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**Intimate Partner Violence Screening in Adolescent and Young Adult
Females**

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Abstract

Problem Adolescents and young adult females are at risk for experiencing intimate partner violence (IPV). Females aged 16- to 24-years of age experience IPV three times more likely than males. Universal screening for adolescent IPV is considered a gold standard for adolescent anticipatory guidance. The purpose of this quality improvement initiative was to evaluate the impact of an adolescent IPV screening instrument in an urban, Midwestern shelter for pregnant adolescent and young adult females.

Methods An observational, descriptive design. All adolescent and young adult females presenting for intake evaluation were screened for IPV using the Healthy Relationship Quiz over a three-month period.

Results There were 19 females (N=19) screened. The majority of participants had a documented positive screening (n=18, 95%). A chi-square test of independence analysis between screening and education provided by intake ($\chi^2 = 5.00$, $df=1$, $p = .025$) and between screening and referral to outside resources ($\chi^2 = 14.00$, $df=1$, $p < .001$) was found. A high score on the Healthy Relationship Quiz prompted referral to resources with the odds of being referred to resources increasing by approximately 6% per one unit increase in score.

Implications For Practice Screening using the Healthy Relationship Quiz identified most adolescent and young adult females living in a shelter experienced IPV. Identifying IPV enabled referral to internal, community, and counseling

resources to provide intervention, reduction of future risk, and enhanced personal safety. Ideally, all adolescent and young adult females should receive anticipatory guidance and education for IPV prevention by the agency or healthcare organization.

Intimate Partner Violence Screening in Adolescent and Young Adult Females

An interpersonal relationship milestone for adolescents begins with intimate partnerships such as dating. Dating can be a maturing factor in the life of the adolescent, but without the knowledge and skills for a healthy relationship the relationship can be harmful to the adolescent's health and wellbeing (Tharp et al., 2013; Mercy & Tharp, 2015). Intimate partner violence (IPV) is an experience not exclusive to adult relationships and occurs most commonly in adolescence and young adulthood. Though common in young relationships, IPV can be serious and preventable. Since IPV perpetration and victimization declines with age, prevention at an early age may be effective in preventing IPV across the lifespan (Center for Disease Control & Prevention [CDC], 2017). Over the past two decades, the incidence of IPV has become a serious pediatric and public health issue (Masters, 2015; Karsberg, Bramsen, Lasgaard, & Elklit, 2018). In 2010, Congress named the month of February as National Teen Dating Violence Awareness and Prevention Month in an effort to bring national recognition to the topic (S. Res. 373, 2010).

While IPV in adolescence mirrors IPV in adulthood, it is an experience requiring consideration of key relational developments occurring during this time (Masters, 2015; Exener-Cortens, 2014; Mercy & Tharp 2015). Violence in adolescent dating relationships is the first opportunity for violence in a romantic context, which may predicate a context of violence in future relationships (Mercy

& Tharp, 2015). Adolescent IPV is often referred to more specifically as teen dating violence and includes stalking, physical, emotional, and sexual dating violence. In addition, any sexual dating violence has expanded to include digital abuse, which is online harassment or misuse of sexually explicit messages or images (Kistin, Rothman, & Bair-Merritt, 2019; S. Res. 373, 2010; Masters, 2015; Mendoza & Mulford, 2018; CDC, 2017; Dick et al., 2014). Regardless of the term used (i.e., IPV, teen dating violence, sexual dating violence, dating abuse, adolescent relationship abuse, and partner abuse), all are used as interchangeable terms.

The National Intimate Partner and Sexual Violence Survey estimated 8.5 million U.S. women annually have reported experiencing physical violence, sexual violence, or stalking by a partner before age 18-years (CDC, 2017). One in three adolescents are victims of physical, sexual emotional, or verbal abuse from a dating partner (Department of Health and Human Services [HHS, b], n.d.). The American Academy of Pediatrics (AAP, 2009) recommended clinicians familiarize themselves with adolescent IPV since 51% of 7th graders reported dating and 72% of 8th and 9th graders report dating (HHS [b], n.d.). Dating relationships are important for adolescent development and should be included as an anticipatory guidance topic of health promotion and violence prevention during well child visits. Clinicians are recommended to be prepared in offering anticipatory guidance to adolescents and parents about teen IPV (AAP, 2009).

