HHS Public Access

Author manuscript

Violence Vict. Author manuscript; available in PMC 2023 October 16.

Published in final edited form as:

Violence Vict. 2023 June 01; 38(3): 375–395. doi:10.1891/VV-2022-0165.

Violent Victimization During Childhood in the United States: Associations With Revictimization and Health

Kathleen C. Basile, PhD,
Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia, USA

Jieru Chen, PhD,
Division of Injury Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia, USA

Sharon G. Smith, PhD,
Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia, USA

Heather B. Clayton, PhD,
Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia, USA

Thomas R. Simon, PhD,
Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia, USA

James A. Mercy, PhD
Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia, USA

Abstract

Childhood violence victimization is a serious adverse childhood experience with lasting health impacts. This study examined the prevalence and characteristics of five forms of childhood violence victimization and their association with revictimization and negative health conditions among adults. Data are from the 2010–2012 National Intimate Partner and Sexual Violence Survey. Age at first victimization and perpetrator sex were assessed; adjusted odds ratios assessed associations with revictimization and health. Ages 14–17 were the most common age at first victimization for most violence types; almost half of male (46.7%) and a quarter of female (27.0%) rape victims reported first victimization before age 10. Most victimization was associated with revictimization and negative health, controlling for adult victimization. Primary prevention of childhood violence may reduce later health risks.

Correspondence regarding this article should be directed to Kathleen C. Basile, PhD, Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 4770 Buford Highway NE, MS S106-10, Atlanta, GA, 30340, USA. kbasile@cdc.gov.

Disclosure. The authors have no relevant financial interest or affiliations with any commercial interests related to the subjects discussed within this article.

Keywords

adverse childhood experiences; inmate partner violence; sexual violence; stalking; revictimization; health

Adverse childhood experiences (ACEs) are traumatic events in the lives of young people (under age 18), which have traditionally been measured to include a range of experiences, such as violence victimization by a parent or caregiver, witnessing familial violence, or other challenges in the home (e.g., parental substance use or incarceration) (Merrick et al., 2019). ACEs can have a lasting negative effect on future health and well-being (Dube et al., 2003; Felitti et al., 1998; Hughes et al., 2017; Kalmakis & Chandler, 2015). In a recent study of 25 American states, 61% of adults reported experiencing at least one ACE, and one in six reported four or more (Merrick et al., 2019). Violence victimization experienced as a minor is a particularly common ACE in the United States, but not all experiences of violence before the age of 18 (e.g., dating violence, peer sexual violence [SV], and stalking) have traditionally been captured as ACEs in previous research. In the United States, 25.8% of women and 14.6% of men who experienced intimate partner violence (IPV) first experienced it as a child, 43.2% of female and 51.3% of male rape victims were first raped as a child, and 21.2% of female and 12.9% of male stalking victims first experienced stalking as a child (Smith et al., 2018). These forms of childhood victimization are associated with negative health outcomes and revictimization. Childhood sexual and physical abuse and dating violence are linked to mental health problems, substance misuse, suicidal ideation and attempts in adulthood (Dube et al., 2005; Exner-Cortens et al., 2013; Fergusson et al., 2008; Thompson et al., 2002), and adult SV and IPV victimization and perpetration (Desai et al., 2002; Ports et al., 2016; Tharp et al., 2013; Walker et al., 2019; Whitfield et al., 2003). Although less is known about the impacts of childhood stalking victimization (Roberts et al., 2016), it is associated with health issues, such as post-traumatic stress disorder symptoms and substance use in youth (Reidy et al., 2016). Associations between childhood violence victimization and subsequent chronic health conditions (e.g., diabetes, cancer, and heart disease) have been established (Merrick et al., 2019), but more information is needed to understand specific forms of childhood victimization not typically captured as ACEs (e.g., victimization outside home or by peers) and their relationship to health.

This study describes the characteristics of childhood rape, being made to penetrate (MTP), stalking, and IPV victimization and tests their association with adult violence victimization and 11 negative health conditions diagnosed or experienced at some point in life. We hypothesized that for women and men childhood victimization will be associated with: (a) adult victimization and (b) lifetime negative health conditions, even after controlling for adult victimization.

METHODS

Data originated from the 2010–2012 National Intimate Partner and Sexual Violence Survey (NISVS) conducted through random-digit-dial telephone interviews. Participants are noninstitutionalized English- and Spanish-speaking U.S. adults, randomly selected to

form a large nationally representative sample. The NISVS study protocol was approved by the Institutional Review Board of RTI International, Inc. A total of 41,174 respondents completed the survey (22,590 women and 18,584 men), 56.7% by cellular and 43.3% by landline phone. The overall weighted response rates ranged from 27.5% to 33.6%, and the weighted cooperation rates ranged from 80.3% to 83.5%. For detailed information about NISVS, see (Smith et al., 2017). The NISVS was developed by the U.S. Centers for Disease Control and Prevention (CDC). Public-use data are archived with the Inter-University Consortium for Political and Social Research at the University of Michigan.

Measures

Survey respondents' age at interview was calculated based on the year when a respondent was born and the time of interview followed by a classification of four categories: 18–24, 25–34, 35–44, and 45 years and older. Respondents' race and ethnicity (separate questions) were combined into these categories: non-Hispanic White, non-Hispanic Black, Hispanic, and other non-Hispanic. The highest level of education was coded as less than high school, high school graduate but without a 4-year college degree, and a 4-year college degree or higher.

Behaviorally specific questions assessed completed or attempted rape (13 questions) and MTP (10 questions), including vaginal, oral, or anal penetration by any perpetrator through the use of physical force or alcohol/drug facilitation. Combining a respondent's disclosure of victimization experiences in one of the subtypes of rape or MTP, respondent's sex, and perpetrator's sex, a respondent was coded as a nonvictim or a victim of a complete or attempted rape in the analysis. In addition, we included a measure of "rape or MTP," a combination of one or both types of violence. A person was considered a stalking victim if (a) she/he experienced multiple harassing/threatening tactics or a single harassing/threatening tactic multiple times by the same perpetrator and (b) felt very fearful or believed that she/he or someone close to her/him would be harmed or killed as a consequence of the perpetrator's behavior. IPV included the following forms of violence by a current or former intimate partner: *SV* (rape, MTP, sexual coercion, unwanted sexual contact, and noncontact unwanted sexual experiences); *physical violence* (behaviors ranging from slapping/pushing/shoving to severe acts, such as hit with a fist, beaten); *stalking* (as defined above); and *psychological aggression,* including expressive aggression (e.g., name-calling) and coercive control and entrapment (e.g., monitoring or controlling). The analysis also included an "any victimization" measure, which combines rape, MTP, or stalking by any perpetrator, and/or any IPV. All victimization questions can be found in Smith et al. (2017). Victims were asked the sex of their perpetrators. If a victim had multiple perpetrators for a form of violence, the victim reported whether she/he had male perpetrators only, female perpetrators only, or both male and female perpetrators.

