Abstract:
Teen dating violence (TDV) is an underrecognized and significant public health problem that affects millions of adolescents each year. Many teens seek care in the emergency department (ED) for their injuries due to TDV, and are at risk for negative short- and long-term outcomes. With a better understanding by ED clinicians of normal adolescent development, as well as the impact of TDV on the health and safety of teen patients, the ED setting can serve as an effective site for both intervention and violence prevention. This article provides an overview of the importance of this issue, the impact of technology and social media on TDV, and best practices for ED screening, documentation, and referral.

Keywords:
teen dating violence; adolescent medicine; intimate partner violence; emergency medicine

*Division of Emergency Medicine, The Children's Hospital of Philadelphia, Philadelphia, Pennsylvania; †Department of Pediatrics, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania; ‡Lutheran Settlement House, Philadelphia, Pennsylvania.
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Reprint requests and correspondence: Ashlee Murray, MD, MPH, Division of Emergency Medicine, The Children's Hospital of Philadelphia, 34th St. & Civic Center Blvd., Philadelphia, Pennsylvania, 19104.
murraya2@email.chop.edu

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Teen Dating Violence: Old Disease in a New World

Ashlee Murray, MD, MPH*†, India Azzinaro, BSW‡

As a child, Candace* witnessed severe intimate partner violence (IPV) in her home for many years. During one argument, she recalled her father separating her from her mother and threatening that she would never see her again. Once Candace started dating as a young teen, she considered it "normal" for yelling, insults, and threats to occur within the relationship. She was victim to abuse in person and through the use of technology, with her partner tracking her location at all times and expecting her to respond immediately to text messages. She reported that this made her feel "special and loved," rather than the victim of extreme controlling behavior and stalking. Sex was a frequent topic within the relationship, and Candace felt pressured, eventually giving in to the coercion and manipulation she experienced. At age 15, Candace became pregnant.

BACKGROUND

The adolescent period has often been regarded as a time of increased vulnerability to violence.[1] During adolescence, the teen brain and body undergoes significant physical and emotional changes, intense social learning, and ongoing internal pressures to conform and belong.[2] Teens lack experience in mature communication and negotiation within romantic relationships, which may lead to the use of poor coping strategies, putting them at increased risk for TDV.[3] Critical to understanding TDV is recognizing the key differences between adolescent and adult victims of intimate partner violence (IPV). Effective strategies that interrupt the cycle of violence in families and

* *All identifiable demographics have been altered for the confidentiality of this case.*

their communities can improve outcomes for teens, and prevent the progression of IPV into adulthood.

Definitions

Teen dating violence involves a pattern of coercive, manipulative behavior that one partner exerts over the other for the purpose of establishing and maintaining control. Similar to adult IPV, TDV is often depicted as a cycle of power and control (Figure 1).[4] Because TDV has only recently been recognized as a significant public health problem, the complex nature of this phenomenon is not yet fully understood. Moreover, reported prevalence rates vary considerably, with data collection further challenged by a lack of standardized definitions.[5] Some researchers restrict the TDV definition to acts of physical violence alone, while others include psychological and emotional abuse in their definition. Some studies record violence that has occurred in a single or recent relationship, while others study the violence that occurs in multiple relationships over a longer time span.

Statistics

A recent meta-analysis found that 20% of adolescents have reported experiencing physical TDV (with a reported range of 1-61%) and 9% reported experiencing sexual TDV (range <1-54%).[6] In addition, 70% of females and 52% of males have sustained physical injuries following violence in TDV,[7] with many of these victims seeking emergency care. In a recent study of nearly 600 teens seeking treatment in an urban ED for violent injuries, teen dating violence was the cause of 44% of injuries in females and 4% of injuries in males.[8] Unlike IPV in adults, TDV is often reciprocal, with both

