


Addressing Adolescent Relationship Abuse in the Context of Reproductive Health Care

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Abstract

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Adolescent relationship abuse (ARA) is a significant public health issue that includes physical, sexual, psychological and cyber abuse, reproductive coercion, and/or sexual exploitation within an intimate relationship in which one or both partners is a minor. ARA is associated with numerous negative outcomes that include all domains of health. Many negative outcomes of ARA are related to reproductive and sexual health (RSH); thus, reproductive health care providers must be equipped to recognize and address ARA. This article will review the epidemiology and outcomes of ARA, followed by a discussion of means to robustly address ARA in health care settings. We recommend a strengths-based approach that promotes healthy adolescent relationships, connects adolescents experiencing ARA to harm reduction resources, and equips adolescents to serve as a resource for their peers.

Adolescent relationship abuse (ARA) is a pervasive public health epidemic with impacts on multiple domains of health, including those related to reproductive and sexual health (RSH). RSH care providers must understand ARA and be equipped both to promote healthy adolescent relationships and to connect adolescents experiencing ARA to harm reduction resources. Such practices can be part of multilevel, community-wide efforts that provide multiple opportunities to reinforce healthy adolescent relationship behaviors and mitigate the negative outcomes of ARA.

ARA has replaced “teen dating violence” as the preferred term for abusive relationships for several reasons.¹ “Dating” may be defined variably by different individuals and groups, resulting in those who do not consider themselves to be dating to not recognize experiences of “dating violence.” Similarly, the word “abuse” replaces “violence” as the former

has broader applications and may be less likely to be understood as limited to physical, sexual, or severe abuse.

ARA encompasses a broad range of behaviors that may be used by an abusive partner to maintain power and control within an intimate or romantic relationship in which one or both partners is a minor adolescent (i.e., less than 18 years).¹ It is common for adolescents in an abusive relationship to experience multiple forms of abuse.^{2–4} This may include physical, sexual and psychological abuse. More recently, reproductive coercion has been recognized as a form of relationship abuse that occurs among both adults and adolescents. Reproductive coercion limits an individual's autonomous decision-making around reproductive choices.⁵ Such abuse may include hormonal and non-hormonal contraception sabotage, preventing access to reproductive health services, forced pregnancy through psychological coercion

or rape, or control over decisions around abortion. A growing body of literature also identifies cyber abuse as a form of ARA.^{2,3} Technology may be used in many ways to perpetrate abuse, including stalking, psychological or sexual harassment, and coerced sharing of passwords. Further, technology offers abusive partners opportunities to harass their partner even when not physically present. Finally, ARA may include sexual exploitation, defined as the attempt to profit financially, socially or politically from the sexual use of another's body.⁶ Although less well-studied than other forms of ARA, sexual exploitation may occur within the context of a romantic relationship. Evidence suggests that some adolescents may engage in transactional sexual activity as an outgrowth of their romantic attachment to a dating partner.^{7–9} For some adolescents, transactional sexual activity may be viewed as an acceptable behavior within romantic partnerships.⁸

Epidemiology

ARA is a globally pervasive public health epidemic. Highest prevalence of intimate partner violence (IPV) is seen among women of child-bearing age. The World Health Organization (WHO) found that 24% of adolescent females aged 15–19 who report having been in a relationship have experienced physical and/or sexual violence from an intimate partner or husband, with 16% of young women aged 15–24 experiencing such violence in the past 12 months.¹⁰ The United States (US) National Survey on Teen Relationships and Intimate Violence surveyed 1,804 adolescents ages 12–18 and found that among those reporting current or past-year dating, 69% reported lifetime ARA victimization (60% psychological, 18% physical, and 18% sexual).¹¹ The US Youth Behavioral Risk Survey found that 7% of participants reported past-year sexual ARA and 8% reported past-year physical ARA.¹¹ Youth that have been marginalized, including those in the foster care system or who experience housing instability, report even higher prevalence of ARA.¹² Additionally, cyber ARA impacts 25–41% of adolescents.^{2,3} Reproductive coercion is reported by 20% of adolescent women, with 12% of U.S. high school females reporting reproductive coercion in the past three months.^{4,13} Prevalence of sexual exploitation within adolescent romantic relationships has not been as well described in studies to date, although 3–7% of adolescents and young adults report surviving transactional or exchange sex.^{14,15} Further, emerging data suggests that prevalence and severity of gender-based violence has increased over the course of the COVID-19 pandemic.¹⁶