Respondents were asked their age at first victimization with respect to each perpetrator. A respondent was categorized as a childhood victim of a form of violence if the youngest age at first victimization across all perpetrators was before 18 years of age. We studied age at first victimization in three age groups (10 years or younger, 11–13 years, and 14–17 years). In each age group, victims were represented once under a given form of violence if a

perpetrator (or multiple perpetrators) first committed that form of violence when the victim was in that age group. If the victim experienced victimization of the same type (e.g., rape) by different perpetrators for the first time at different ages (e.g., one perpetrator at 11–13 years and another at 14–17 years), the victim was counted in each age group once. The age grouping-specific estimate provides the proportion of victims within each form of violence who reported at least one perpetrator first victimized them when they were in that age group. If a victim first experienced multiple forms of violence in the same age group (including when one perpetrator committed multiple forms of violence), then the victim would be represented once in that age group under each form of violence. To measure *revictimization*, respondents who experienced victimization as both a minor (17 and younger) and an adult (18 and older) were characterized as having been revictimized.

Prior to answering questions about violence victimization, respondents were asked whether they had experienced or were diagnosed at any point in their life with asthma, irritable bowel syndrome (IBS), diabetes, high blood pressure, frequent headaches, chronic pain, difficulty sleeping, and activity limitations due to physical, mental, or emotional problems. Additionally, participants self-rated their physical and mental health (excellent, very good, good, fair, and poor). Finally, participants answered whether they had any health problems that required the use of special equipment (e.g., cane).

Data Analysis

Data were weighted to account for the complex sampling design and analyzed using SUDAAN (version 11.01). An estimated proportion was the weighted percentage of victims who reported experiencing the specific form of violence at least once. An estimate is not reported when the relative standard error is >30% or when the numerator case count is ≤20. When assessing associations (adjusted odds ratio [AOR]) between childhood victimization and adulthood victimization experiences, we conducted logistic regression and controlled for demographic characteristics (race/ethnicity, age, and educational attainment at the interview). When assessing associations (AOR) between childhood victimization and negative health conditions, we conducted logistic regression and controlled for the same demographic characteristics with and without controlling for adulthood victimization experiences to eliminate the potential confounding effect of victimization experienced as an adult on the association between childhood victimization and negative health conditions. The statistical significance of any association measured was established when the computed 95% confidence interval (CI) of the AOR did not contain 1.0.

RESULTS

Victim Characteristics

Overall, 17.4% of females and 10.4% of males reported experiencing at least one of the measured forms of violence during childhood, with higher prevalence among females and males who were younger at the time of the interview and those with lower education levels. The proportion of females and males reporting each specific type of violence, stratified by age group, race/ethnicity, and education is provided in Table 1.

Age at First Victimization

Among female victims before 18 years of age, age 14–17 years old was the most common age at first victimization for all types of childhood violence examined (Table 2). For rape, more than three in five (65.8%) were first victimized by at least one perpetrator when they were 14–17 years old. In addition, more than one quarter (27.0%) of victims reported that they were first raped by at least one perpetrator at age 10 or younger, and more than one in seven victims (15.0%) were aged 11–13. Among those stalked as a child, the majority (80.9%) of female victims reported first victimization by at least one perpetrator when they were aged 14–17, followed by 11–13, and 10 or younger (14.4% and 9.8%, respectively). For childhood IPV victimization, almost all female victims (98.1%) were first victimized by at least one partner when they were aged 14–17. Although uncommon (3.7%), some female victims were first victimized by a partner between ages 11 and 13. Among female victims of any violence as a child, close to 9 in 10 (87.0%) reported that they were first victimized by at least one perpetrator when they were aged 14–17.

For males, nearly half (46.7%) of victims of rape reported experiencing this form of victimization for the first time when they were 10 and under. Over 3 in 10 (30.6%) and more than 1 in 4 (26.6%) were first raped by at least one perpetrator at 14–17 and 11–13 years, respectively. For all other types of childhood violence, male victims most commonly reported first victimization when they were 14–17 (Table 2). More than 6 in 10 (67.0%) male MTP victims were first victimized by at least one perpetrator at an age range of 14–17, while about 2 in 10 (19.4%) experienced such a form of violence before age 11. Almost 7 in 10 (69.8%) victims were stalked at an age range of 14–17, and more than 2 in 10 (20.5%) reported first stalking victimization before age 11. For childhood IPV, almost all (97.7%) victims were first victimized by at least one partner at an age range of 14–17. Similarly, most (92.8%) victims of any childhood violence reported their first experience by at least one perpetrator when they were aged 14–17.

Perpetrator Sex

Among female victims of all forms of childhood violence assessed, most victims reported having male perpetrators only (Table 3). For males, 93.5% of victims of childhood rape and 63.7% of victims of stalking during childhood reported only male perpetrators. In contrast, among male victims of MTP, IPV, and any of the other forms of childhood victimization examined, more victims reported only female perpetrators, especially IPV victims (97.6%).

Revictimization During Adulthood

Among females, after controlling for demographics, childhood victims of each form of violence examined except MTP (which was unstable and not reported) had significantly higher adjusted odds of experiencing all forms of violence during adulthood (Table 4). For example, rape victims had at least four times the odds of experiencing all forms of violence as an adult compared with those who had not been raped as a child. For males, experiencing each form of violence as a child was significantly associated with experiencing almost all forms of violence as an adult, with only three exceptions (childhood rape: adult rape [unstable]; childhood IPV: adult rape; and childhood stalking: adult stalking [unstable]).

For both males and females, each specific form of violence was associated with adult victimization from any violence.

Association With Negative Health Conditions

Association Without Controlling for Adulthood Victimization Experiences.—

After controlling for demographics, female childhood victims of each form of violence were significantly more likely to report having IBS, activity limitations, chronic pain, difficulty sleeping, poor mental health, and poor physical health at some point in life compared with nonvictims. In addition, all forms of violence except MTP were associated with having asthma and frequent headaches. Conversely, having been victimized as a child for any form of violence measured was not associated with high blood pressure (Table 5). Controlling for demographics, male child victims had higher odds of reporting activity limitations, chronic pain, difficulty sleeping, and frequent headaches compared with nonvictims, regardless of the type of victimization. In addition, men who were stalked as a child had over four times the odds of reporting IBS (AOR = 4.2, 95% CI = 1.8–9.8) compared with nonvictims. Men who reported MTP, rape/MTP, or stalking victimization in childhood had higher odds of reporting poor mental health compared with those without such victimization. The combined indicator for any childhood victimization was associated with all negative health conditions except diabetes, high blood pressure, IBS, and poor physical health. High blood pressure was not significantly associated with childhood victimization of any kind (Table 6).

Association After Controlling for Adulthood Victimization Experiences.—

Controlling for demographics and any form of adult victimization, women who were victimized as children were significantly more likely to report chronic pain, difficulty sleeping, and poor mental and physical health, regardless of the victimization type. The combined indicator for any childhood victimization was significantly associated with asthma, IBS, activity limitations, chronic pain, difficulty sleeping, frequent headaches, poor mental health, poor physical health, and the use of special equipment (Table 5).

Controlling for demographics and adult victimization, male childhood victims had higher odds of reporting activity limitations, chronic pain, and difficulty sleeping, regardless of the type of victimization (Table 6).

DISCUSSION

This study’s findings uncover important characteristics about experiences of childhood rape, MTP, IPV, and stalking victimization in the United States and suggest that these experiences are associated with higher odds of adult revictimization and a range of negative health conditions. These forms of childhood victimization, although not traditionally captured as such, can be conceptualized as ACEs, potentially traumatic events in the lives of children (younger than age 18) that traditionally have also included a range of experiences beyond direct victimization, such as witnessing violence, parental substance misuse, or parental incarceration (Felitti et al., 1998). ACEs can have a lasting negative effect on future health (Merrick et al., 2019). Teen dating violence, SV by peers or other noncaregivers, and stalking victimization have not traditionally been captured as ACEs, although these

childhood exposures constitute adversity and, based on our analyses, are associated with traumatic impacts.