Likewise, secondary prevention strategies such as screening and educational programs for IPV have been recommended. Due to the dangerous and lasting effects of adolescent IPV, clinicians are encouraged to routinely screen for IPV to reduce future adverse health outcomes (Exner-Cortens, Eckenrode, & Rothman, 2013; Kistin et al., 2019; S. Res. 373, 2010). In a study by Kistin et al. (2019), the pediatric medical home was identified as a primary source for IPV screening and prevention; whereas, educational programs such as *Safe Dates* and *Dating Matters* which are school-based and aimed at high-risk populations, are considered secondary prevention sources (Tharp et al., 2013; De Koker, Matthews, Zuch, Bastien, & Mason-Jones, 2014). Less than 10% of abused teens seek help and if they do, it is rarely sought from parents or teachers to whom educational programs have primarily been aimed. While educational programs offered at school may increase awareness of the problem, violence screening and prevention conducted within the pediatric medical home may enable clinicians to assess patients individually for risk and identify those who may have experienced adolescent IPV and also refer them to appropriate resources. Hence, screening for IPV has been supported by the AAP, American Medical Association (AMA), and the American Academy of Family Physicians (AAFP) (Rabin, Jennings, Campbell, & Bair-Merritt, 2009).

Despite the recommendation for IPV screening and prevention in adolescents, most primary care pediatric practices have not incorporated screening

into routine practice. Furthermore, adolescents have reported trust and confidence in their health care provider for information on healthy dating relationships, yet few reported any discussion regarding dating relationships occurring during a medical visit (Kistin et al., 2019). The HHS ([a], n.d.) developed an online *Healthy Relationships Quiz* available to adolescents for self-evaluation and for providers at no charge in response to this health crisis (Appendix A). This quiz was written specifically for adolescents, unlike other IPV instruments written for adults. The *Healthy Relationships Quiz* is available on-line and may be considered for use as a screening instrument for adolescents who are dating.

The purpose of this quality improvement initiative was to evaluate the impact of an adolescent IPV screening instrument in an urban, Midwestern shelter for pregnant adolescent and young adult females. Traditionally, the intake process relied on a case manager directed conversation with non-standardized questions about IPV or dating, and may or may not have been documented in the intake record. The aim of this study was to achieve a 70% adherence rate of a standardized IPV screening documented in the intake process over a three-month period. Implementation of the IPV adolescent questionnaire, the *Healthy Relationship Quiz*, was sought. Outcome measures of interest were: demographics, the number of intake assessments, the number of intake assessments accepted into the shelter, number of intake assessments with IPV screening using the *Healthy Relationship Quizzes* documented, number of

adolescents who screened positive for IPV, and if positive, the number of adolescents referred to resources for IPV. The question for study was: In adolescent and young adult females aged 16-23 years seeking admission into a residential shelter for adolescent mothers, how does standardized screening for IPV affect the identification or referral for services for those who may be victims of IPV?

Review of the Literature

A literature search was performed using the Cochrane Database of Systematic Reviews, CINAHL, PubMed, EBSCO Host, and Google Scholar between the years 2000-2019. Key words included *intimate partner violence*, *adolescence*, *teen dating violence*, *screening*, *secondary prevention*, *dating abuse*, and *partner abuse*. The Boolean operators used were AND and OR. The initial search yielded 156 publications. To refine the search, inclusion criteria were studies focused on intimate partner victimization, adolescent or teen dating relationships, screening, and the role of the primary care practitioner. Exclusion criteria were studies focused on intimate partner violence perpetration, adult relationships, domestic violence, child abuse, and studies unrelated to healthcare. Hence, there were 25 publications selected for this review.