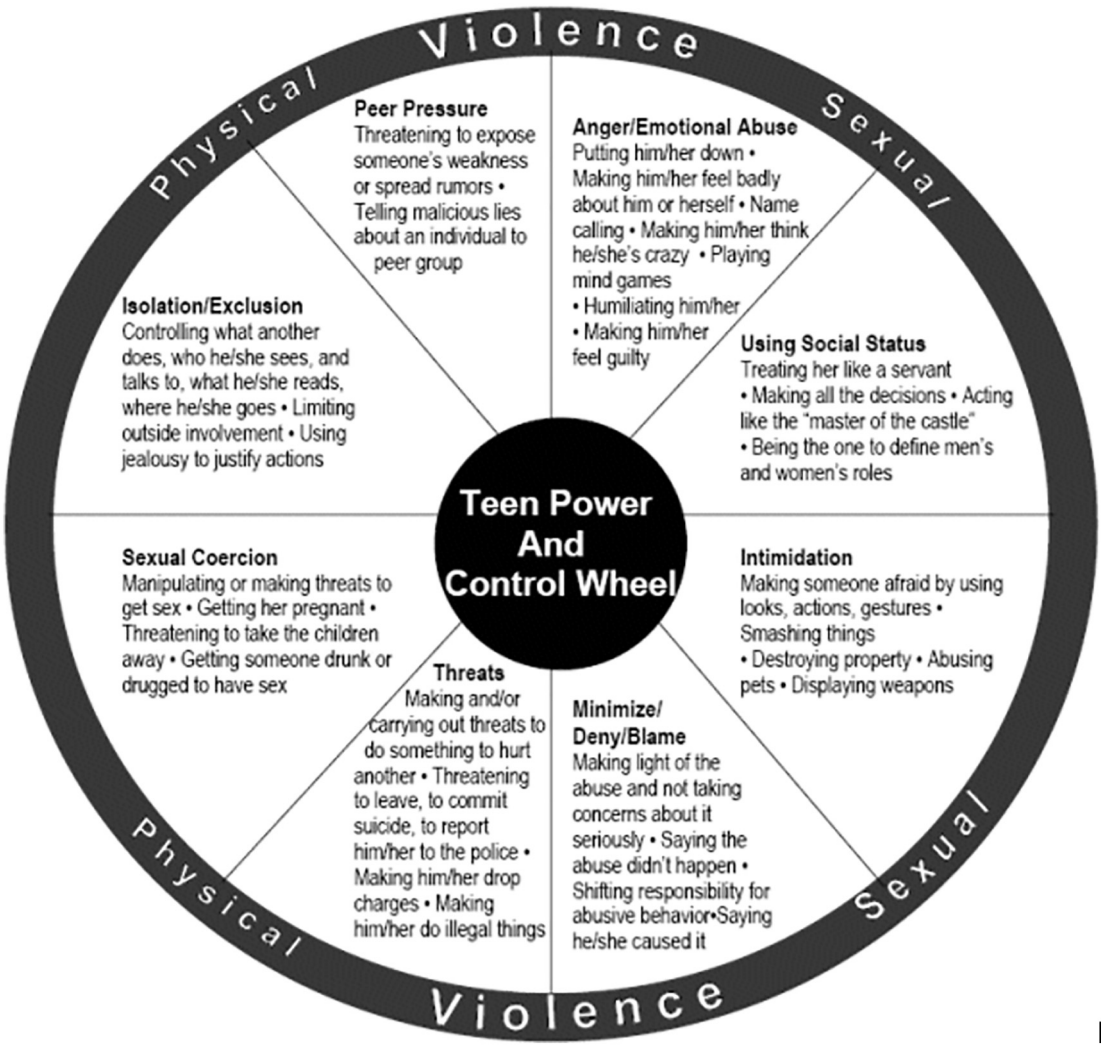

Figure 1. Teen power and control wheel.[4]

partners perpetrating violence.[7,9-11] Between 15 and 40% of teens report perpetrating physical or sexual violence toward a romantic partner at some point during adolescence.[12-14] Evidence also suggests a racial and ethnic disparity. Prevalence of TDV victimization is nearly twice as high among black students as among white students,[15] and a higher percentage of Hispanic students (11.4%) report physical TDV victimization as compared to non-Hispanic white students (7.6%).[16] These disparities have been documented in the physical, sexual, and psychological abuse of TDV.[17,18]

Types of Abuse Unique to Teen Victims

Intimate partner violence is broadly recognized as a continuum of abuse, which can range from incidents of emotional and verbal abuse, to rape and murder.[19] Definitions of IPV include physical violence, emotional and/or psychological violence, sexual violence, technological abuse, economical and/or financial abuse, and stalking. There are particular forms of violence and abuse more common among adolescents, including cyber dating abuse, mutual violence, and peer-centered violence (Table 1). Cyber dating abuse is an emerging phenomenon in which the intent to harm a partner is perpetrated through the Internet and digital technologies. This form of abuse has no geographic or temporal barriers, and causes significant harm to the mental well-being of the victim.[20] Mutual violence, occurring in 49% of cases studied, is the most common type of TDV reported amongst adolescents.[13] Peer-centered violence extends the abuse to a victim's entire social network and can lead to reputation defamation and significant social isolation.[21]

Childhood Risk Factors

TDV transcends race, ethnicity, socioeconomic status, and gender. Numerous studies, however, have described the association of specific childhood risk factors with TDV victimization, including child maltreatment, poverty, and exposure to parental IPV.[22,23] In addition, participation in high-risk behaviors, including alcohol use, marijuana use, and adolescent sexual activity, have been associated with TDV victimization.[15] Research has also revealed childhood protective factors against TDV victimization. For female high school students, advanced social skills afford protection against victimization. For both male and female students, early parental bonding was found to be further protective against TDV victimization.[23] Overall, the behavioral model for TDV victimization is a complicated and reciprocal relationship amongst childhood risk factors, protective factors, and early teen externalizing and internalizing behaviors (Figure 3).[23] Externalizing behaviors are those that harm others (e.g. bullying, defiance, physical aggression), while internalizing behaviors exert harm to the self.