For all victimization types assessed in this study, the late teen years, ages 14–17, seem to be the most common developmental stage to first experience these forms of violence, except for male rape victimization, which was most commonly experienced at age 10 or younger. In addition, the results are consistent with previous findings that most SV against girls is perpetrated by males, and most SV against boys is perpetrated by females (Dube et al., 2005), with the exception of rape of boys which was found to be more commonly male perpetrated. Consistent with previous research (Fisher et al., 2014), our study found that stalking victimization of adolescents is more commonly perpetrated by males. There is limited literature on precise age intervals for the first occurrence of victimization—the majority of studies focus broadly on childhood, adolescence, and young adulthood, which could reflect the underlying brain science that documents the vulnerability of the brain during key developmental periods (National Scientific Council on the Developing Child, 2020). Our study highlights early childhood (<10 years) and late teens (14–17 years) as the most common developmental stages for first victimization. Similarly, a previous study (Bonomi et al., 2012) on age at first dating violence explored narrow teenage categories and also found differences in patterns of victimization by age (13–15 and 16–17 years) and sex, suggesting types of dating violence might have different patterns of emergence for girls and boys. Understanding precise age at first victimization patterns for numerous types of childhood violence and perpetrator sex is important to inform prevention because it can help determine the timing (i.e., before teen years) and participants for primary prevention efforts. For example, our findings suggest that sexual and teen dating violence primary prevention programs in middle school (before the ages of 14–17) that focus on healthy relationships, gender roles, and related topics might be helpful to prevent the types of victimization most commonly reported in this study.

Consistent with results from numerous studies that examined the link between exposure to ACEs and violence victimization in adulthood (Desai et al., 2002; Ports et al., 2016; Walker et al., 2019; Whitfield et al., 2003), we found that, for female and male victims, all forms of childhood victimization examined in this study (except MTP of females) were associated with increased odds of “any” adult victimization as well as most of the specific forms of adult revictimization. Moreover, “any” childhood victimization was also associated with increased odds of experiencing many negative health conditions (i.e., activity limitations, chronic pain, difficulty sleeping, and poor mental health) for both males and females, and these associations remained after controlling for adult victimization. Some possible explanations for why this finding did not hold for all negative health conditions in the study are the prevalence in the U.S. population of some of the nonsignificant health conditions (e.g., high blood pressure and diabetes), the potential for recall bias for older respondents that may be particularly relevant to conditions with later onsets, like high blood pressure, and the fact that some of the nonsignificant conditions are medically diagnosed rather than self-reported and limited access to medical care among those with more ACEs could potentially contribute to that pattern.

The current findings are consistent with previous studies demonstrating that ACEs, as they have been traditionally conceptualized, are associated with numerous negative health outcomes, from revictimization in adulthood to mental health conditions (Desai et al., 2002; Exner-Cortens et al., 2013; Fergusson et al., 2008; Ports et al., 2016; Thompson et al., 2002; Walker et al., 2019; Whitfield et al., 2003). The ACEs construct (which includes childhood violence victimization) has also been linked to a wide spectrum of chronic diseases, such as asthma, diabetes, heart disease, obesity, and cancer (Bhan et al., 2014; Exley et al., 2015; Merrick et al., 2019; Miller et al., 2011; Morris et al., 2019). This study contributes to the literature by, first, expanding the types of childhood violence that might be considered ACEs to include teen dating violence, SV by any perpetrator, and stalking in childhood and, second, by demonstrating associations of each of these specific forms of violence with health conditions.

The high prevalence of childhood victimization and its associations with subsequent risk for violence and negative health conditions underscore the ethical and strategic importance of early prevention strategies to reduce multiple forms of violence in childhood. Decades of research have resulted in substantial knowledge about programs, policies, and practices that can effectively prevent violence outcomes and key risk and protective factors for violence. To help states make use of the best available evidence, the CDC released a series of technical packages that describe key strategies and existing evidence for preventing child abuse and neglect, SV, intimate partner/dating violence, and youth violence (https://www.cdc.gov/violenceprevention/communication-resources/pub/technical-packages.html#technicalPackages) common under age 10. The current results combined with those from prior ACEs research suggest that violence prevention efforts during childhood are strategically important for reducing immediate risk for injury and trauma and potentially preventing a range of negative health conditions with possible lifelong consequences.

Some limitations are noteworthy. First, as a telephone survey, NISVS does not capture those without a phone, such as persons who are incarcerated. Second, given the sensitive and stigmatizing nature of victimization questions, victimization reported is likely an undercount. Third, some estimated associations between childhood and adulthood victimization had relatively wide CIs and should be considered with caution. Fourth, reporting childhood victimization decreases with respondent age, suggesting there might be some recall bias for older respondents. If older respondents underreport child victimization and are more likely to suffer from health problems, this could suggest an underestimation of the impacts of childhood victimization on the health conditions examined. Fifth, because the data neither contain information about the onset of any health condition or diagnosis nor the date of any experience of violence victimization, a causal link between victimization and experience of health conditions could not be established. However, the data revealed some significant associations between ACEs and many negative health conditions. Finally, stratified analyses by racial and ethnic subgroups were not explored in this study due to the relatively low prevalence of several forms of violence victimization in this study and the limited sample size for some racial and ethnic subgroups after stratifying results by sex. Research has demonstrated that there is substantial variation in the prevalence of many forms of violence victimization, such as homicide, rape, stalking victimization, and IPV

victimization among racial and ethnic minority populations (Breiding et al., 2014; CDC: WISQARS, 2021). When considering differences in violence victimization among racial and ethnic minority populations, it is important to consider the larger socioeconomic context. Social and structural conditions, such as neighborhood crime rates, concentrated poverty, and economic and housing instability may contribute substantially to inequities in risk for violence among racial and ethnic minority populations (Nation et al., 2021). Some additional limitations of the NISVS methodology have been described previously (Smith et al., 2017).

CONCLUSION

This study demonstrates that childhood victimization (SV, IPV, and stalking) is associated with revictimization in adulthood as well as most of the negative health conditions measured. Importantly, although certain violence experiences happened at younger ages (e.g., male rape was most common under age 10), this study also identified the late teen years (i.e., ages 14–17) as the most common developmental stage to first experience most of these forms of violence and showed that stalking and IPV in childhood, although not traditionally considered ACEs, have similar health impacts as childhood SV. Additional research to understand the impact of multiple forms of violence during the late teen years on both behavioral and biological mechanisms for negative health conditions and the potential mediating role of adult victimization on the relationship between childhood victimization and health conditions is warranted. Taken together, this study's findings highlight the importance of early violence prevention strategies to reduce childhood exposure to multiple types of violence and help reduce the potential risk for long-term health consequences.

Acknowledgments.

The findings and conclusions in this paper are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.The following people contributed to the original development of the National Intimate Partner and Sexual Violence Survey: Kathleen Basile, PhD, Michele Black, PhD, Matthew Breiding, PhD, James Mercy, PhD, Linda Saltzman, PhD, Sharon Smith, PhD, Division of Violence Prevention, National Center for Injury Prevention and Control, CDC.

Funding.

The author(s) received no specific grant or financial support for the research, authorship, and/or publication of this article.

