Current Trauma Reports (2022) 8:54–60
https://doi.org/10.1007/s40719-022-00226-4

INTENTIONAL VIOLENCE (S BONNE AND M CRANDALL, SECTION EDITORS)

Intimate Partner Violence in Adolescents: Emerging Research for the Trauma Practitioner

Jamie Schwartz[1] · **Govind Kallumkal**[1]

Accepted: 28 December 2021 / Published online: 22 March 2022

Abstract

Purpose of Review This review article aims to discuss important concepts related to intimate partner violence (IPV) in adolescents. It seeks to answer questions regarding the risk factors for such violence and to address considerations relevant to the practice of emergency room and trauma physicians.

Recent Findings IPV in adolescents is different from adult IPV in a few important ways, due to unique aspects of adolescent development and socialization. There are many risk factors for dating violence in this population that practitioners must be aware of. Additionally, the intersections between this type of violence and specific trauma-related concerns are complex and not fully understood.

Summary Despite its prevalence, adolescent dating violence is an understudied issue, one that impacts not just adolescents but the adults that they become. In order to improve the health and wellness of our communities, practitioners must seek a better understanding of IPV as an adolescent phenomenon.

Keywords Adolescent partner violence · Teen dating violence · Intimate partner violence · Trauma

Introduction

Intimate partner violence (IPV) is a serious public health issue in the USA. It is a phenomenon that encompasses physical, emotional, and/or sexual abuse by a current or previous partner [1]. In the USA, an estimated 1 in 10 men and 1 in 4 women have experienced IPV in the form of physical violence, sexual violence, or stalking [1]. IPV in adolescents, defined as individuals between the ages of 10 and 19 and also referred to as adolescent dating violence (ADV) or teen dating violence (TDV), is a common problem [1–3]. An estimated two-thirds of adolescents who are in or have been in a relationship over the past year are affected by partner violence [4••]. Of those who have experienced IPV, over 1 in 5 women and over 1 in 7 men confirm that the first incidence of abuse occurred before the age of 17 [3]. In fact, young women between the ages of 16 and 24 experience dating violence at a rate 3 times the national average, suggesting the widespread nature of ADV [5]. Due to the magnitude of this issue, research on ADV is necessarily increasing and has important implications for health care providers.

Specifically, the physical forms of IPV in adolescents are highly relevant to the practice of trauma physicians and emergency room providers as they are a common and potentially underrecognized occurrence. Roughly 1 in 5 adolescents experience physical IPV [6]. Unfortunately, the rate of physical ADV leading to injuries significant enough to warrant medical attention has not been well studied [7••]. However, given that approximately 15% of adult men and 21% of adult women have experienced relationship violence that includes severe acts such as choking, burning, beating, or the use of a knife or gun, it is reasonable to believe that a high burden of physical injury also exists in the context of adolescent IPV [8]. As such, it is crucial for physicians involved in the care of these adolescents to be aware of the latest research on ADV. This will allow for better identification and treatment of these individuals, as well as an improved ability to promote ADV prevention.

This article is part of the Topical collection on *Intentional Violence*

✉ Jamie Schwartz
jschwartz@ufl.edu

[1] College of Medicine, University of Florida, 1600 SW Archer Road, Gainesville, FL 32610, USA

Concerns Unique to ADV

In thinking about ADV, it is crucial to recognize the unique features that distinguish it from adult IPV, as there are relevant differences that can inform the practice of emergency physicians and trauma doctors. One of the most important differences is that ADV is more frequently bidirectional, meaning involved parties are more likely to be both a victim as well as a perpetrator of violence [4••]. This is essential to consider for two reasons. First, different patterns of injury can be seen when suffering versus enacting violent behavior, and both may be more likely in an adolescent involved in IPV as compared with an adult. Second, recent work indicates that bidirectional partner violence among adolescents is associated with higher rates of physical injury [6].

Other things that differentiate ADV relate to developmental features of adolescence, such as the impulsivity that characterizes the brain during this period, as well as the critical importance of peer relationships and social image [4••]. This impulsivity, combined with significant concern about peer perceptions, may influence the teen's style of conflict resolution. Moreover, the lack of significant relationship experience may interfere with the adolescent's ability to recognize certain behaviors, whether physical or psychological, as abusive [9]. Thus, it is essential for providers to ask specific questions about both peer and romantic partner connections and to elicit objective information from the individual, as the subjective experience of the victim or perpetrator might not portray a clear picture of IPV.