Short- and Long-Term Outcomes

TDV victimization has been found to be associated with numerous adverse social and health consequences. Ten-year trends from the Youth Risk Behavior Surveillance System saw that physical TDV was associated with greater risk of depression, posttraumatic stress disorder (PTSD), suicidal ideation, and risky sexual behavior in young adulthood.[24] Additional research has demonstrated TDV increases the risk of poor school performance, substance abuse, eating disorders, adult IPV victimization, HIV infection, and chronic pain.[25-33] Cyber dating abuse has similarly been associated with adverse psychological outcomes, such as depression, anxiety, and suicide.[34] One study showed that TDV victimization was one of the highest risk factors for depressed females, with the TDV victim 61% more likely to attempt suicide than the non-victimized individual.[35] A more recent study

TABLE 1. Specific examples of TDV. *

Physical violence	Punching, kicking, slapping, pushing, choking
Emotional and/or psychological violence	Being verbally threatening and/or demeaning
Sexual violence	Forced sex, unwanted touching or groping
Technological abuse	Excessive texting, calling, sexting
Economical and/or financial abuse	Ruining personal credit, controlling money
Stalking	Recurring harassing behavior resulting in fear
Mutual violence	Reporting both victimization and perpetration over the course of the relationship
Cyber dating abuse	Cyber bullying that occurs between amorous and sexual partners or ex-partners
Peer-centered violence	Social isolation, creating rumors, threatening a person's reputation, turning friends against a former dating partner

* TDV – teen dating violence

examining the experiences of 67 teen suicide victims found similar results.[36]

Teen dating violence victimization has been linked to both TDV and adult IPV perpetration.[28,37] TDV perpetration is on the rise and adolescents who report bully/victim status have increased risk of perpetrating TDV themselves.[38] In the age grouping 13- to 16-year-olds, approximately 13% of males and 20% of females perpetrated physical TDV. These rates were slightly higher (19% and 23%) in the age group 17 to 20 years.[39] In general, the overall patterns of dating conflict experienced in adolescence are linked to the quality of romantic relationships in adulthood, with numerous studies demonstrating the important link between TDV victimization and perpetration later in life.[28,40,41]

UNIQUE FEATURES OF THE ADOLESCENT VICTIM

Teen Experience

Adolescents are especially vulnerable to TDV since it may interfere with two tasks that are integral to health and social development: (1) Establishing caring and meaningful relationships, and (2) developing interpersonal intimacy.[42] Caring relationships require the ability and willingness to empathize, communicate effectively, and respect another's boundaries, all emerging concepts and skills for the developing teen. Adolescents are transitioning from egocentric (or self-motivated) thinking into a deeper capacity for empathy and relationship building. It is theorized that victimized teens may be at greater risk than adults for physical and psychological harm due to their desire for independence, but reliance on support from immature peers, and their lack of relational experiences.[43] While teens rely on their peers for advice and validation, this may serve to perpetuate the social norm of violence in dating.

Teen Anatomy

Although significant, TDV is not solely the result of relationship inexperience. Evidence has supported the theory that brain development and biology contribute to the unique vulnerability of the victimized teen. During adolescence, brain development includes an increase in synaptic connections between neurons (Figure 2).[44] The pre-frontal cortex, responsible for decision-making, has been described as less active during adolescence.[45] Evolutionarily, this change is linked to the desire to "leave the nest," and the risk-taking required to create an independent life. In addition, because the pre-frontal cortex is not yet fully developed in the adolescent, response to stress can involve impulsive or aggressive action. Finally, the teen brain has been characterized as craving novelty, adventure, and challenge, which in the long run can lead to life enrichment. In the short-term, however, such drive may produce high-risk behaviors and engagement in unhealthy relationships.[46]

Teen Attitudes

Similar to adult victims of IPV, teens are embarrassed to disclose both TDV victimization and perpetration.[47] Adolescents often disclose the behavior unknowingly during healthcare encounters. For instance, when a teen divulges victimization in the form