REFERENCES

Bhan N, Glymour MM, Kawachi I, & Subramanian SV (2014). Childhood adversity and asthma prevalence: Evidence from 10 US states (2009–2011). BMJ Open Respiratory Research, 1(1), e000016. 10.1136/bmjresp-2013-000016

Bonomi AE, Anderson ML, Nemeth J, Bartle-Haring S, Buettner C, & Schipper D. (2012). Dating violence victimization across the teen years: Abuse frequency, number of abusive partners, and age at first occurrence. BMC Public Health, 12, 637. 10.1186/1471-2458-12-637 [PubMed: 22882898]

Breiding MJ, Smith SG, Basile KC, Walters ML, Chen J, & Merrick MT (2014). Prevalence and characteristics of sexual violence, stalking, and intimate partner violence victimization – national intimate partner and sexual violence survey, United States, 2011. Morbidity and Mortality Weekly Report. Surveillance Summaries, 63(8), 1–18.

Centers for Disease Control and Prevention: WISQARS. (2021). Explore fatal injury data visualization tool. https://www.cdc.gov/injury/wisqars/

Desai S, Arias I, Thompson MP, & Basile KC (2002). Childhood victimization and subsequent adult revictimization assessed in a nationally representative sample of women and men. Violence and Victims, 17(6), 639–653. 10.1891/vivi.17.6.639.33725 [PubMed: 12680680]

Dube SR, Felitti VJ, Dong M, Giles WH, & Anda RF (2003). The impact of adverse childhood experiences on health problems: Evidence from four birth cohorts dating back to 1900. Preventive Medicine, 37(3), 268–277. 10.1016/s0091-7435(03)00123-3 [PubMed: 12914833]

Dube SR, Anda RF, Whitfield CL, Brown DW, Felitti VJ, Dong M, & Giles WH (2005). Long-Term consequences of childhood sexual abuse by gender of victim. American Journal of Preventive Medicine, 28(5), 430–438. 10.1016/j.amepre.2005.01.015 [PubMed: 15894146]

Exley D, Norman A, & Hyland M. (2015). Adverse childhood experience and asthma onset: A systematic review. European Respiratory Review, 24(136), 299–305. 10.1183/16000617.00004114 [PubMed: 26028641]

Exner-Cortens D, Eckenrode J, & Rothman E. (2013). Longitudinal associations between teen dating violence victimization and adverse health outcomes. Pediatrics, 131(1), 71–78. 10.1542/peds.2012-1029 [PubMed: 23230075]

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, & Marks JS (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The adverse childhood experiences (ACE) study. American Journal of Preventive Medicine, 14(4), 245–258. 10.1016/s0749-3797(98)00017-8 [PubMed: 9635069]

Fergusson DM, Boden JM, & Horwood LJ (2008). Exposure to childhood sexual and physical abuse and adjustment in early adulthood. Child Abuse & Neglect, 32(6), 607–619. 10.1016/j.chiabu.2006.12.018 [PubMed: 18565580]

Fisher BS, Coker AL, Garcia LS, Williams CM, Clear ER, & Cook-Craig PG (2014). Statewide estimates of stalking among high school students in Kentucky: Demographic profile and sex differences. Violence against Women, 20(10), 1258–1279. 10.1177/1077801214551574 [PubMed: 25267605]

Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, Jones L, & Dunne MP (2017). The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. The Lancet. Public Health, 2(8), e356–e366. 10.1016/S2468-2667(17)30118-4 [PubMed: 29253477]

Kalmakis KA, & Chandler GE (2015). Health consequences of adverse childhood experiences: A systematic review. Journal of the American Association of Nurse Practitioners, 27(8), 457–465. 10.1002/2327-6924.12215 [PubMed: 25755161]

Merrick MT, Ford DC, Ports KA, Guinn AS, Chen J, Klevens J, Metzler M, Jones CM, Simon TR, Daniel VM, Ottley P, & Mercy JA (2019). Vital signs: Estimated proportion of adult health problems attributable to adverse childhood experiences and implications for prevention-25 states, 2015–2017. Morbidity and Mortality Weekly Report, 68(44), 999–1005. 10.15585/mmwr.mm6844e1 [PubMed: 31697656]

Miller GE, Chen E, & Parker KJ (2011). Psychological stress in childhood and susceptibility to the chronic diseases of aging: Moving toward a model of behavioral and biological mechanisms. Psychological Bulletin, 137(6), 959–997. 10.1037/a0024768 [PubMed: 21787044]

Morris G, Berk M, Maes M, Carvalho AF, & Puri BK (2019). Socioeconomic deprivation, adverse childhood experiences and medical disorders in adulthood: Mechanisms and associations. Molecular Neurobiology, 56(8), 5866–5890. 10.1007/s12035-019-1498-1 [PubMed: 30685844]

National Scientific Council on the Developing Child. (2020). Connecting the brain to the rest of the body: Early childhood development and lifelong health are deeply intertwined: Working paper no.15. https://harvardcenter.wpenginepowered.com/wp-content/uploads/2020/06/wp15_health_FINALv2.pdf

Nation M, Chapman DA, Edmonds T, Cosey-Gay FN, Jackson T, Marshall KJ, Gorman-Smith D, Sullivan T, & Trudeau AT (2021). Social and structural determinants of health and youth violence: shifting the paradigm of youth violence prevention. American Journal of Public Health, 111, S28–S31. 10.2105/AJPH.2021.306234 [PubMed: 34038155]

Ports KA, Ford DC, & Merrick MT (2016). Adverse childhood experiences and sexual victimization in adulthood. Child Abuse & Neglect, 51, 313–322. 10.1016/j.chiabu.2015.08.017 [PubMed: 26386753]

Reidy DE, Smith-Darden JP, & Kernsmith PD (2016). Behavioral and mental health correlates of youth Stalking victimization: A latent class approach. American Journal of Preventive Medicine, 51(6), 1007–1014. 10.1016/j.amepre.2016.08.035 [PubMed: 27743623]

Roberts K, Tolou-Shams M, & Madera K. (2016). Adolescent versus adult Stalking: A brief review. Journal of Forensic Psychology Practice, 16(4), 236–252. 10.1080/15228932.2016.1192334 [PubMed: 31249475]

Smith SG, Chen J, Basile KC, Gilbert LK, Merrick MT, Patel N, & Jain A. (2017). The national intimate partner and sexual violence survey (NISVS): 2010–2012 state report. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Smith SG, Zhang X, Basile KC, Merrick MT, Wang J, Kresnow M, & Chen J. (2018). The national intimate partner and sexual violence survey (NISVS): 2015 data brief – updated release. National Center forInjury Prevention and Control, Centers for Disease Control and Prevention.

Tharp AT, DeGue S, Valle LA, Brookmeyer KA, Massetti GM, & Matjasko JL (2013). A systematic qualitative review of risk and protective factors for sexual violence perpetration. Trauma, Violence & Abuse, 14(2), 133–167. 10.1177/1524838012470031

Thompson MP, Arias I, Basile KC, & Desai S. (2002). The association between childhood physical and sexual victimization and health problems in adulthood in a nationally representative sample of women. Journal of Interpersonal Violence, 17(10), 1115–1129. 10.1177/08862605-0201710-06

Walker HE, Freud JS, Ellis RA, Fraine SM, & Wilson LC (2019). The prevalence of sexual revictimization: A meta-analytic review. Trauma, Violence & Abuse, 20(1), 67–80. 10.1177/1524838017692364

Whitfield CL, Anda RF, Dube SR, & Felitti VJ (2003). Violent childhood experiences and the risk of intimate partner violence in adults. Journal of Interpersonal Violence, 18(2), 166–185. 10.1177/0886260502238733

TABLE 1.