The term IPV is broad, and when occurring in adolescence, has included teen dating violence, partner abuse, dating abuse, sexual abuse or violence, and adolescent dating violence. Adolescent IPV encompasses any stalking, physical,

emotional, or sexual violence perpetrated by a current or former intimate partner such as a boyfriend, girlfriend, dating partner, or sexual partner (Karsberg, Bramsen, Lasgaard, & Elklit, 2018; CDC, 2017). The experience of IPV can be conducted in-person with the perpetrator, through mobile devices, and social media platforms (CDC, 2017). Emotional and psychological abuse includes but is not limited to jealousy, verbal demeaning, isolation from friends and family, possessiveness, making false accusations, or coercion (Korioth, 2015). Sexual violence is inclusive of more than forced intercourse and includes “sexual things” such as kissing, touching, or forced sexual intercourse (Kann et al., 2018). Physical dating violence is inclusive of abuse with a weapon, being hit, kicked, or physically forced into a stationary object (Kann et al., 2018).

Adolescent IPV affects girls and boys, but girls experience higher rates of severe physical and sexual victimization (The Family Violence Prevention Fund, 2004; Exner-Cortens et al., 2013). In fact, one in three girls are reported to be victim to physical, emotional, or verbal abuse by a partner (S. Res. 373, 2010). Furthermore, females aged 16- to 24-years of age experienced IPV three-times more likely than boys when in a dating relationship (HHS [b], n.d.). Adhia et al. (2019) found 6.9% of adolescent homicides were intimate partner homicides, with the majority of deaths by firearm. Though data is limited in lesbian, gay, transgender, bisexual, transsexual, and questioning populations, existing literature suggests a high incidence of dating abuse (The Family Violence Prevention Fund,

2004). A past history of child maltreatment is also associated with an increased risk of victimization in a dating relationship. Child sexual abuse is a significant predictor of adolescent dating violence (Karsberg et al., 2018). Finally, witnessing IPV in the home, commonly referred to as domestic violence, is a risk factor for perpetrating or becoming victim to partner abuse (Korioth, 2015; Tapp & Moore, 2016).

Similarly, experiencing any form of partner abuse heightens the risk for experiencing additional abuse and is known as re-victimization. In the adolescent who has experienced emotional and sexual abuse, the risk for re-victimization in the form of IPV is elevated (CDC, 2017). Moreover, IPV often begins in adolescence as early as 12-years of age, increasing the severity of continued IPV into adulthood (S. Res. 373, 2010; HHS [b], n.d.). Unfortunately, re-victimization can be perceived as normal and right when violence begins in adolescence without intervention and education.

Adolescent IPV victimization may result in adverse mental and physical health outcomes. Exner-Cortens et al., (2013) conducted a longitudinal study on adolescents from 1994-2002 and found the experience of teen dating violence was a determinate of adverse health outcomes in young adulthood. Prior to this study, there had not been a nationally representative sample available to demonstrate the lasting health concerns of adolescent IPV. Hence, experiencing IPV in adolescence is reported to have lasting consequences and is associated with

increases in high risk sexual behaviors; difficulties in school performance; continued violence victimization; substance abuse; eating disorders; teen pregnancy; suicide; transmission of sexually transmitted infections; or escalation to the most severe form of IPV which is intimate partner homicide (IPH) (HHS [b], n.d.; Exner-Cortens et al., 2013; Kistin et al., 2019; Masters, 2015; CDC, 2017; Karsberg et al., 2018; Koriath, 2015; The Family Violence Prevention Fund, 2004). Last, girls who were victims of IPV are five-times more likely to die by suicide than those who have not experienced IPV (CDC, 2017).

Violence prevention programs have evolved to include adolescent IPV and have been adopted by many schools. School-based violence prevention programs focus on adolescent IPV prevention; however, DeLaRue, Polanin, Espelage, and Pigott (2017) performed a meta-analysis of school-based initiatives and found violent behavior perpetration and victimization in adolescent relationships were not significantly reduced. The AAP encouraged parents to discuss characteristics of a healthy relationship with adolescents as early as middle school before dating begins (cited in Koriath, 2016). Likewise, the role of the parent in prevention is thought to provide positive role modeling to decrease the perpetration of violence and acceptance of victimization, while increasing satisfaction when a healthy romantic relationship exists (Koriath, 2015). Although parents can play an essential role in the prevention of adolescent IPV, reportedly 81% of parents do not believe or do not know adolescent IPV may be an issue affecting their child

(HHS [b], n.d.). Additionally, 58% of parents could not identify signs of adolescent IPV, despite an 82% confidence rate reported in recognizing the signs (HHS [b], 2017).