Risk Factors

Many of the risk and protective factors for IPV in adolescents mirror those of adult partner violence. And although adolescent partner violence is often bidirectional in terms of victimization and perpetration, much of the research has focused on studying these risks in a unidirectional context. Thus, while discussing them together, we will consider factors for victimization and perpetration as independent entities, focusing on those that have been studied most extensively in recent years. In doing so, a general framework will be applied that categorizes these factors as relating to societal structures, family dynamics, and individual characteristics (Table 1).

Societal Determinants of ADV

From the societal perspective, beliefs in traditional gender roles and norms are among the most studied in terms of their association with acts of ADV. It is a well-established fact that patriarchal attitudes promote violence against women of all ages. However, recent work demonstrates that adolescents of both genders who hold a less egalitarian view of female and male roles in romantic relationships are at a higher likelihood of IPV victimization and perpetration [10]. Additionally, the role of engrained sex and gender norms in dating violence is highlighted by the fact that deviance from these traditional concepts has also been associated with adolescent IPV. Specifically, those identifying as sexual and gender minorities experience higher rates of all types of IPV, regardless of their partner's gender identity or sexual orientation [11, 12•]. These associations are at least partially

Table 1 Risk factors for adolescent IPV

	Victimization	Perpetration
Societally based risk factors	-Endorsement of traditional sex and gender roles and norms -Racial discrimination -Limited economic opportunities	-Endorsement of traditional sex and gender roles and norms -Racial discrimination -Limited economic opportunities -Exposure to community violence
Household/family-based risk factors	-Low socioeconomic status -Family member involvement in IPV -Exposure to violence within the home	-Low socioeconomic status -Family member involvement in IPV -Exposure to violence within the home -Harsh or authoritarian parenting style
Individual risk factors	-Firearm access -Firearm carrying -Sex or gender minority status -Racial or cultural minority status -History of abuse as a child -History of being bullied -Affiliation with delinquent peers -Mental illness -Substance use -Unintended pregnancy	-Firearm carrying -Sex or gender minority status -Racial or cultural minority status -History of abuse as a child -History of being bullied -Affiliation with delinquent peers -Anxiety/depressive symptoms -Substance use -Impulsivity

attributable to maltreatment and peer victimization, which can reasonably be assumed to stem from perceived "violations" of traditional gender and sex roles [12•].

Caregiver Determinants of ADV

At the level of the family unit, the modeling of romantic relationships that occurs within the home is most crucial to the development of a child's understanding and reenactment of intimate relationships [13]. In addition, certain parental dynamics experienced by a child as early as 12 months have the capacity to increase that child's later risk of engaging in dating violence. Specifically, children exposed to aggressive interparental conflict are at higher risk, as are children reared by authoritarian-style parenting [14, 15]. By contrast, parenting styles characterized by open communication, sensitivity, warmth, and involvement in the child's activities were found to be protective [14–17]. One hypothesis behind these associations posits that the development of impaired self-regulation and externalizing behavior is encouraged by observation of hostile conflict within the home and discouraged by a warm and caring environment [14]. Furthermore, disengaged or harsh parenting can produce emotional insecurity which promotes acting out within close relationships [17].

Individual Determinants of ADV

On an individual basis, many things confer risk when it comes to enacting or enduring dating violence. Prior work indicates that experiencing physical and/or sexual violence in childhood is one of the most significant risk factors for ADV exposure [9, 18]. Moreover, mental health and substance use have been found to have an association with involvement in ADV, specifically symptoms of depression and anxiety and consumption of alcohol, marijuana, and other illicit drugs [19, 20]. It is unclear whether these are linked, in terms of whether the childhood abuse increases the risk of mental illness and substance use which then in turn heightens the risk for ADV. Alternatively, it is possible that physical and/or sexual abuse in childhood is itself an independent risk factor, regardless of its effects on mental health and substance use behaviors.

Another recent area of work that should be of great interest to those involved in trauma care focuses on the risk of actual physical injury stemming from ADV. Individual factors that increase the risk of sustaining injury secondary to acts of ADV are white racial identity, engagement in multiple forms of partner violence, and concomitant perpetration of ADV [7••]. Additionally, female sex is a risk factor for severe physical injury related to ADV. It becomes an even more pronounced risk factor when it comes to ADV that results in homicide [7••, 21••]. In other words, while adolescents presenting with injury secondary to IPV can be either male or female, especially given the bidirectional nature of ADV, it is far more likely for the severely injured patient to be female. Furthermore, in looking at infliction of physical violence, specific age confers risk, with those in middle to late adolescence (15 years and older) having the greatest propensity for ADV perpetration [22•].