Demographic Characteristics of U.S. Females and Males by Type of Childhood Victimization, NISVS 2010–2012

	Females victimized as a child[a]											
	Rape		Made to penetrate		Rape or made to penetrate		Stalking		Any intimate partner violence[b]		Any victimization	
Demographics	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI
Age at interview, years												
18–24	11.0	(9.1, 13.2)	*d*		11.0	(9.1, 13.2)	5.9	(4.7, 7.4)	31.5	(28.6, 34.6)	35.4	(32.4, 38.6)
25–34	7.0	(5.9, 8.2)	*d*		7.0	(5.9, 8.2)	3.6	(2.9, 4.5)	16.7	(15.0, 18.6)	20.9	(19.0, 22.9)
35–44	10.1	(8.4, 12.0)	*d*		10.1	(8.5, 12.0)	4.1	(3.0, 5.5)	14.7	(12.9, 16.6)	21.6	(19.4, 23.9)
45+	5.2	(4.7, 5.8)	0.2	(0.1, 0.3)	5.2	(4.7, 5.8)	1.6	(1.3, 1.9)	7.1	(6.5, 7.7)	10.9	(10.1, 11.7)
Race/ethnicity[c]												
Hispanic	5.1	(3.7, 6.8)	*d*		5.1	(3.7, 6.8)	3.5	(2.4, 5.1)	15.5	(13.3, 18.1)	19.0	(16.5, 21.8)
Black, non-Hispanic	8.3	(6.8, 10.1)	*d*		8.3	(6.8, 10.1)	2.4	(1.7, 3.4)	12.8	(11.0, 14.9)	17.4	(15.3, 19.7)
White, non-Hispanic	7.3	(6.7, 8.0)	0.1	(0.1, 0.2)	7.3	(6.7, 8.0)	2.8	(2.5, 3.3)	12.8	(12.1, 13.6)	17.4	(16.5, 18.3)
Other, non-Hispanic	6.0	(4.5, 8.0)	*d*		6.1	(4.6, 8.1)	2.7	(1.8, 4.1)	10.4	(8.2, 13.2)	14.8	(12.1, 18.0)
Education at interview												
Less than high school	8.1	(6.4, 10.2)	*d*		8.1	(6.4, 10.2)	3.4	(2.3, 4.8)	18.3	(15.6, 21.2)	21.5	(18.7, 24.6)
High school < bachelor's degree	8.6	(7.8, 9.4)	*d*		8.6	(7.8, 9.4)	3.4	(2.9, 3.9)	14.8	(13.9, 15.8)	20.1	(19.0, 21.2)
Bachelor's degree or higher	4.5	(3.9, 5.2)	*d*		4.5	(3.9, 5.2)	2.0	(1.6, 2.5)	8.9	(8.0, 9.8)	12.4	(11.4, 13.5)
All females	7.0	(6.5, 7.6)	0.1	(0.1, 0.2)	7.0	(6.5, 7.6)	2.9	(2.6, 3.2)	13.0	(12.3, 13.7)	17.4	(16.7, 18.2)

Demographics	Females victimized as a child[a]											
	Rape		Made to penetrate		Rape or made to penetrate		Stalking		Any intimate partner violence[b]		Any victimization	
	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI
Demographics	**Males victimized as a child[a]**											
	Rape		**Made to penetrate**		**Rape or made to penetrate**		**Stalking**		**Any intimate partner violence[b]**		**Any victimization**	
Demographics	**Weighted%**	**95% CI**	**Weighted%**	**95% CI**	**Weighted%**	**95% CI**	**Weighted%**	**95% CI**	**Weighted%**	**95% CI**	**Weighted%**	**95% CI**
Age at interview, years												
18–24	*d*		2.2	(1.6, 3.2)	2.7	(1.9, 3.8)	2.5	(1.5, 4.3)	28.7	(25.9, 31.7)	30.0	(27.2, 33.1)
25–34	*d*		1.8	(1.1, 3.1)	2.1	(1.3, 3.4)	0.5	(0.3, 0.9)	11.9	(10.4, 13.5)	13.5	(11.8, 15.4)
35–44	0.9	(0.5, 1.4)	1.3	(0.8, 1.9)	1.7	(1.2, 2.5)	*d*		8.3	(6.9, 9.8)	9.4	(8.0, 11.0)
45+	0.6	(0.5, 0.9)	0.9	(0.7, 1.3)	1.2	(0.9, 1.5)	0.5	(0.3, 0.7)	2.8	(2.4, 3.4)	4.1	(3.6, 4.8)
Race/ethnicity[c]												
Hispanic	*d*		1.6	(1.0, 2.6)	1.9	(1.2, 3.0)	*d*		12.2	(10.0, 14.8)	10.6	(8.6, 12.9)
Black, non-Hispanic	*d*		*d*		1.4	(0.8, 2.2)	*d*		9.9	(8.0, 12.2)	13.6	(11.3, 16.3)
White, non-Hispanic	0.7	(0.5, 0.9)	1.1	(0.9, 1.4)	1.5	(1.2, 1.8)	0.7	(0.5, 0.9)	8.3	(7.7, 9.1)	9.6	(8.9, 10.4)
Other, non-Hispanic	*d*		*d*		*d*		*d*		7.9	(5.9, 10.4)	10.4	(7.8, 13.7)
Education at interview												
Less than high school	*d*		1.5	(0.9, 2.4)	2.0	(1.3, 3.0)	1.8	(1.0, 3.1)	12.5	(10.2, 15.2)	14.1	(11.7, 16.9)
High school < bachelor's degree	0.6	(0.4, 0.9)	1.8	(1.4, 2.3)	2.0	(1.6, 2.6)	0.9	(0.6, 1.4)	11.2	(10.3, 12.2)	12.7	(11.7, 13.8)
Bachelor's degree or	0.6	(0.4, 0.8)	0.7	(0.5, 1.0)	1.1	(0.8, 1.4)	0.3	(0.2.0.6)	5.0	(4.3, 5.8)	6.0	(5.2, 6.8)

Demographics	Females victimized as a child[a]											
	Rape		Made to penetrate		Rape or made to penetrate		Stalking		Any intimate partner violence[b]		Any victimization	
	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI
higher												
All males	0.6	(0.5, 0.8)	1.3	(1.1, 1.6)	1.7	(1.4, 2.0)	0.8	(0.6, 1.1)	9.0	(8.4, 9.7)	10.4	(9.7, 11.1)

Note. CI = confidence interval; NISVS = National Intimate Partner and Sexual Violence Survey.

[a]Victimization as a child was defined as the victim was less than 18 years of age when first experiencing the specific type of violence.

[b]Includes the following forms of violence committed by a current or former intimate partner: sexual violence, stalking, physical violence, and psychological aggression.

[c]Race/ethnicity was self–identified. Other, non-Hispanic includes Asian/Pacific Islander, American Indian or Alaska Native, and multiracial persons.

[d]Estimate is not reported; relative standard error >30% or cell size ≤20.

TABLE 2.