There is a gap in the literature for valid and reliable adolescent screening instruments for adolescent IPV. Though many screening tools are approved for use with adults, few are written for adolescents (CDC, 2007). Universal screening for adolescent IPV is considered a gold standard for adolescent anticipatory guidance with screening by health care providers being encouraged (Cutter-Wilson & Richmond, 2011). However, many practitioners defer screening due to unfamiliarity with screening instruments, educational resources, or the lack of mental health or social resources for referral if a positive screen is obtained (Cutter-Wilson & Richmond, 2011).

Screening for adolescent IPV includes more than physical or sexual violence. Miller et al. (2009) assessed IPV occurrence in adolescent females seeking healthcare in urban adolescent clinics using a Revised Conflict Tactics Scale (CTS2). The CTS2 is one of the most popular screening instruments for IPV utilizing 18-items measuring three conflict management themes: reasoning, verbal aggression, and physical violence (Miller et al., 2009). This study found 75% of the adolescents felt providers and nurses should inquire about relationships and whether or not the adolescent felt safe in their current or former relationship (Miller et al., 2009). Of the respondents, only 30% reported having

ever being screened by a healthcare provider for IPV (Miller et al., 2009). This study provided some insight into IPV screening in adolescence, however, the screening limited results to physical and sexual violence. Miller et al. (2009) did not perform an investigation of emotional, mental, or stalking behaviors; therefore, a more comprehensive screening for IPV was not done. The danger of under-screening (limiting screening to physical and sexual violence only) may result in rates of adolescent IPV that are artificially low (Cutter-Wilson & Richmond, 2011). In fact, Cutter-Wilson and Richmond (2011) found when other forms of adolescent IPV were considered, including controlling behaviors and emotional abuse, the number of positive screenings dramatically increased.

In another study, Carroll et al. (2011) sought to determine the prevalence of dating violence experienced by adolescents presenting to an urban pediatric emergency department (ED). This cross-sectional study also utilized the CTS2 to screen 327 adolescents in the ED and followed-up with participants one-month after screening by telephone to determine if provider recommended resources were utilized. Reportedly there was a higher rate of dating violence than previous studies in urban adolescent clinics, reproductive care settings, or United States high schools with a lifetime rate of adolescent IPV reported by 54.8% of the sample. No significant difference was seen between male and female respondents (Carroll et al., 2011). This study recommended providers in the pediatric ED to

also routinely screen adolescents for IPV and to refer them to appropriate resources (Carroll et al., 2011).

Several screening methods are available for provider use; however, the provider's definition of adolescent IPV can affect selection of the instrument used. The Youth Risk Behavior Survey (YRBS) is an 89-item standardized questionnaire for high school students to evaluate for behaviors related to grades, oral health, diet and weight, physical activity, sleep, asthma, unintentional injuries, violence, tobacco, alcohol, and other drug use, and risks associated with sexual behaviors (CDC, 2019). This questionnaire requires time for administering the survey and time to score the results. There is also the Audio Computer Assisted Survey Instrument (ACASI) which is a self-administered questionnaire on the computer (Cutter-Wilson & Richmond, 2011). Time for administering is variable depending on the version, however, scoring is immediate. Caution is encouraged when selecting screening instruments for adolescents especially if the instrument was originally designed for adults since there are developmental differences to be considered between adult relationships and adolescent relationships (Cutter-Wilson & Richmond, 2011). The HHS ([a], n.d.) developed an online and printable *Healthy Relationships Quiz* designed for and available to adolescents and providers on the internet for self- or provider-evaluation at no charge (Appendix A). This is a 26-item quiz written specifically for adolescents and is easy to use by asking yes/no questions and requiring only a few minutes to

complete. This screening instrument also has free posters and cards with information about adolescent IPV with information to a telephone hotline number (HHS [a], n.d.). The presence of educational literature in the clinical environment is recommended, and providers may use these resources to introduce conversation about adolescent healthy dating during routine medical examinations (Cutter-Wilson & Richmond, 2011).