Special Trauma Considerations

Firearms and ADV

To date, the relationship between ADV and gun violence has not been extensively researched, other than to identify an association between adolescent IPV and firearm access [4••]. Until such time, more general work on adolescents and gun violence can help inform practitioners about some of the relevant considerations. As the second leading cause of death of adolescents in the USA, firearms have long been considered a major public health issue facing teens and young adults. Most of these deaths result from intentional acts of homicide or suicide [23]. However, in the specific context of ADV, the use of firearms is less common compared with other types and methods of abuse. This perhaps explains why gun violence among adolescents as it relates to ADV has not been extensively studied [4••]. Nevertheless, we know that firearms, particularly in the hands of older adolescents aged 18–19, are the most frequent cause of adolescent intimate partner homicide (IPH), the most severe manifestation of ADV [21••, 23, 24].

One particular concern is how the circumstances surrounding ADV demonstrate crossover with those of youth firearm access. Specifically, adolescents with the aforementioned risk factors for ADV, including parental detachment, psychologic distress, and gender/sexual orientation nonconformity, are shown to have greater access to firearms than those adolescents without such risk factors [25, 26]. And while firearm access may not be sufficient for gun violence in situations of ADV, it is certainly necessary, and the overlap in risk factors among those who are prone to ADV and those who are able to acquire a firearm suggests a relationship that must not be ignored.

Though this access to firearms most often occurs illegally in adolescents, legal procurement of guns in adolescents ages 18 and 19 is possible in certain states given existing federal firearms laws [27]. The ramifications of the legal avenues of obtaining a gun at age 18–19 must be considered, especially given that it is these older adolescent individuals who comprise the vast majority of teen IPH perpetrators [21••]. That is to say, most IPH is perpetrated by a subgroup of adolescents that theoretically has lawful access to firearms. Although no statement of causality can be made without further study, research on the effects of gun control support the idea that legal access to firearms contributes

to the higher rate of IPH in this group of adolescents. This research includes findings that older adolescents in states with stricter gun control laws are less likely to carry a firearm [28, 29]. In other words, stricter regulation of the legal means of accessing guns is a promising avenue for reduction of gun violence, and potentially IPH, among adolescents.

Suicide and ADV

While emergency and trauma physicians frequently encounter adolescent dating violence in the setting of physical assault, it is also crucial to identify the indirect circumstances by which physicians come across patients experiencing ADV. In addition to being a risk factor for perpetration and victimization of dating violence, mental illness is also a major consequence of IPV [30]. Evidence for the relationship between dating violence and adverse effects on mental health are well-documented. These adverse effects can manifest as low self-esteem, anxiety, depression, and post-traumatic stress disorder and do not discriminate based on gender [30–32].

As may be expected, the link between ADV and adverse mental health outcomes subsequently translates into an association between ADV and suicidality/self-harm [33, 34•, 35, 36•]. Interestingly, although thoughts of non-suicidal self-injury (NSSI) are not necessarily more prevalent in adolescents engaged in violent romantic relationships versus those who are not, actual NSSI behaviors are [34•]. This suggests that of adolescents presenting for self-directed injury, a disproportionate number may be impacted by IPV. With regard to suicidality, another important context in which physicians may encounter ADV, recent studies have found that adolescents who experienced physical dating violence were around 2 times more likely to have suicidal ideations and almost 2.5 times more likely to attempt suicide as compared with their peers who had not experienced ADV [35, 36•]. This suicidality is not just a transient consequence of adolescent dating violence, but rather has been shown to persist for years after victimization [37]. Additionally, while the direction of this relationship is unclear, perpetration of ADV is also linked to an increase in suicidal ideation [38].

Although suicide can be the result of mental health issues, it is also true that in a large proportion of adolescents, suicide and suicide attempts can result from an impulsive decision in someone who otherwise has no previous psychiatric history [39]. This impulsivity also characterizes many acts of ADV and thus there is reason to suspect an association between ADV and impulsive suicidality [40, 41]. However, a definitive association between individuals who exhibit impulsive suicidal behavior and ADV must be studied directly before these conclusions may be drawn. Ultimately, what can be surmised from existing work is that ED and trauma physicians are treating a high number of adolescents for suicide attempts and self-harm behaviors that are involved in victimization and/or perpetration of ADV.