Age When First Victimized by a Perpetrator,[a] Among U.S. Female and Male Childhood Victims, NISVS 2010–2012

	Victimized as a child[b,c]											
	Rape		Made to penetrate		Rape or made to penetrate		Stalking		Any intimate partner violence[c]		Any victimization	
	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI
Females: age at first victimization, years												
10 and younger	27.0	(23.5, 30.8)	*d*		27.0	(23.6, 30.8)	9.8	(6.1, 15.5)	0.6	(0.4, 1.1)	12.3	(10.7, 14.1)
11–13	15.0	(12.5, 17.9)	*d*		15.0	(12.5, 17.9)	14.4	(10.8, 18.9)	3.7	(2.8, 4.9)	9.8	(8.5, 11.3)
14–17	65.8	(62.0, 69.4)	*d*		65.7	(61.9, 69.3)	80.9	(76.1, 84.9)	98.1	(97.1, 98.7)	87.0	(85.2, 88.5)
Males: age at first victimization, years												
10 and younger	46.7	(35.3, 58.4)	19.4	(13.8, 26.5)	24.7	(18.9, 31.4)	20.5	(11.7, 33.5)	*d*		5.7	(4.5, 7.3)
11–13	26.6	(16.4, 39.9)	16.8	(10.8, 25.1)	19.2	(13.1, 27.2)	*d*		5.4	(3.9, 7.4)	8.6	(6.8, 10.9)
14–17	30.6	(20.3, 43.4)	67.0	(57.8, 75.1)	60.6	(52.1, 68.5)	69.8	(55.7, 80.9)	97.7	(96.2, 98.6)	92.8	(90.9, 94.4)

Note. CI = confidence interval; NISVS = National Intimate Partner and Sexual Violence Survey.

[a]Reflects the known age at first victimization by each perpetrator and allows victims with multiple perpetrators to be included in each relevant age category for each type of victimization.

[b]Victimization as a child was defined as the victim was less than 18 years of age when first experiencing the specific type of violence.

[c]Because victims may have had multiple perpetrators during different age ranges for each type of victimization, combined column percentages may exceed 100%. Includes the following forms of violence committed by a current or former intimate partner: sexual violence, stalking, physical violence, and psychological aggression.

[d]Estimate is not reported; relative standard error >30% or cell size ≤20.

TABLE 3.

Sex of Perpetrator of Those Victimized as a Child, Among U.S. Female and Male Victims, NISVS 2010–2012

	Victimized as a child[a]											
	Rape		Made to penetrate		Rape or made to penetrate		Stalking		Any intimate partner violence[b]		Any victimization	
	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI	Weighted %	95% CI
Female victims: perpetrator sex												
Male only	97.9	(96.5, 98.7)	83.3	(63.5, 93.5)	97.7	(96.4, 98.6)	88.0	(82.4, 92.0)	98.1	(97.0, 98.8)	95.7	(94.4, 96.7)
Female only	*c*		*c*		*c*		6.0	(4.1, 8.7)	1.4	(0.8, 2.4)	1.4	(0.9, 2.2)
Both male and female	*c*		*c*		*c*		*c*		*c*		2.1	(1.3, 3.2)
Male victims: perpetrator sex												
Male only	93.5	(86.1, 97.1)	35.7	(27.2, 45.2)	47.4	(38.8, 56.1)	63.7	(49.1, 76.1)	2.3	(1.4, 3.8)	9.7	(8.0, 11.8)
Female only	*c*		59.1	(49.4, 68.1)	47.8	(39.0, 56.6)	26.9	(16.6, 40.4)	97.6	(96.1,98.5)	85.1	(82.3, 87.5)
Both male and emale	*c*		*c*		*c*		*c*		*c*		4.6	(3.1, 6.9)

Note.CI = confidence interval; NISVS = National Intimate Partner and Sexual Violence Survey.

[a]Victimization as a child was defined as the victim was less than 18 years of age when first experiencing the specific type of violence.

[b]Includes the following forms of violence committed by a current or former intimate partner: sexual violence, stalking, physical violence, and psychological aggression.

[c]Estimate is not reported; relative standard error >30% or cell size ≤20.

Violence Vict. Author manuscript; available in PMC 2023 October 16.

TABLE 4.

Association Between Victimization as a Child and Victimization as an Adult, U.S. Females and Males, NISVS 2010–2012

	Victimized as an adult											
	Rape		Made to penetrate		Rape or made to penetrate		Stalking		Any intimate partner violence[b]		Any victimization	
	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI
Females victimized as a child [a]												
Rape	4.3	(3.6, 5.2)	5.7	(2.8, 11.4)	4.3	(3.6, 5.1)	4.6	(3.9, 5.5)	4.3	(3.6, 5.2)	5.4	(4.4, 6.7)
Made to penetrate	*d*		*d*		*d*		*d*		*d*		*d*	
Rape or made to penetrate	4.3	(3.6, 5.2)	5.6	(2.8, 11.4)	4.3	(3.6, 5.2)	4.6	(3.9, 5.5)	4.3	(3.5, 5.2)	5.4	(4.4, 6.7)
Stalking	4.5	(3.4, 5.9)	7.4	(3.2, 17.4)	4.5	(3.4, 5.9)	16.2	(12.5, 21.1)	3.9	(3.0, 5.2)	7.0	(5.0, 9.9)
Any intimate partner violence	3.0	(2.6, 3.6)	2.2	(1.1, 4.6)	3.0	(2.6, 3.6)	3.1	(2.7, 3.7)	5.9	(5.1, 6.9)	5.8	(5.0, 6.8)
Any victimization	3.4	(2.9, 3.9)	4.2	(2.1, 8.2)	3.3	(2.9, 3.9)	4.2	(3.6, 4.8)	5.2	(4.6, 5.9)	5.9	(5.2, 6.8)
Males victimized as a child [a]												
Rape	*d*		7.9	(4.1, 14.9)	10.0	(5.6, 18.0)	10.1	(5.8, 17.7)	6.5	(3.4, 12.2)	6.1	(3.2, 11.4)
Made to penetrate	15.9	(7.6, 33.0)	13.8	(8.8, 21.6)	13.5	(8.7,21.1)	5.2	(3.1, 8.5)	3.3	(2.2, 5.0)	5.2	(3.3, 8.2)
Rape or made to penetrate	20.3	(10.9, 37.7)	12.1	(8.0, 18.4)	12.6	(8.4, 18.9)	6.3	(4.1, 9.8)	3.9	(2.7, 5.7)	5.7	(3.8, 8.7)
Stalking	5.9	(1.3,27.5)	2.6	(1.1, 5.9)	2.4	(1.1, 5.5)	*d*		3.5	(1.8, 6.8)	7.4	(3.6, 15.0)
Any intimate partner violence	0.9	(0.4, 1.9)	1.7	(1.3, 2.4)	1.6	(1.2, 2.2)	2.1	(1.6, 2.9)	3.6	(3.0, 4.3)	3.6	(3.0, 4.4)
Any victimization	3.3	(1.7, 6.3)	2.5	(1.8, 3.5)	2.4	(1.8, 3.4)	3.5	(2.7, 4.6)	3.6	(3.0, 4.3)	3.8	(3.2, 4.6)

Note.AOR = adjusted odds ratio; CI = confidence interval; NISVS = National Intimate Partner and Sexual Violence Survey.

[a]Victimization as a child was defined as the victim was less than 18 years of age when first experiencing the specific type of violence.

[b]Includes the following forms of violence committed by a current or former intimate partner: sexual violence, stalking, physical violence, and psychological aggression.

[c]Adjusted odds ratios: controlled for age at interview, race/ethnicity, and education at interview. The association between victimized as a child and victimized as an adult was significant when the computed 95% confidence interval of the adjusted odds ratio did not contain 1.