Although ARA impacts all youth, groups that have been historically marginalized are most at risk. Girls and young women are more likely to experience sexual assault and reproductive coercion as compared with men.¹⁷ Gender and sexual minority youth are also more likely to experience physical and sexual ARA.¹⁸ In a nationally representative sample, sexual minority youth (i.e., identify as LGB) were more likely to experience ARA as compared with heterosexual youth; youth who were unsure about their sexual identity were the most likely to experience ARA.¹⁹ Evidence is mixed in terms of ARA

disparities among youth belonging to minoritized racial and ethnic groups. Some studies suggest that racial and ethnic minority youth experience more ARA, while others have shown similar ARA prevalence to that among non-Hispanic White youth.^{11,17} It is critical to note that these disparities are firmly rooted in structural-level inequities (i.e., racism, transphobia, sexism, etc.), rather than interpersonal- or individual-level factors. For example, one study found that a strong positive association between identifying as a gender or sexual minority youth and experiencing ARA may attenuate after adjusting for experiences of discrimination and peer victimization.¹⁸

In addition to the above disparities, ARA survivors belonging to groups that have been marginalized may have more challenges engaging in supportive services. For example, acculturation differences between first-generation immigrant parents and their adolescents may impact the ways in which parents and adolescents communicate about romantic relationships and ARA.^{20,21} Latinx and Black youth are less likely to engage in help-seeking behaviors and more likely to use informal rather than formal supports.^{22,23} Gender and sexual minority youth may not be able to engage in help-seeking due to fear that they will be forced to share their gender or sexual identity.^{24,25} Further, in terms of peer/bystander intervention, White women may be less likely to intervene to prevent a sexual assault if the survivor has a distinctly Black name versus a non-distinct name.^{26,27}

It is important to consider the experiences of communities that have been marginalized through an intersectional lens. Intersectionality recognizes that individual experiences of privilege and inequity are the result of overlapping forms of structural oppression related to varied aspects of identity, such as racism, sexism, xenophobia, and classism.^{28,29} For example, one study of transgender women of color noted intersectional inequities and interpersonal stigma impacting relationship violence and engagement in survival strategies.³⁰

ARA can occur concurrently with other forms of youth violence exposure or adverse experiences, including exposure to parental IPV, experiencing child abuse and neglect, and experiencing community violence. Youth who perpetrate violence may do so in multiple contexts, such as with peers and dating partners.^{31,32} These multiple forms of violence exposure and experiences have shared risk and protective factors.³³ Thus, the socio-ecological model is a useful theoretical framework to consider interweaving risk and protective factors at individual, interpersonal, neighborhood, and structural levels.³⁴

Developmental Considerations

Adolescents may be at a higher risk of abuse by an intimate partner, compared with adults, due to a combination of factors influenced by adolescent psychosocial development. Adolescence is a sensitive period of development during which the brain transits intense emotional states. Adolescent decision-making capacity is not fully developed and peer influences during this development period are paramount. Together, these aspects of adolescent development may interfere with adolescents' ability to identify relationship

behaviors as abusive, forced, or coerced.^{35,36} Even when behaviors are identified as abusive, adolescents may lack knowledge or skills to address unhealthy relationships, including how and when to ask for help. As with many other reproductive health-related matters, adolescents often turn to peers for advice and support when experiencing ARA, rather than disclosing their concerns to adults who might be better prepared to provide advice and minimize harm.^{37,38}

Power imbalance due to age difference may also complicate adolescent relationships as many female adolescents date older partners.³⁹ This age difference, which is often greater than two years, places the younger adolescent in a position of power imbalance that may render them unable to negotiate safe sexual practices including condom use, STI screening and treatment, and even contraception use.⁴⁰