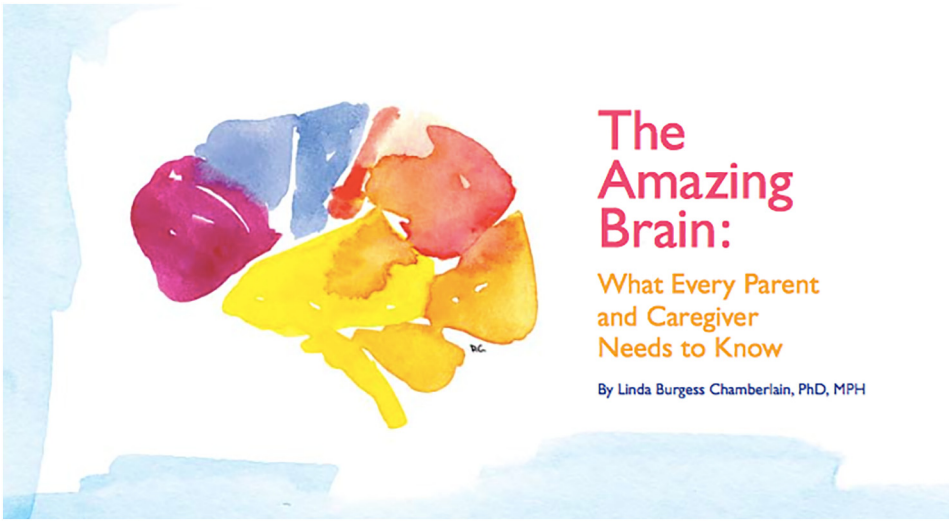

Figure 2. Link to "The amazing brain: what every parent and caregiver needs to know."(Do NOT print in hard copy. Only recommend for digital print. Embedded: link: http://www.instituteforsafefamilies.org/sites/default/files/isfFiles/The_Amazing_Brain-1.pdf)

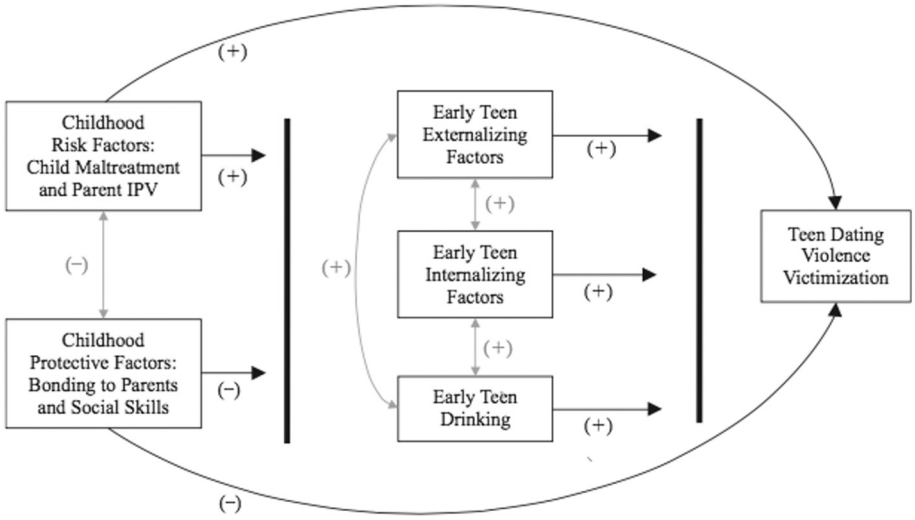

Figure 3. Conceptual model for TDV victimization.[23] *TDV, teen dating violence; IPV, intimate partner violence.

of name-calling, possessiveness, or sex-shaming from a partner, they often do not categorize these behaviors as TDV. Teens often minimize the behaviors, and/or define behavior as abusive only in specific contexts. For example, jealous behaviors are considered abusive if there is repetition or a threat of physical harm. However, if perceived as "kidding" or "caring," it is no longer identified as abusive. Double standards also exist for the use and perception of physical abuse by boys versus girls. A physically abusive girl does not usually cause physical harm to her male victim, such behavior may be "laughed off" or minimized, often characterized as "joking around."[47] Girls tend to describe behaviors as abusive if the impact is negative, whereas boys describe behaviors as abusive if the intent is negative.[47] Such disparity in gender-specific perceptions may contribute to our understanding the high rates of mutual violence (reciprocal victimization and perpetration) that exist in TDV.

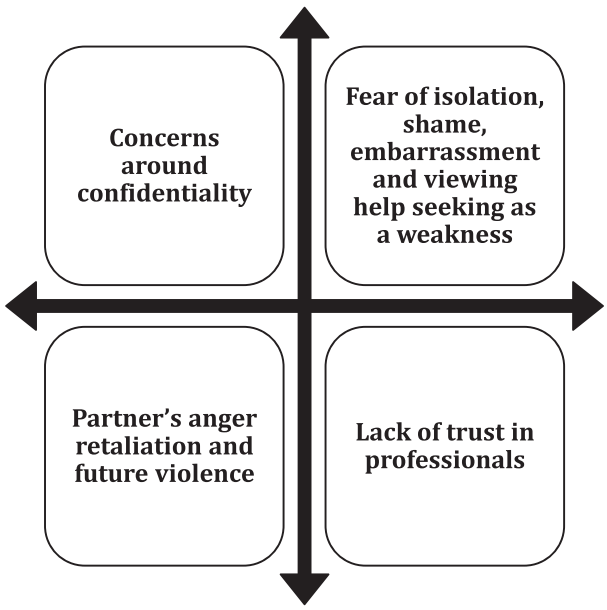

Figure 4. Adolescent barriers to TDV disclosure and help seeking.[69] *TDV, teen dating violence.