[d]Estimate is not reported because of small cell size.

TABLE 5.

Association Between Victimization as a Child and Negative Health Conditions, With and Without Controlling for Adult Victimization, U.S. Females, NISVS 2010–2012

	Victimized as a child[a]: without controlling for adult victimization											
	Rape		Made to penetrate		Rape or made to penetrate		Stalking		Any intimate partner violence[b]		Any victimization	
	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI
Negative health conditions												
Medically diagnosed												
Asthma	1.8[d]	(1.5, 2.1)	0.6	(0.2, 1.8)	1.7[d]	(1.5, 2.1)	1.7[d]	(1.3, 2.3)	1.5[d]	(1.3, 1.7)	1.6[d]	(1.4, 1.8)
Diabetes	1.4[d]	(1.1, 1.7)	2.1	(0.8, 5.6)	1.4[d]	(1.1, 1.7)	1.4	(1.0, 2.1)	1.2	(1.0, 1.4)	1.2	(1.0, 1.5)
High blood pressure	1.0	(0.8, 1.3)	0.6	(0.2, 1.8)	1.0	(0.8, 1.3)	1.3	(0.9, 1.9)	0.9	(0.8, 1.1)	1.0	(0.8, 1.1)
Irritable bowel syndrome	2.0[d]	(1.7, 2.5)	4.0[d]	(1.2, 13.6)	2.0[d]	(1.7, 2.5)	1.9[d]	(1.4, 2.6)	1.6[d]	(1.4, 2.0)	1.8[d]	(1.5, 2.1)
Self-reported												
Activity limitation	3.2[d]	(2.7, 3.9)	3.4[d]	(1.2, 9.3)	3.2[d]	(2.7, 3.8)	3.6[d]	(2.8, 4.7)	2.0[d]	(1.8, 2.4)	2.5[d]	(2.2, 2.8)
Chronic pain	2.9[d]	(2.4, 3.5)	8.0[d]	(3.3, 19.5)	2.9[d]	(2.4, 3.5)	3.1[d]	(2.4, 4.2)	1.8[d]	(1.5, 2.1)	2.2[d]	(1.9, 2.5)
Difficulty sleeping	2.9[d]	(2.5, 3.5)	8.4[d]	(3.3, 21.4)	2.9[d]	(2.5, 3.5)	3.0[d]	(2.4, 3.8)	2.0[d]	(1.7, 2.3)	2.4[d]	(2.1, 2.7)
Frequent headaches	2.1[d]	(1.7, 2.5)	2.4	(0.8, 7.2)	2.1[d]	(1.8, 2.5)	2.2[d]	(1.7, 2.8)	1.5[d]	(1.3, 1.7)	1.8[d]	(1.6, 2.0)
Poor mental health	3.8[d]	(2.7, 5.4)	8.6[d]	(2.7, 27.3)	3.8[d]	(2.7, 5.4)	2.8[d]	(1.7, 4.4)	2.6[d]	(1.9, 3.7)	3.2[d]	(2.4, 4.2)
Poor physical health	2.9[d]	(2.2, 3.9)	6.0[d]	(2.4, 15.0)	2.9[d]	(2.2, 3.9)	3.3[d]	(2.2, 4.9)	2.2[d]	(1.7, 2.9)	2.6[d]	(2.0, 3.3)
Use of special equipment	1.7[d]	(1.3, 2.3)	3.5	(0.7, 16.4)	1.7[d]	(1.3, 2.2)	2.0[d]	(1.4, 2.9)	1.1	(0.9, 1.4)	1.5[d]	(1.2, 1.8)
	Victimized as a child: after controlling for adult victimization											
Medically diagnosed												
Asthma	1.5[d]	(1.2, 1.8)	0.5	(0.2, 1.5)	1.5[d]	(1.2, 1.8)	1.5[d]	(1.1, 1.9)	1.3[d]	(1.1, 1.5)	1.4[d]	(1.2, 1.6)
Diabetes	1.3	(1.0, 1.7)	2.0	(0.8, 5.3)	1.3	(1.0, 1.7)	1.4	(0.9, 2.0)	1.1	(0.9, 1.4)	1.2	(1.0, 1.4)
High blood pressure	1.0	(0.8, 1.3)	0.7	(0.2, 1.8)	1.0	(0.8, 1.3)	1.4	(0.9, 2.0)	0.9	(0.8, 1.1)	1.0	(0.8, 1.1)
Irritable bowel syndrome	1.8[d]	(1.4, 2.2)	3.4	(1.0, 11.4)	1.8[d]	(1.4, 2.2)	1.6[d]	(1.1, 2.2)	1.4[d]	(1.2, 1.7)	1.6[d]	(1.3, 1.9)
Self-reported												

	Victimized as a child[a]: without controlling for adult victimization											
	Rape		Made to penetrate		Rape or made to penetrate		Stalking		Any intimate partner violence[b]		Any victimization	
	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI
Activity limitation	2.6[d]	(2.2, 3.2)	2.6	(0.9, 7.1)	2.6[d]	(2.2, 3.2)	2.9[d]	(2.2, 3.8)	1.6[d]	(1.4, 1.9)	2.0[d]	(1.7, 2.3)
Chronic pain	2.3[d]	(1.9, 2.8)	6.3[d]	(2.6, 15.2)	2.3[d]	(1.9, 2.8)	2.5[d]	(1.9, 3.3)	1.4[d]	(1.2, 1.6)	1.8[d]	(1.5, 2.0)
Difficulty sleeping	2.3[d]	(2.0, 2.8)	6.4[d]	(2.4, 16.7)	2.3[d]	(2.0, 2.8)	2.3[d]	(1.8, 3.0)	1.5[d]	(1.3, 1.7)	1.9[d]	(1.6, 2.1)
Frequent headaches	1.8[d]	(1.5, 2.1)	1.9	(0.6, 5.8)	1.8[d]	(1.5, 2.1)	1.8[d]	(1.4, 2.4)	1.2[d]	(1.1, 1.4)	1.5[d]	(1.3, 1.7)
Poor mental health	2.9[d]	(2.0, 4.1)	6.2[d]	(1.9, 20.1)	2.9[d]	(2.0, 4.1)	2.0[d]	(1.2, 3.3)	1.9[d]	(1.4, 2.7)	2.3[d]	(1.8, 3.1)
Poor physical health	2.3[d]	(1.7, 3.0)	4.5[d]	(1.8, 11.4)	2.3[d]	(1.7, 3.0)	2.5[d]	(1.7, 3.7)	1.7[d]	(1.3, 2.2)	2.3[d]	(1.8, 3.1)
Use of special equipment	1.6[d]	(1.3, 2.1)	3.2	(0.7, 15.2)	1.6[d]	(1.3, 2.1)	1.8[d]	(1.3, 2.7)	1.0	(0.8, 1.3)	1.4[d]	(1.1, 1.7)

Note.AOR = adjusted odds ratio; CI = confidence interval; NISVS = National Intimate Partner and Sexual Violence Survey.

[a]Victimization as a child was defined as the victim was less than 18 years of age when first experiencing the specific type of violence.

[b]Includes the following forms of violence committed by a current or former intimate partner: sexual violence, stalking, physical violence, and psychological aggression.

[c]AORs: controlled for age at interview, race/ethnicity, education, and experience of any form of violence discussed in this study (rape, made to penetrate, stalking, and intimate partner violence as defined for this study).