Substance Use and ADV

Substance use is highly associated with traumatic injury, particularly in adolescents, with one contemporary study demonstrating 53% of young trauma patients tested positive for drugs and 14% tested positive for alcohol [42]. The correlation between substance use and traumatic injury in this population continues to hold true when looking at IPV. As discussed above, this correlation is, at least in part, due to substance use as a risk factor for ADV. However, the relationship appears to be much deeper than that. One focus group identified elements of substance use in many facets of adolescent partnerships. It can be the thing that brings individuals together in the first place, a means of coping once the tumultuous relationship has been established, and/or a way of dealing with the stress of the relationship ending [43]. This suggests it is important for physicians involved in the care of adolescent trauma patients to screen for substance use and ADV, even if the patient is not under the influence at the time of the injury.

On a promising note, the role of substance use in ADV appears to be moderated by factors that can provide a potential means of reducing such violence beyond just promoting abstinence. This is critical, as simply encouraging cessation of substance use among adolescents has shown to be an ineffective approach [44, 45]. Existence of social cohesion, positive community engagement of adolescents, and prosocial peer networks have been shown to dampen the association between drug and alcohol use and ADV, possibly via demonstration of nonviolent conflict resolution and a subsequent decrease in propensity for aggression [46]. Therefore, in addressing the interplay of substance use and adolescent IPV, it may be beneficial to focus on local community dynamics and social programs, as opposed to merely targeting adolescent substance use in direct fashion.

Discussion

High rates of ADV suggest that emergency departments and trauma centers are treating a significant number of adolescents suffering from acts of IPV. As such, it is important for emergency and trauma practitioners to be aware of the factors that place an individual at increased risk of victimization and/or perpetration, as well as to engage with the specific concerns and implications for practice.

And while there is a breadth of research investigating the various risk and protective factors associated with ADV, there is a striking dearth of evidence-based information on the characteristics and outcomes of IPV among adolescents. It is difficult to imagine that the medical and public health fields will be able to develop highly effective solutions to prevent occurrence and progression of ADV without such

research to support policy implementation and societal reform. It is also important to consider that difficulties in reducing adult IPV may be related to the fact that we have not adequately addressed ADV, which is very often the origin of dating violence for victims and perpetrators [1, 36•, 47••]. This further demonstrates the importance of studying IPV as an adolescent phenomenon.

In addition to expanding research on the nature and consequences of ADV, the types of studies being conducted must be carefully considered. The current body of information is limited due to the survey-based methodology employed by much of the research. Heavy reliance on self-reporting is problematic, and evidence supporting this concern is exemplified by the fact that things like reported rates of victimization and perpetration in heterosexual adolescents do not align as expected, with rates of perpetration being significantly lower than victimization [6]. Another example of the concern with self-reporting is the potential underreporting of both victimization and perpetration by males due to societal gender norms that may make them feel uncomfortable admitting to suffering from abuse or due to feelings of shame about being an abuser [6, 48]. More broadly, the use of a variety of instruments to obtain data also influences the results of these studies, as answers are subject to differ based on how a question is asked [6]. Until studies are designed that overcome these obstacles, it is imperative to have these shortcomings in mind when reviewing the literature on ADV.

As discussed, ADV is enmeshed with many of the common issues that permeate trauma-related care. With respect to firearms, though the data directly relating ADV and guns is limited, research connecting ADV and firearm access indicates, unsurprisingly, that stricter gun control will help keep adolescents out of our trauma bays and out of our morgues [28, 49, 50]. As for patients presenting with suicide attempts and self-harm, it is key for providers to consider comorbid ADV perpetration or victimization as a potential part of the patient's story and to be sure to ask carefully about these issues. Finally, more effort must be made to understand the role of substance use in ADV and how to moderate this relationship in a way that decreases morbidity and mortality.

Ultimately, there is reason to be hopeful that the incidence and consequences of ADV can be mitigated and perhaps someday eliminated. Some recent studies have shown that screening and subsequent brief intervention in emergency department and school settings can reduce rates of ADV [51, 52]. Importantly, despite these studies and the fact that numerous professional organizations promote universal screening for ADV, no widely accepted, adolescent-specific tools for intimate partner violence screening yet exist. A few studies are beginning to validate screening instruments in small populations of teens and young adults, but more extensive work is urgently needed to compare various approaches to screening and to potentially adapt screening tools used in adult populations [53, 54]. Likewise, adolescent-specific IPV prevention programs have been successful in smaller studies, but future investigation is necessary to determine the sustainability and long-term success of these interventions, as well as the best ages and settings in which to implement them. Furthermore, such studies must capture a broader range of socio-cultural groups and geographic environments [55–57].