Outcomes

ARA is associated with negative RSH outcomes. Sexually active adolescent females reporting current or past ARA are up to 3.5 times more likely to have been pregnant.^{41,42} Adolescent females experiencing ARA are more likely to fear talking to their partner about pregnancy prevention, compared with non-abused peers.⁴³ Additionally, pregnant adolescents are at a significantly higher risk of IPV compared with the adult population. A 20-year retrospective review of pregnant trauma patients found that one in five pregnant trauma patients less than 18 years in this study had intentional injuries related to intimate partner violence.⁴⁴ ARA also negatively impacts sexual health. History of ARA is associated with 2–3 times the risk for STI,^{43,45} and both verbal and physical ARA are associated with inconsistent condom use.^{43,46,47}

Further, numerous studies demonstrate increased risk for negative outcomes of ARA beyond those associated with RSH. Adolescents with history of ARA are more likely to report depressive symptoms, anxiety, disordered eating, and suicidality.^{48–50} These outcomes may differ depending on adolescent age, gender, and sexuality and are associated with multiple forms of ARA. The negative impacts of ARA on mental and behavioral health extend beyond the period of abuse.⁴⁹ Additionally, adolescents experiencing ARA are more likely to report substance use, including tobacco, alcohol, marijuana, and electronic cigarettes (vaping).^{49,51–53} ARA perpetration is also associated with other forms of youth peer violence, including bullying, as well as weapons carrying, antisocial behaviors such as lying and theft, and gambling.^{32,48,54} Additionally, ARA is associated with decreased educational achievement and economic outcomes including lower levels of school connectedness and higher rates of truancy.⁵⁵ Lower educational achievement during adolescence may in turn result in decreased economic achievement during adulthood for survivors of ARA.⁵⁶ Finally, ARA also contributes to adolescent homicide rates, particularly for females.^{16,57–59} Among 2,188 U.S. adolescent homicides, 7% of homicides among those age 11–18 years and 15% among those 19–24 years were committed by an intimate partner.⁵⁷

We present these outcomes to note the profound impact of ARA on adolescent health and wellbeing. Healthcare providers have both responsibility and unique opportunity to promote healthy adolescent relationships and support ARA survivors by connecting adolescents to point-of-care harm reduction resources, as well as leveraging resilience and fostering social connections.

Addressing ARA in Healthcare Settings

Before discussing specific opportunities to address ARA in healthcare settings, it is important to consider the broad clinical context within which such efforts occur. A healing-centered engagement approach can be used for all patient care but may be particularly helpful when addressing trauma-related concerns such as ARA. Healing-centered engagement is a trauma-sensitive practice that recognizes that both trauma and resilience are universal experiences, and that healing occurs in the context of safe and secure relationships.^{60,61} As such, providers may find it beneficial to shift from the question of “what is wrong with you” to the questions of “what has happened to you” and “what is right with you.”⁶⁰ Providers must also recognize the adolescent as the expert on their own lived experiences and having a critical role in generating solutions. Additionally, healing-centered engagement acknowledges that trauma is experienced collectively as well as individually. Thus, services to address trauma must acknowledge that both trauma and healing are influenced by positive and negative environmental factors such as culture, identity, and systemic structural inequities.

Universal Education

Universal education and resource provision is a strategy that can be used both to promote healthy relationships and to provide ARA resource information within pediatric healthcare settings.⁶² Universal education offers several advantages to screening, especially in the context of sensitive topics which patients may not feel safe or comfortable disclosing to healthcare providers. Additionally, unlike screening, use of universal education acknowledges that ARA may manifest in numerous ways and may include controlling behaviors not commonly listed on screening tools. A universal education strategy may be employed using the Confidentiality, Universal Education, Empowerment, and Support (CUES) approach, comprised of education and resources provision for all patients.⁶³ By providing resources to everyone, universal education via the CUES approach empowers adolescents to share ARA information with their family and peers, thus helping reduce ARA in communities.

