimization. Important questions are yet to be answered, such as: Who is most at risk for being repeatedly exposed to violence throughout adolescence and adulthood? Whose risks for victimization increase, decrease, or remain stable into adulthood? How do these patterns vary by type of victimization? Some Add Health research has started to identify trajectories of violent victimization from adolescence through adulthood, finding evidence of four distinct groups: (1) one that experiences little to no violent victimization over time, (2) an “adolescence limited” group (defined by moderately high levels of victimization in adolescence and low levels of victimization in adulthood), (3) a “high decreasing” group (with high levels of victimization in adolescence and moderate levels in adulthood), and (4) an “increasing victimization” group (with low levels of victimization in adolescence and high levels of victimization in adulthood) [22]. This work is useful in conveying the developmental variation in patterns of victimization from adolescence through young adulthood, but there is much left to learn. The reasons some individuals are more likely to follow different victimization trajectories than others, and the processes that explain increases and decreases in victimization across trajectory groups, remain unclear. This line of inquiry can have implications for a life course theory and policy by helping to identify individuals who are most

at risk for repeated exposures to violence across several decades of their lives.

In addition, researchers should attempt to further examine the dynamic sources of victimization and ETV across different stages of the development. Scholarship is yet to clearly identify those vulnerability, risk, and protective factors that have “general” effects across all ages versus those that are “age-graded” and particular to a certain life stage. The bulk of the literature focuses on victimization in adolescence, but less is known about the sources of violence later in adulthood. The relative importance of various individual, peer, school, and family factors can vary with age as individuals move out on their own, deepen relationships with romantic partners, and become parents themselves. Due to social and developmental changes, certain lifestyles may also carry different risks for victimization in adolescence than early adulthood. Drinking alcohol and hanging out with peers, for example, may be less risky in one’s mid-30s than in the teen years [66,84], and thus represent an age-specific risk factor for victimization. Significant life transitions that increase victimization during particular stages of development are also underexplored (e.g., romantic unions, employment, parenthood, arrest, school dropout) [54–57]. Understanding how the magnitude of risk and protective factors change over time can help to inform age-graded theories of victimization and clarify the need for age-specific interventions for victims of crime.

In terms of consequences, it should also be determined how the timing and sequencing of violence exposures over the life course affect the severity, type, and duration of adverse outcomes. How do the consequences of victimization in adolescence compare with victimization experienced in emerging or early adulthood? Some research has identified mid-to-late adolescence as a period in which the health impacts of weapons-related ETV are most pronounced [85], yet there are more diverse forms of victimization to examine and a wider range of consequences to explore (e.g., IPV, sexual assault, other forms of street victimization). There are competing perspectives regarding how severe and enduring the impacts of victimization should be on the life course depending on when it happens, such as during the teenage years—a sensitive and critical developmental period—versus adulthood—when violence is rarer but individuals have more cognitive coping abilities and resources to overcome their experiences [66]. The extent to which victimization erodes positive social ties should also be explored over time (e.g., friendships, school connectedness, romantic partnerships, employment) given the importance of social attachments to healthy development and wellbeing.

Furthermore, it is imperative to continue to identify the mechanisms that link neighborhood, family, and school contexts to patterns of victimization and ETV over the life course. Contextual research is far more focused on criminal offending than victimization [40,41,43], and thus there is much to clarify in the victimization literature regarding when, why, and for whom neighborhood, family, and school conditions are most consequential [86]. Researchers should also make continued efforts to specify and measure the causal processes that link victimization and ETV to negative life outcomes. Numerous theoretical perspectives have been put forth to explain the proliferation of trauma, yet, as discussed, the processes specified by these theories are rarely assessed directly. Given that many sources of victimization and ETV can also be mediators, moderators, and consequences, more work is needed to help disentangle these



effects across the lifespan. A dynamic (rather than static) conceptualization of environmental influences should be embraced, wherein individuals are not seen as passive subjects of environmental influence but rather as helping to shape their environments through their behaviors and emotional states [87]. Reciprocal dynamics between individuals and their social contexts should be specified to better recognize that victimization, its sources, and its consequences can be mutually reinforcing and contribute to a cascade of adjustment problems over time [88]. Such an approach moves beyond the identification of one-directional paths to explore more complex transactional, bidirectional associations between victimization, ETV, and other mediating processes and outcomes.

In the end, Add Health provides many unique opportunities to test and refine various developmental perspectives on victimization and ETV. By continuing to advance research in this area, we can learn ways to better prevent violence and support those who suffer its consequences over the life course.

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