Teen Use of Technology

Researchers suggest that the loss of privacy in adolescence as a result of technological advances and enthusiastic participation in social media has facilitated unhealthy relationship behaviors, with cyber dating abuse increasingly prevalent.[48] In a recent sample of more than 4,200 ninth-grade students across 11 states in the US, 56% reported victimization in the form of cyber dating abuse.[49] Furthermore, these victims are more likely to perpetrate cyber dating abuse themselves. In a school-based sample of students in grades 7 through 12, investigators reported that nearly one in ten teens endorsed reciprocal cyber dating abuse perpetration in the previous year. Adolescent females in this sample were more likely to endorse reciprocal or perpetration-only cyber dating abuse than their male peers.[50]

Technological abuse includes repetitive texting or phone calls, online insults or threats, and posting photos, videos, and intimate messages without consent. These behaviors serve two purposes: (1) humiliation and defamation of the victim, and (2) assertion of control over the victim.[20] In one study, common abusive behaviors reported by respondents included the use of mobile phones and text messaging to monitor the partner's activities,

reading messages without the partner's knowledge or consent, leaving threatening voice and text messages, threatening harm if he/she fails to respond to a message, and posting insulting or threatening content on social media.[51] In another study, more than 50% of the reported cases of cyber dating abuse were practiced via message services or apps, 40% via social networks, and 7% via email.[52]

Adolescents generally do not view the various forms of cyber dating abuse as violence, but "annoying" behaviors by their partners.[53] Controlling and abusive behaviors, often characterized as a "proof of love," may be the adolescent new normal for romantic attachment. These behaviors and the high usage of technology among teens, informs the healthcare discussion of TDV for the future. Building awareness of all the forms of TDV, supporting victims, and effecting prevention campaigns must hinge on novel and effective uses of social media and technology.

THE HEALTHCARE RESPONSE

Emergency department clinicians are in a unique position to intervene, through TDV screening and detection, adolescent and family education, and referrals for counseling and care. Teen victims of TDV are more likely to seek assistance from healthcare providers than professionals in mental health or community-based IPV agencies.[54] In fact, healthcare providers are often the only people to whom TDV victims entrust the disclosure of abuse. Therefore, it is imperative that risk factor assessment and TDV screening is integrated into routine practice (Table 2).

Adolescents frequently rely on emergency services for medical care, rather than using primary care providers and other outpatient clinics.[55,56] In addition, adolescents who use EDs as their primary source of care are more likely to come from vulnerable populations.[55] National annual prevalence rates of TDV have remained consistent over the past decade, but there is mounting evidence that among youth seeking care in EDs, rates of dating violence are significantly higher.[56] The rates of physical TDV presenting to urban EDs have been reported to range from 52-76%, higher among females than males.[8,57,58] With a higher likelihood of physical injury in females, these TDV victims are more likely to seek emergency care.[8]

Victims of TDV seeking ED treatment are also more likely to report depressive symptoms, screen positive for alcohol problems, smoke marijuana, use illicit drugs, and carry a weapon than their non-victimized peers.[59,60] Moreover, a recent multivariate analysis examining adolescent ED visits for intentional injury, found higher odds of TDV victimization in females.[59] Study of alcohol use among victims seeking ED treatment show victims are more likely to have used alcohol on the days during which TDV occurred than on days with no TDV.[8,58] These studies highlight the importance of recognizing victims of TDV, and the opportunities for assessment and intervention within this clinical setting.

TABLE 2. Warnings signs for the ED clinician.

Suicidal behavior	Self-injurious behavior
Unexplained bruising and/or injuries	Noticeable weight change
Numerous unexplained somatic complaints	Lack of self-care
School absenteeism or poor school performance	Social isolation and/or social anxiety
Drug and/or alcohol abuse	Teen pregnancy

RECOMMENDATIONS: SCREENING FOR TDV

Overwhelmingly, the literature supports screening all adolescents, 13 years and older, for TDV in numerous healthcare settings, regardless of chief complaints.[11,54,61,62] The high rates of TDV reported among adolescent ED patients, the negative impact of undiagnosed and untreated victimization, and the frequent use of EDs by TDV victims for a wide variety of complaints highlight the utility and importance of universal TDV screening of all adolescents seeking treatment in the ED.[63] The American Academy of Pediatrics created the clinical guide "*Connected Kids: Safe Strong Secure*" to provide all pediatric clinicians with a comprehensive and logical approach to integrate violence prevention efforts into their practice.[64] The Joint Commission on Accreditation and Healthcare Organizations also mandates clinicians screen patients for IPV in all healthcare settings.[65] Most recently, the United States Preventive Services Task Force reviewed the evidence for IPV screening and continues to recommend screening asymptomatic adolescents for TDV and provide intervention services (Grade B Recommendation).[66]

Barriers and Best Practices

Despite this robust support for routine TDV screening, one study revealed less than 30% of adolescents report ever being asked by a healthcare provider about dating violence.[54] When adolescents were asked about their attitudes about screening for TDV, most teens responded positively.[67] The literature further

indicates that adolescents will more likely disclose TDV to their healthcare provider when a safe clinical environment is created and there is acknowledgement of TDV presence and prevalence.[54,62,68] Throughout the ED should be placed posters, brochures, and cards with information about TDV risk factors, prevention, and intervention. Screening for TDV should occur during every ED visit, regardless of chief complaint.[54,62,68]