The CUES approach for ARA has been evaluated in school-based healthcare centers using a brief provider script on both healthy and unhealthy relationships and provision of a resource card. This approach has been shown to be acceptable and potentially efficacious in increasing knowledge about ARA resources, self-efficacy to use harm reduction behaviors, and decreasing ARA victimization among adolescents with history of ARA.^{64,65} Evidence also supports the use of the CUES approach with young adults in other

Table 1 Using CUES to promote healthy adolescent relationships and connect adolescents to resources⁶³

Confidentiality
Speak with the adolescent alone for a part of every visit. Know and share limits of confidentiality: “Before I get started, I want you to know that everything here is confidential, meaning that I won’t talk to anyone else about what is happening unless you tell me that you are being hurt physically or sexually by someone, or planning to hurt yourself.”
Universal Education + Empowerment
Give the adolescent resource information (multiple copies, for adolescent to keep and/or share). Make sure they know you are a safe person to talk to. “I’m giving this information to all adolescents, in case it’s ever something you need but also because I think it’s important for you to have the info to help a friend. The card talks about relationships and how they can affect your health. It also talks about situations where youth are made to do things they don’t want to do, and tips so you don’t feel alone. The back of the card has 24/7 text and help lines that have folks who really understand complicated relationships. You can also talk to me about any health issues or questions you have. Because I know a lot of patients aren’t ready or may be afraid to share certain things about their health or relationships, I want you to know that you can use these resources for yourself or for a friend, regardless of what you choose to share with me today.”
Support
Disclosure is not the goal of universal education, but it will happen. Provide a warm hand-off to resources and a care plan that takes ARA into consideration. “Thank you for trusting me with this part of your story. Relationships can be complicated, and it can be hard to know how to handle things with a partner. I’d like to connect you to [name], who can let you know about some of the resources other teens have found helpful and ways that we can help.”

healthcare settings.^{66–68} For providers interested in using this approach, we provide a sample script in **Table 1** and recommend additional resources available online through Futures Without Violence and an article by Ragavan, et al.⁶²

Universal Screening

Universal screening is an approach that assesses every patient for a condition of interest. The U.S. Preventive Services Task Force does recommend IPV screening for women of reproductive age.⁶⁹ However, there is scant evidence to date on universal screening for ARA. Validated IPV screening instruments have primarily been studied among adult populations and are often limited to questions about physical and sexual abuse.⁷⁰ Validated instruments used for ARA assessment may be impractical for busy pediatric settings due to their length.^{71,72} Additionally, screening-based resource provision may also result in missed opportunities to support adolescents experiencing ARA as there are many reasons that adolescents may choose not to disclose ARA in response to screening in health care settings.⁷³ Should providers choose to implement universal ARA screening, we recommend that it be incorporated with an educational component that addresses why screening is being done, available resources, and limits of confidentiality, as well as in conjunction with a well-delineated plan for resource provision after disclosure. Studies among adult survivors of IPV suggest that universal screening alone does not result in increased use of services or improved outcomes.^{74,75}

Parent Involvement in Promoting Health Adolescent Relationships

For many adolescents, parents and other trusted adults serve as an important resource both to help prevent ARA and to support young people who are experiencing ARA.^{76,77} In

particular, increasing parental monitoring and parent-adolescent communication may be modifiable intervention targets. Parental monitoring comprises parental knowledge of a child’s activities, a child’s communication about their activities, and the active structuring of a child’s environment (e.g., limit/rule setting).⁷⁸ Past literature with parents and youth demonstrates that higher levels of general and dating/ARA-specific parental monitoring (e.g., knowledge of a child’s dating activities and partners) are associated with decreased ARA.^{79,80} Parent-adolescent communication around dating and ARA is also protective against ARA.^{81,82} However, a study examining conversations between parents and adolescents on health-related topics showed that ARA is discussed less frequently than substance use or sexual health. Parents are often difficult to engage in school and community-based ARA interventions and are thus rarely included.⁸³ The adolescent well-visit is an ideal location to engage parents or other caregivers as parents often bring their children to adolescent well-visits.⁸⁴

Indicator-Based Assessment for ARA

Providers should consider that indicator-based assessment for ARA may be used when they identify risk factors for ARA. As discussed, behaviors associated with ARA that are of particular relevance to RSH care providers include early sexual debut, multiple sexual partners, condom non-use, and sexual activity concurrent with substance abuse. As noted above, RSH outcomes more likely to occur among adolescents experiencing ARA include STI and pregnancy (including rapid repeat pregnancy). Providers should keep in mind that behaviors and health outcomes associated with ARA may be related to other factors as well. **Table 2** provides example scripts that provider may consider for indicator-based assessment for specific clinical scenarios.