Clearly, much work remains in the study of and societal response to ADV. However, by maintaining a good fund of knowledge about current research on ADV, emergency and trauma practitioners need not wait for independently validated screening tools or formal programs to screen their adolescent patients and refer them to appropriate community resources.

Conclusion

ADV is a widespread, understudied problem with an expanding base of research. Given the implications that it has for individuals from adolescence into adulthood, as well as for society at large, it is incumbent upon physicians involved in the care of trauma patients to be current in the knowledge of ADV-related issues. By recognizing the factors that promote and protect against adolescent IPV, potential outcomes, and unique trauma-related ADV concerns, doctors can be better advocates for their patients and their communities.

Compliance with Ethical Standards

Conflict of Interest The authors declare no competing interests.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subject performed by any of the authors.

References

Papers of particular interest, published recently, have been highlighted as:
- • Of importance
- •• Of major importance

1. Centers for Disease Control and Prevention. Preventing intimate partner violence. 2020. https://www.cdc.gov/violenceprevention/intimatepartnerviolence/fastfact.html. Accessed 2 March 2021.
2. World Health Organization. Adolescent health. https://www.who.int/health-topics/adolescent-health/#tab=tab_1. Accessed 2 March 2021.
3. Centers for Disease Control and Prevention. Intimate partner violence in the United States-2010. 2010. https://www.cdc.gov/

violenceprevention/pdf/cdc_nisvs_ipv_report_2013_v17_single_a.pdf. Accessed 2 March 2021.

4.•• Bender AK, Koegler E, Johnson SD, Murugan V, Wamser-Nanney R. Guns and intimate partner violence among adolescents: a scoping review. J Fam Violence. 2020. https://doi.org/10.1007/s10896-020-00193-x. **First contemporary review to look at risk factors for gun-related ADV.**

5. J Flowers Health Institute. Teen dating violence. https://jflowershealth.com/teen-dating-violence/#Resources. Accessed 3 March 2021.

6. Wincentak K, Connolly J, Card N. Teen dating violence: a meta-analytic review of prevalence rates. Psychol Violence. 2017;7(2):224–41.

7.•• Tharp AT, Reyes HLM, Foshee V, Swahn MH, Hall JE, Logan J. Examining the prevalence and predictors of injury from adolescent dating violence. J Agress Maltreat Trauma. 2017;26(5):445–61. **One of the first and only studies to look at prevalence of physical injury secondary to IPV among adolescents.**

8. Smith SG, Zhang X, Basile KC, et al. The national intimate partner and sexual violence survey (NISVS): 2015 data brief-updated release. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. 2018. https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf. Accessed 7 Mar 2021.

9. Rome ES, Miller E. Intimate partner violence in the adolescent. Pediatr Rev. 2020;41(2):73–80.

10. Wesche R, Dickson-Gomez J. Gender attitudes, sexual risk, intimate partner violence, and coercive sex among adolescent gang members. J Adolesc Health. 2019;64(5):648–56.

11. Whitton SW, Dyar C, Mustanski B, Newcomb ME. Intimate partner violence experiences of sexual and gender minority adolescents and young adults assigned female at birth. Psychol Women Q. 2019;43(2):232–49.

12.• Martin-Storey A, Pollitt AM, Baams L. Profiles and predictors of dating violence among sexual and gender minority adolescents. J Adolesc Health. 2020. https://doi.org/10.1016/j.jadohealth.2020.08.034. **Stressors associated with minority-group identity account for higher rates of IPV in sexual and gender minority adolescents.**

13. Cadely HS-E, Mrug S, Windle M. Comparisons of types of exposure to violence within and across contexts in predicting the perpetration of dating aggression. J Youth Adolesc. 2019;48(12):2377–90.

14. Livingston JA, Eiden RD, Lessard J, Casey M, Henrie J, Leonard KE. Etiology of teen dating violence among adolescent children of alcoholics. J Youth Adolesc. 2018;47(3):515–33.