[d]AOR is statistically significant. The association between victimized as a child and the health condition as an adult was significant when the computed 95% CI of the AOR did not contain 1.0.

TABLE 6.

Association Between Victimization as a Child and Negative Health Conditions, With and Without Controlling for Adult Victimization, U.S. Males, NISVS 2010–2012

	Victimized as a child[a]: without controlling for adult victimization											
	Rape		Made to penetrate		Rape or made to penetrate		Stalking		Any intimate partner violence[b]		Any victimization	
	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI
Negative health conditions												
Medically diagnosed												
Asthma	1.7	(0.9, 3.1)	1.7[d]	(1.1, 2.8)	1.6	(1.0, 2.4)	3.2[d]	(1.6, 6.5)	1.2	(0.9, 1.5)	1.3[d]	(1.1, 1.6)
Diabetes	1.2	(0.6, 2.4)	2.0[d]	(1.2, 3.4)	1.8[d]	(1.1, 2.9)	1.6	(0.7, 4.0)	1.1	(0.7, 1.5)	1.3	(0.9, 1.7)
High blood pressure	1.5	(0.8, 2.6)	1.1	(0.8, 1.7)	1.1	(0.8, 1.7)	1.6	(0.9, 3.1)	1.1	(0.8, 1.3)	1.1	(0.9, 1.3)
Irritable bowel syndrome	1.4	(0.5, 3.6)	0.8	(0.4, 1.9)	1.0	(0.5, 2.1)	4.2[d]	(1.8, 9.8)	1.2	(0.8, 1.8)	1.4	(1.0, 2.1)
Self-reported												
Activity limitation	4.0[d]	(2.5, 6.6)	3.8[d]	(2.5, 5.8)	4.0[d]	(2.8, 5.7)	3.8[d]	(2.2, 6.4)	1.6[d]	(1.3, 2.0)	2.0[d]	(1.7, 2.4)
Chronic pain	3.3[d]	(2.0, 5.4)	2.6[d]	(1.7, 4.0)	2.7[d]	(1.8, 3.9)	3.0[d]	(1.7, 5.4)	1.8[d]	(1.4, 2.2)	1.9[d]	(1.6, 2.4)
Difficulty sleeping	5.1[d]	(3.1, 8.4)	3.5[d]	(2.3, 5.3)	3.9[d]	(2.7, 5.6)	2.9[d]	(1.7, 5.0)	1.8[d]	(1.5, 2.1)	2.1[d]	(1.7, 2.5)
Frequent headaches	3.8[d]	(2.2, 6.6)	2.8[d]	(1.7, 4.4)	2.7[d]	(1.8, 4.1)	3.1[d]	(1.7, 5.7)	1.4[d]	(1.1, 1.7)	1.5[d]	(1.2, 1.9)
Poor mental health	3.0	(0.9, 10.4)	5.2[d]	(2.4, 10.9)	4.1[d]	(2.0, 8.6)	3.8[d]	(1.4, 10.4)	1.6	(1.0, 2.6)	2.0[d]	(1.3, 3.1)
Poor physical health	2.0	(0.7, 5.4)	2.5[d]	(1.2, 5.4)	2.2[d]	(1.1, 4.7)	2.1	(0.8, 5.6)	1.0	(0.6, 1.8)	1.2	(0.7, 1.8)
Use of special equipment	2.7[d]	(1.5, 4.9)	2.9[d]	(1.8, 4.6)	2.7[d]	(1.8, 4.2)	2.3	(1.0, 5.5)	1.3	(0.9, 1.9)	1.5[d]	(1.1, 2.1
	Victimized as a child: after controlling for adult victimization											
Medically diagnosed												
Asthma	1.5	(0.8, 2.8)	1.6	(1.0, 2.5)	1.4	(0.9, 2.2)	2.9[d]	(1.4, 5.8)	1.1	(0.9, 1.4)	1.2	(1.0, 1.5)
Diabetes	1.2	(0.6, 2.4)	2.0[d]	(1.2, 3.5)	1.8[d]	(1.1, 3.0)	1.6	(0.7, 4.1)	1.1	(0.7, 1.5)	1.3	(0.9, 1.7)
High blood pressure	1.5	(0.8, 2.6)	1.1	(0.7, 1.7)	1.1	(0.8, 1.6)	1.6	(0.9, 3.1)	1.1	(0.8, 1.3)	1.1	(0.9, 1.3)
Irritable bowel syndrome	1.3	(0.5, 3.5)	0.8	(0.3, 1.8)	0.9	(0.4, 2.0)	4.1[d]	(1.7, 9.5)	1.2	(0.8, 1.8)	1.4	(1.0, 2.1)
Self-reported												

	Victimized as a child[a]: without controlling for adult victimization											
	Rape		Made to penetrate		Rape or made to penetrate		Stalking		Any intimate partner violence[b]		Any victimization	
	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI	AOR[c]	95% CI
Activity limitation	3.3[d]	(2.0, 5.5)	3.2[d]	(2.1, 4.9)	3.3[d]	(2.3, 4.8)	3.1[d]	(1.8, 5.2)	1.4[d]	(1.1, 1.7)	1.7[d]	(1.4, 2.1)
Chronic pain	2.7[d]	(1.6, 4.4)	2.1[d]	(1.4, 3.3)	2.2[d]	(1.5, 3.2)	2.4[d]	(1.3, 4.3)	1.5[d]	(1.2, 1.8)	1.6[d]	(1.3, 2.0)
Difficulty sleeping	4.1[d]	(2.5, 6.8)	2.9[d]	(1.9, 4.4)	3.2[d]	(2.2, 4.6)	2.3[d]	(1.3, 4.0)	1.5[d]	(1.2, 1.8)	1.7[d]	(1.5, 2.1)
Frequent headaches	3.1[d]	(1.8, 5.5)	2.3[d]	(1.4, 3.7)	2.3[d]	(1.5, 3.4)	2.5[d]	(1.3, 4.7)	1.1	(0.9, 1.4)	1.3	(1.0, 1.6)
Poor mental health	2.5	(0.7, 8.8)	4.4[d]	(2.1, 9.3)	3.5[d]	(1.7, 7.3)	3.2[d]	(1.2, 8.6)	1.4	(0.8, 2.3)	1.7[d]	(1.1, 2.7)
Poor physical health	1.7	(0.6, 4.5)	2.1	(1.0, 4.6)	1.9	(0.9, 3.9)	1.7	(0.6, 4.6)	0.9	(0.5, 1.5)	1.0	(0.6, 1.5)
Use of special equipment	2.5[d]	(1.4, 4.5)	2.6[d]	(1.6, 4.2)	2.5[d]	(1.6, 3.8)	2.1	(0.9, 5.0)	1.2	(0.8, 1.7)	1.4	(1.0, 1.9)

Note.AOR = adjusted odds ratio; CI = confidence interval; NISVS = National Intimate Partner and Sexual Violence Survey.

[a]Victimization as a child was defined as the victim was less than 18 years of age when first experiencing the specific type of violence.

[b]Includes the following forms of violence committed by a current or former intimate partner: sexual violence, stalking, physical violence, and psychological aggression.

[c]AORs: controlled for age at interview, race/ethnicity, education, and experience of any form of violence discussed in this study (rape, made to penetrate, stalking, and intimate partner violence as defined for this study).

[d]AOR is statistically significant. The association between victimized as a child and the health condition was significant when the computed 95% CI of the AOR did not contain 1.0.