Even though most adolescents support screening, numerous barriers to disclosure and seeking help have been identified (Figure 4).[69] Most important, adolescents have reported fearing a breach of confidentiality. They have also reported the need for healthcare providers to show empathy and understanding with any disclosure. Clinicians need to provide clear instruction to teens, and discuss what will happen with the information if they disclose. When screening is done in a safe and effective way, female victims are more likely to disclose and receive services.[70]

Important provider barriers to effective screening of IPV exist as well. The most frequently reported include provider discomfort with the topic, lack of training and knowledge, and time constraints (Table 3).[71] One study. that analyzed the TDV screening practices of resident physicians, found that even though the doctors understood the importance of TDV screening and believed it to be their role, they did not routinely screen or proceed with intervention in TDV cases, reporting inadequacy of training.[72]

There is limited data on best approaches and practices to screen adolescents for TDV in the ED. More robust data resides in studies of adult IPV screening in the ED setting.[73] Routine universal screening of IPV results in higher identification rates, with women more likely to disclose when screened using computer-based questionnaires and/or self-completed written questionnaires.[74-77] In addition, screening is most effective if a team approach is used. A patient may be reluctant to speak to the physician about IPV, but may discuss it with the nurse or social worker.[78]

Several tools and approaches to screening adolescents for TDV have been explored. The Violence Prevention Emergency Tool (VPET) and Violence Exposure Scale for Children (VEX), represent two separate tools that assess for exposure to violence. These are not TDV specific tools, but demonstrate high rates of enrollment and completion when administered and studied in a pediatric ED.[79,80] The most effective and reliable method for TDV screening in adolescents is the Audio Computer Assisted Survey Instruments (ACASI),[81] with follow-up interviews conducted by a clinician. Studies comparing ACASI screening versus face-to-face interview alone, for numerous sensitive topics, have found that respondents are more likely to answer honestly when screening via ACASI.[82] A more comprehensive web-based adolescent psychiatric assessment tool, with similar interface to ACASI, demonstrated effective implementation in a busy pediatric ED.[83]

Several studies have been done to determine if screening for IPV in adult ED patients posed any harm to the victim. In general, whether in-person face-to-face questioning, or use of a computer-interface for screening, no harm to patients has been reported. However, none of these studies were specific to adolescents.[84,85] Example screening questions are listed in Table 4 and a summary of best practices for screening adolescents for TDV are available in Table 5.

TABLE 3. Common barriers to screening for TDV.

Provider-Specific Barriers	System-Specific Barriers
Lack of provider self-efficacy	Time constraints
Fear of offending someone	Logistics of screen: when to screen, where to screen, who should administer the screen?
Lack of knowledge of how to screen	Lack of follow up resources
Fear of being overwhelmed with positive responses	Difficulty with accessing outpatient resources
Prioritization of other medical emergencies	
Not knowing what to do with a positive screen	
Lack of knowledge of how to quickly access resources	

Medical Documentation of TDV

Healthcare providers report concern about explicit documentation of TDV, with fears stemming from

TABLE 4. Screening questions for TDV.

Relationships can be tough. When you and your partner argue, what does it look like?
Does your partner get jealous?
Do you ever feel afraid of your partner or someone in your life?
Has your partner or someone in your life ever pushed, kicked, slapped, or choked you?
Has your partner or someone in your life every forced you to have sex or made you do sexual things that made you feel uncomfortable?

breach of confidentiality, medical liability, and potential harm to the patient (from an abuser) due to disclosure. However, complete documentation of IPV and victimization in the medical record is vital. Documentation helps ensure that each clinician who cares for that patient, whether in the ED, primary care office, or subspecialty clinic, understands the impact of TDV on the care of the teen, including the diagnosis of an illness or injury and provision of necessary medical care, referrals for psychological/social supports, and safety planning/prevention of future abuse. Careful documentation in the medical record provides important data in cases that involve police investigation and prosecution. Medical encounters for assault-related injuries are often within close time proximity to the violent event, providing important and credible support for a victim's disclosure to an investigator. Accurate documentation and coding of TDV support specific clinical care plans, but also serve to improve our understanding of the epidemiological impact of TDV and its associated medical conditions.[86] While there are no published guidelines for medical documentation of TDV, one can extrapolate from best practices and specific recommendations of adult IPV case documentation, which is summarized in Table 6.

Safety Planning with Teens

Domestic violence advocates define a "safety plan" as an individualized plan for reducing the risks generated by the abusive partner's violence and control.[87] The plan may or may not include leaving the partner. Because of the potential for an increase in the severity and intensity of violence when leaving an abusive relationship, pressure by a well-meaning professional to leave an abuser in the absence of a safety plan could result in harm to the teen victim. Therefore, consultation with on-site social services, local IPV and social agencies, local law enforcement, community-based counselors, supportive family members and friends, all serve to provide a vital safety net to ensure safety, recovery, and prevention. Important to note is that the resources available to adults seeking support are not the same, or may be unavailable, to victims under 18 years of age.