15. Muniz-Rivas M, Vera M, Povedano-Diaz A. Parental style, dating violence, and gender. Int J Environ Res Public Health. 2019;16(15):2722.

16. Garthe RC, Sullivan TN, Gorman-Smith D. The family context and adolescent dating violence: a latent class analysis of family relationships and parenting behaviors. J Youth Adolesc. 2019;48(7):1418–32.

17. Mumford EA, Liu W, Taylor BG. Parenting profiles and adolescent dating relationship abuse: attitudes and experiences. J Youth Adolesc. 2016;45(5):959–72.

18. Sanz-Barbero B, Baron N, Vives-Cases C. Prevalence, associated factors and health impact of intimate partner violence against women in different life stages. PLoS ONE. 2019. https://doi.org/10.1371/journal/pone.0221049.

19. Yu R, Pepler DJ, van de Bongardt D, Josephson WL, Connolly J. Internalizing symptoms and dating violence perpetration in adolescence. J Adolesc. 2018;69:88–91.

20. Reyes HLM, Foshee VA, Bauer DJ, Ennett ST. Proximal and time-varying effects of cigarette, alcohol, marijuana and other hard drug use on adolescent dating aggression. J Adolesc. 2014;37(3):281–9.

21.•• Adhia A, Kernic MA, Hemenway D, Vavilala MS, Rivara FP. Intimate partner homicide of adolescents. JAMA Pediatr. 2019;173(6):571–7. **The most comprehensive study that is uniquely devoted to the study of intimate partner homicide characteristics.**

22.• Shorey RC, Cohen JR, Lu Y, Fite PJ, Stuart GL, Temple JR. Age of onset for physical and sexual teen dating violence perpetration: a longitudinal investigation. Prev Med. 2017;105:275–9. **Takes a unique look at age of onset for IPV within the adolescent period.**

23. Cunningham RM, Walton MA, Carter PM. The major causes of death in children and adolescents in the United States. N Engl J Med. 2018;379(25):2468–75.

24. Bush AM. A multi-state examination of the victims of fatal adolescent intimate partner violence, 2011–2015. J Inj Violence Res. 2020;12(1):73–83.

25. Tracy BM, Smith RN, Miller K, et al. Community distress predicts youth gun violence. J Pediatr Surg. 2019;54(11):2375–81.

26. Ganson KT, Nagata JM. Gender and sexual orientation bullying victimization are associated with gun carrying among adolescent boys. Child Adolesc Social Work J. 2020. https://doi.org/10.1007/s10560-020-00689-x.

27. Bureau of Alcohol, Tobacco, Firearms and Explosives. https://www.atf.gov (2020). Accessed 5 April 2021.

28. Gunn III JF, Boxer P. Gun laws and youth gun carrying: results from the youth risk behavior surveillance system, 2005-2017. J Youth Adolesc. 2021. https://doi.org/10.1007/s10964-020-01384-x.

29. Xuan Z, Hemenway D. State gun law environment and youth gun carrying in the United States. JAMA Pediatr. 2015;169(11):1024–31.

30. Taquette SR, Monteiro DLM. Causes and consequences of adolescent dating violence: a systematic review. J Inj Violence Res. 2019;11(2):137–47.

31. Amanor-Boadu Y, Stith SM, Miller MS, Cook J, Allen L, Gorzek M. Impact of dating violence on male and female college students. Partn Abus. 2011;2(3):323–43.

32. Garthe RC, Sullivan TN, Behrhorst KL. A latent class analysis of early adolescent peer and dating violence: association with symptoms of depression and anxiety. J Interpers Violence. 2021;36(5–6):2031–49.

33. Belshaw SH, Siddique JA, Tanner J, Osho GS. The relationship between dating violence and suicidal behaviors in a national sample of adolescents. Violence Vict. 2012;27(4):580–91.

34.• Levesque C, Lafontaine M-F, Bureau J-F, Cloutier P, Dandurand C. The influence of romantic attachment and intimate partner violence on non-suicidal self-injury in young adults. J Youth Adolesc. 2010;39(5):474–83. **One of the only studies looking specifically at ADV and NSSI thoughts and behaviors.**

35. Nahapetvan L, Orpinas P, Song X, Holland K. Longitudinal association of suicidal ideation and physical dating violence among high school students. J Youth Adolesc. 2014;43(4):629–40.