Table 2 Indicator-based assessment scripts

There are a lot of reasons that teens may not use condoms consistently, like forgetting about it or your partner not wanting to use one. Is using a condom each time you have sex something you can talk to your partner about?
It sounds like you're not wanting to be pregnant right now, but you're not sure about using birth control. [pause for response] Has your partner ever told you they'd like you to be pregnant? How does/would your partner respond to a conversation about preventing pregnancy?
When youth have a new partner since I last saw them, I always remind them that everyone deserves a partner that treats them with respect. This is so important because your relationships impact just about every part of your life, including your health. Tell me about some of the ways you know your partner respects you . . . Are there things your partner does that make you feel disrespected?
When I'm seeing patients for prenatal care, I always ask how your relationship with the baby's father is. This is important because that relationship impacts your health and your baby's health. How are things going with the baby's father?
When my patients have problems with [abdominal pain, headache, etc.], I always ask about stressful things that may be going on. We know that stress lives in our bodies and can cause pain, or that stress can make health problems worse. Some stressful things that youth tell me about include school and dating or other relationships. What things are particularly stressful for you right now?
We can certainly do an [STI test, pregnancy test] today. When patients ask about this, I always check in to make sure that your partner is respecting your boundaries about sexual things, like wearing a condom. How is this going for you?
I always check in with my patients about taking birth control regularly because it's easier said than done. Tell me how taking the pill is going for you . . . Is there anything or anyone that makes it challenging for you to take the pill consistently each day . . . Sometimes a partner may make it hard to take your pill each day. If this is something that ever happens to you, we can talk about some options for navigating that.
Tell me how things are going with you and social media. How often have you been put down or harassed by anyone, or pressured to do something that made you feel uncomfortable? I'm asking because sometimes these things affect how you feel, and your health.

Support after ARA Disclosure

Given the prevalence of ARA and associations between ARA and RSH behaviors and outcomes, RSH care providers must be prepared to address ARA disclosure in their practice. Such preparation should include development of a standard response for ARA disclosure, educating the full clinical team on this response and each team member's role in addressing ARA within the practice setting, and understanding relevant mandatory reporting laws and any limits of confidentiality.

Response to ARA disclosure begins with validating the disclosure, followed by a warm hand-off to resources (see script in ► **Table 1**). A warm hand-off is important, as evidence suggests that simply providing a list of resources is an insufficient response when relationship abuse is identified. To facilitate a warm hand-off, the healthcare team can personally connect the adolescent to ARA resources. Such resources may vary between practice settings. For some, resource provision may include a connection to an onsite social worker or IPV advocate. At a minimum, providers can offer national resources available 24 hours daily, such as Love is Respect (phone line, text service, online chat) and the National Domestic Violence Hotline (phone line, online chat). It may be helpful to offer for the adolescent to use a phone or computer in the healthcare setting as some abusive partners may monitor phone use, including call logs, text messages, and internet activity. Providers can also ensure that adolescents experiencing ARA are aware of point-of-care harm reduction resources available in health clinic settings at the time of disclosure or if desired later. These may include emergency contraception, hormonal contraception, STI testing and treatment, and condom provision. When discussing resources, providers should keep in

mind that survivors are the expert on their lived experiences and safety risks. Providers should only connect an ARA survivor to resources if they feel safe and secure engaging with those resources.

Confidentiality after ARA Disclosure

ARA involving minors may raise questions about mandatory child abuse reporting requirements and statutory rape laws. Providers must be aware of their legal requirements for confidentiality of health information and reporting of child abuse, for example, US state mandatory reporting laws. Reporting requirements may be dependent on the type of abuse disclosed. ARA may not meet mandatory reporting requirements as the perpetrator of abuse does not typically have care, custody, or control of the victim as a parent or other adult as in cases of child abuse. However, some healthcare institutions may have policy stipulating that some types of ARA, such as sexual assault, will result in a report to child protective services. Resources that may aid healthcare teams in addressing the concerns and requirements of mandatory reporting include social work and/or ethics consultation, hospital and state medical societies' legal counsel, and domestic violence and sexual assault coalitions.⁵