When safety planning with a teen, continue in the same non-judgmental tone as used in screening for TDV. Refer to specific safety plan questions that empower the teen to prioritize self-care, prevent future injury, and seek immediate help in crisis (Table 7). *LoveIsRespect* is a project of the National Domestic Violence Hotline, which serves to inform youth and end dating abuse.[88] The website discusses the most common forms of abuse encountered by teens and

TABLE 5. Best practices for screening adolescents for TDV. *

Screen the adolescent alone
Make screening routine and expected at all ED encounters, regardless of chief complaint
Establish a culture of universal screening amongst staff and patients
Advertise resources for IPV victims throughout the ED (posters, brochures, etc.)
Create a safe and trusting environment with the teen and screen in a non-judgmental way
Address confidentiality and its limits early in the conversation
Screen for TDV by asking specific questions (Table 4)
Upon disclosure, make sure to validate and affirm the teen
Assess for immediate safety concerns (see Safety Planning)
Provide referral resources, ideally with a "warm hand-off" to local community agency

* TDV – teen dating violence, ED – emergency department, IPV – intimate partner violence

TABLE 6. Recommendations for documentation of TDV in the medical chart. [105] *

1. Write legibly if documenting in paper chart
2. Record time of delay of patient encounter, as well as time of abuse
3. Describe the patient's overall demeanor (crying, anxious, calm, etc.)
4. Take photographs of known or suspected injuries and include in EMR
5. Set off the patient's own words in quotation marks or use phrases such as "patient reports" or "patient states"
6. Avoids phrases which may imply doubt, such as "patient claims" or "patient alleges"
7. Use medical terms and avoid legal terms, such as "assailant" or "alleged perpetrator"
8. Describe the perpetrator by using quotation marks. For example: *The patient reported, "My boyfriend choked me and is verbally abusive to me."*
9. Avoid summarizing a patient's report in conclusive terms. Include factual details. For example: instead of summarizing "the patient was raped," provide specific accounts of the sexual abuse. "Patient was forcibly vaginally penetrated…"
10. Do not place the term teen dating violence or abbreviations, such as TDV or IPV in the diagnosis section of the medical record
11. Develop policies/procedures to protect notes from accidental disclosure to parents and/or unauthorized healthcare personnel. Consider hard-stops in the EMR to prevent printing of sensitive documentation.

* TDV – teen dating violence, EMR – electronic medical record, IPV – intimate partner violence

TABLE 7. Example of safety plan questions for teens.

What have you done in the past to stay safe?
Do you have a code word to use with peers or trusted adult?
Can you stay out of areas where you might get trapped?
How do you think getting to and from school, or work could be safer for you?
Is there someone you could inform whenever you're alone/spending time with your partner?
Would you feel comfortable calling the police if you needed to?
Do you have a cell phone? Make sure to keep it charged and on your person at all times.
If you live with your partner, where could you go if you need to leave the house immediately? Do you have a bag with your essentials you could just grab and go?

offers suggested safety planning tips for teens, family, and friends.[88]

Legal Considerations

In the emergency department, cases may involve a disclosure of violence that prompts reporting to the police for investigation of criminal activity, or state social services agency for child abuse. The legal guidelines for investigation and remedy of TDV among adolescents varies throughout the United States. In some states, domestic violence (DV) legislation applies only to individuals 18 years and older, who are in certain types of intimate, cohabitating relationships, while other states include all teen victims. In Pennsylvania, teen victims of abuse who are under 18 years of age may obtain a "Protection from Abuse Order," but only with the permission of an adult caregiver.[89] This requirement may create a significant barrier to safety, which should prompt a search for agencies that offer teen-specific legal advocacy. In general, statutes that serve to protect and advocate for the teen victim are limited compared to those applied to adult victims of IPV. These legal disparities impact more than just criminal prosecution; they restrict the eligibility of victims for services and protections, as well as the development and evaluation of intervention programs for teens.

With regard to mandated child abuse reporting, disparity exists as well. In many states, children witnessing IPV is not reportable under the law. So, too, a teen abusing another may not meet the legal definition of a mandated report. In contrast, California child abuse laws are applicable to any type of violence or abuse inflicted upon a minor, regardless of the victim-offender relationship.[90] While no universal solution has been found to address these legal disparities, best clinical practices require familiarity with local laws and agencies, and prompt consultation with hospital legal and/or social services professionals.

EMERGENCY DEPARTMENT–BASED INTERVENTION

Most primary and secondary prevention programs have been established within school and community settings. However, data from ED- and hospital-based community violence programs are increasing, with results demonstrating positive outcomes for survivors of violence.[85,91] Additionally, one study of the cost-effectiveness of an ED-based youth violence prevention program found that the cost of prevention for a single injury ranges from three to fifty-four dollars, significantly less than the cost of placing a single intravenous line in an injured patient.[92] Although this study was not specific to violence between intimate partners, results may be extrapolated for TDV and a similarly vulnerable population.