36• Baiden P, Mengo C, Small E. History of physical teen dating violence and its association with suicidal behaviors among adolescent high school students: results from the 2015 youth risk behavior survey. J Interpers Violence. 2019. https://doi.org/10.1177/0886260519860087. **Contemporary and comprehensive look at suicidality and adolescent dating violence.**

37. Exner-Cortens D, Eckenrode J, Rothman E. Longitudinal associations between teen dating violence victimization and adverse health outcomes. Pediatrics. 2013;131(1):71–8.

38. Rivara F, Adhia A, Lyons V, et al. The effects of violence on health. Health Aff (Millwood). 2019;38(10):1622–9.

39. Dodson NA. Adolescent gun violence prevention: what we know, and what we can do to keep young people safe. Curr Opin Pediatr. 2016;28(4):441–6.
40. Dodaj A, Sesar K, Simic N. Impulsivity and empathy in dating violence among a sample of college females. Behav Sci (Basel). 2020;10(7):117.
41. Shorey RC, Brasfield H, Febres J, Stuart GL. An examination of the association between difficulties with emotion regulation and dating violence perpetration. J Aggress Maltreat Trauma. 2011;20(8):870–85.
42. Robinson T, Tarzi C, Zhou X, Bailey K. Screening for alcohol and substance use in pediatric trauma patients: a retrospective review. J Pediatr Surg. 2020;55(5):921–5.
43. Baker CK. Dating violence and substance use: exploring the context of adolescent relationships. J Interpers Violence. 2016;31(5):900–19.
44. Nicholson T, Duncan DF, White J, Stickle F. Focusing on abuse, not use, in drug education. J Subst Use. 2013;18(6):431–9.
45. Beck J. 100 years of "just say no" versus "just say know". Reevaluating drug education goals for the coming century. Eval Rev. 1998;22(1):15–45.
46. Reyes HLM, Foshee VA, Tharp AT, Ennett ST, Bauer DJ. Substance use and physical dating violence: the role of contextual moderators. Am J Prev Med. 2015;49(3):467–75.
47.•• Cortens-Exner D, Eckenrode J, Bunge J, Rothman E. Revictimization after adolescent dating violence in a matched, national sample of youth. J Adolesc Health. 2017;60(2):176–83. **Directly identifies adolescent dating violence as a predecessor to adult IPV.**
48. Fellow of the American College of Surgeons. Best practices guidelines for trauma center recognition of child abuse, elder abuse, and intimate partner violence. 2019. https://www.facs.org/-/media/files/quality-programs/trauma/tqip/abuse_guidelines.ashx. Accessed 17 April 2021.
49. Safavi A, Rhee P, Pandit V, et al. Children are safer in states with strict firearm laws: a national inpatient sample study. J Trauma Acute Care Surg. 2014;76(1):146–50.
50. Goyal MK, Badolato GM, Patel SJ, Iqbal SF, Parikh K, McCarter R. State gun laws and pediatric firearm-related mortality. Pediatrics. 2019. https://doi.org/10.1542/peds.2018-3283.
51. Levesque DA, Johnson JL, Welch CA, Prochaska JM, Paiva AL. Teen dating violence prevention: cluster-randomized trial of teen choices, an online, stage-based program for healthy, nonviolent relationships. Psychol Violence. 2016;6(3):421–32.
52. Ngo QM, Eisman AB, Walton MA, et al. Emergency department alcohol intervention: effects on dating violence and depression. Pediatrics. 2018. https://doi.org/10.1542/peds.2017-3525.
53. Emelianchik-Key K, Colvin KF. The teen screen for dating violence: an item response theory analysis. J Interpers Violence. 2019;36(17–18):10012–34.
54. Rickert VI, Davison LL, Breitbart V, et al. A randomized trial of screening for relationship violence in young women. J Adolesc Health. 2009;45(2):163–90.
55. De Koker P, Mathews C, Zuch M, Bastien S, Mason-Jones AJ. A systematic review of interventions for preventing adolescent intimate partner violence. J Adolesc Health. 2014;54(1):3–13.
56. Finnie RKC, Okasako-Schmucker DL, Buchanan L, et al. Intimate partner and sexual violence prevention among youth: a community guide systematic review. Am J Prev Med. 2021. https://doi.org/10.1016/j.amepre.2021.06.021.
57. Hielscher E, Moores C, Blenkin M, Jadambaa A, Scott JG. Intervention programs designed to promote healthy romantic relationships in youth: a systematic review. J Adolesc. 2021;92:194–236.