Providers should consider that mandatory reporting, although intended to provide support for adolescents experiencing ARA, may also have unintended negative consequences. This is in part due to lack of infrastructure to ensure patient safety and confidentiality following reports.⁹ Additionally, awareness of mandatory reporting requirements may be an important barrier for teen disclosure of ARA.⁸⁵ Breaking confidentiality to meet reporting requirements may damage

an adolescent's trust in both an individual healthcare provider and the health system as a whole. This risk may be decreased by ensuring that limitations around confidentiality are shared before any discussion of ARA (see script in ► **Table 1**), as well as clearly communicating with adolescents about the process and anticipated next steps when a report is required.¹ When possible, the adolescent may also be involved in making a mandatory report and notification of adult caregivers as needed. For example, adolescents may be allowed to choose if they will tell their adult caregiver about the ARA with or without a member of the healthcare team present or if they would prefer for the healthcare provider or social worker to tell the adult caregiver with or without the adolescent present.

Engaging a parent or adult support may be helpful for youth who are experiencing ARA. A recent study found that adolescents and parents find it acceptable for a healthcare provider to inform parents about ARA disclosure, particularly for physical ARA.⁸⁶ When discussing ARA after disclosure, healthcare providers should ask youth if there is an adult support with whom they would feel comfortable sharing their ARA experiences. This person may be a parent or another trusted adult. Whenever possible and with permission from the adolescent, it may be helpful to facilitate conversation in the clinic with the adult support and adolescent. Discussion should center on supporting the adolescent and resource provision for the adolescent and adult support, taking care to avoid blaming the adolescent. If an adolescent does not want to disclose to a parent, the healthcare provider should encourage leveraging the support of another trusted adult. In situations where the adolescent is in a severely abusive relationship or has survived sexual assault, or a minor adolescent is in a relationship with someone who is older, disclosure and mandating reporting to child protective services may be required, depending on legislative policies.

Telehealth Considerations

The recent surge of telehealth use, particularly in the context of the COVID-19 pandemic, creates unique challenges and opportunities and has been successfully used for a variety of adolescent-related services, including reproductive and mental health care.^{87,88} However, concerns with privacy emerge when addressing ARA, particularly because abusive partners often use technology to exert control over their partners, including undisclosed participation, interruption or even disconnecting services.^{89,90} Screening for ARA is not advisable through telehealth; however, use of a CUES approach may allow for resource provision during a telehealth visit without compromising safety and confidentiality.^{62,91} Follow-up in-person visits may also be needed when ARA is suspected or disclosed. Further research is needed to develop best practices for using telehealth to support adolescents and young adults experiencing ARA.

Addressing ARA Beyond Healthcare Settings

Health care-based ARA interventions are an important means to mitigate the negative outcomes of ARA but are not sufficient to fully address this issue. Ideally, interventions in health care settings are only one layer of community-wide efforts to

promote healthy adolescent relationships. Health care providers can advocate for effective community ARA intervention. For example, governmental policies may require relationship education in secondary schools. However, evidence suggests that such policies alone do not significantly impact ARA prevalence.⁹² Health care providers can advocate that such policy is tied to adequate funding and implementation of evidence-based interventions. At a more local level, providers may serve as a resource for schools and other community organizations to provide education directly to adolescents, parents, and/or to organizational leadership on the importance of addressing ARA and effective interventions to support healthy adolescent relationships. The WHO and the US Centers for Disease Control and Prevention provide evidence-informed strategies and approaches to reduce ARA and gender-based violence.^{77,93}

Conclusion

ARA is a highly prevalent public health issue experienced by adolescents across all sociodemographic groups and with potential for lifelong negative outcomes across all domains of health. RSH providers have opportunity in their practice both to promote healthy adolescent relationships and to mitigate the negative consequences of ARA by connecting adolescents to harm reduction resources. Additionally, providers may serve as a source of education and awareness to foster robust community-based ARA education and resource provision that is supported by evidence-informed policy and practices.

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Conflict of Interest

None declared

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