Available evidence demonstrates that brief interventions, both computer-based and in-person, can be successfully implemented in the ED without interrupting patient flow or causing significant increases in ED length of stay.[93,94] In addition, evidence suggests that a majority of eligible patients are interested in IPV interventions in the ED setting, with participation rates as high as 84%.[95] Factors that influence patient participation rates include duration of intervention and safety concerns. Specifically, the victim worries about the abusive partner learning of the intervention, especially when the partner has accompanied the patient to the ED.

More ED-based IPV interventions exist for adults than adolescents, but useful outcomes data provides a springboard for implementation of programs in the pediatric emergency setting. A recent randomized, controlled trial conducted in an ED demonstrated the success of a brief intervention tailored to social risk factors, such as peer violence, alcohol abuse, and TDV. Approximately 400 adolescents, aged 14 to 18 years, with an 88% participation rate, were enrolled in the study and randomized to one of three conditions: (1) computer-based intervention, (2) therapist plus computer-based intervention, and (3) a control group with no intervention. Reduction in moderate to severe TDV occurred for up to one year following either ED intervention strategy when compared to controls.[96]

Another ED-based study examined the effectiveness of the *Real Talk Intervention*.[97] This intervention was designed to combat TDV perpetration, using

motivational interviewing to influence behavior. Researchers integrated this intervention into a busy ED, and found that their teen participants were more likely to seek resources and follow-up with their primary care physician, subsequently demonstrating a lower risk of TDV victimization, with no resultant harm to participants after disclosure. One study examined a text-messaging-based behavioral intervention for adolescents presenting to an urban ED, finding that 50% preferred text-messaging to human-interactive interventions.[98]

When reviewing ED-based interventions for IPV and TDV, certain features emerge that reliably increase success rates. The "SBIRT" model (Screening, Brief Intervention, and Referral to Treatment) is an effective approach in the emergency setting.[99] Strategies that improve TDV screening and intervention include the following: (1) self-administered questionnaires via computer tablets or semi-private information kiosks, (2) designation of a private space (outside of the ED treatment room) for consultation and brief interventions by social services, (3) intervention staff who originate from, reside in, or represent the patient's community, and (4) staff with the communication skill set and expertise specific to adolescent victims.[100-102]

The most important feature of any ED-based intervention is connecting patients to community-based agencies and resources, ensuring ongoing support for the victim after ED departure.[63] If there is no available hospital-based IPV specialist or social worker, a list of community resources is crucial. This list should include IPV- and TDV-specific professionals, which requires ED-to-community connection and established working relationships prior to referral. Identify mental health professionals who work on a sliding scale of payment, and those who accept state health insurance. It is important to understand the quality and availability of local IPV services to prevent exacerbation of the problem, negative experiences, and worsening outcomes for teens.[63,103]

Finally, it is important to identify supports for an adolescent that reside within his or her own family. If a teen presents with a parent or guardian for emergency-related TDV care, enlist the involvement of that adult caretaker after appropriate teen assent. Even when there is family conflict, parents continue to be a major source of support for teens experiencing stress and adversity.[104]

ILLUSTRATIVE CASE: CONCLUSION

At the age of 16, Candace gave birth to a girl, and feeling it was important for the child to have a father in the home, she received her parent's approval to move with her baby into the home of her partner's family. While he participated in the care of their daughter, her partner's verbal and physical abuse toward Candace escalated, at times in the presence of the child. Candace grew depressed, isolated, and fearful for the well-being of her daughter. She regretted leaving her home, but also felt a lack of acceptance from her family as a young mother. She hoped that family and friends would notice her sadness and reach out to her. While she was unable to initiate the conversation, she believed that if one caring person had asked, she would have revealed the truth. She disclosed at last in the setting of a local community center, with professionals providing her with access to counseling, legal advocacy, education, and transitional housing.

SUMMARY

Many adolescents enter into intimate relationships unable to successfully identify and counter unhealthy behaviors that promote TDV. Lacking emotional maturity, effective psychological tools, and at times adult support, teens are uniquely vulnerable to all forms of dating violence. Counseling, education, legal advocacy, and housing resources may be limited for teen victims, in sharp contrast to what is available for adult IPV survivors. As advocates for our adolescent population, the challenge to the ED team tasked with caring for a victim of TDV is two-fold: (1) effective screening that allows the teen to disclose in an environment of empathy and support, and (2) strong connection to community-based resources so that care is promptly available. While an adolescent patient may be unlikely to spontaneously disclose during a routine ED visit, asking the question is the crucial first step toward honest discussion, cessation of violence, and empowerment to seek and maintain healthy relationships. Teens want to be asked. Let's prepare to listen, and respond. ✚✚

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