In summary, adolescent IPV is prevalent, resulting in adverse mental and physical health outcomes. Early recognition and prevention strategies may decrease the incidence of adolescent IPV, however, there is a gap in the literature regarding screening for IPV in adolescence. Most studies have not focused on dating relationships until middle adolescence with subjects aged 15- or 16-years despite dating violence possibly as early as 12-years of age (Karsberg et al., 2018). The CDC produced the annual YRBS as the primary source of surveillance data for youth risk behavior and included sexual dating violence and physical dating violence; however, emotional or psychological dating violence and stalking were not included (Kann et al., 2018). The CTS2 and ACASI instruments were designed primarily for adults and are not considered optimal, especially when screening the younger adolescent. The *Healthy Relationships Quiz* was developed specifically for the adolescent, incorporating a more comprehensive screening for IPV, is easy to use, and requires little time.

The Plan-Do-Study-Act (PDSA) framework was utilized for this quality improvement initiative. Successful quality improvement arises from change. The PDSA model has four stages in the test of change to plan the test of change, implement and do the change, study to observe and analyze the change and learn from the consequences, and act to determine adjustments needed (Christoff, 2018). This framework provides structure to the process of improvement and is one of the most commonly used frameworks for quality improvement (Christoff, 2018).

Method

Design

An observational, descriptive design with a retrospective intake record review was used. This was the first PDSA cycle in this quality improvement initiative. A standardized adolescent IPV screening instrument (*Healthy Relationship Quiz*) began in January 2020 and became part of the intake process. Documentation of IPV screening and use of the *Healthy Relationship Quiz* was evaluated from January 21, 2020 to April 21, 2020. In addition, posters and other resources available from the HHS ([a], n.d.) regarding adolescent IPV was initiated in the life skill seminars offered to residents in the shelter.

Setting

An urban, Midwestern not-for-profit residential shelter for adolescent and young adult mothers. Staff included case managers, family support specialists,

transitional living coaches, and numerous volunteers. This shelter for adolescent and young adult mothers and babies was located in a large metropolitan area with three pediatric hospitals. According to the US Department of Commerce (2018) the population of the city was just over 300,000.

Sample

A convenience sample of adolescent and young adult females aged 16-23 years who encountered an interview for acceptance into the shelter (intake) between January 21, 2020 through April 21, 2020. Inclusion criteria were females aged 16-23 years; an intake evaluation between January 21, 2020 through April 21, 2020; and those who reported a current or past partner relationship. Exclusion criteria were those less than 16-years or older than 23-years of age; and those who had never engaged in a partner relationship.

Approval Processes

Approvals from the not-for-profit residential shelter for adolescent mothers and babies, doctor of nursing practice (DNP) committee, and university institutional review board (IRB) were obtained. Risks of this study were the identification of subjects, however, this was minimized due to the de-identification of collected data. Retrospective medical record review posed minimal risk to the adolescent and young adult mothers. Parental consent was not necessary due to the participants presenting as minor's being emancipated by their condition. Universal IPV screening during intake evaluations offered benefits

such as early identification of participant safety, identification of current and previous IPV and interventions including education, referral to counseling resources, and helpline calls for those identified as in immediate danger.

Data Collection & Analysis

Data included demographics: age and race/ethnicity. In addition, the number of intake evaluations, the number of intake evaluations with IPV screening using the *Healthy Relationship Quiz* documented in the intake record, the number of adolescent females who screened positive for IPV, and the number of adolescent females referred to resources for IPV. All data was de-identified and coded as IE-1, IE-2, IE-3, and so on for those intake evaluations encountered during the study period. The coded data was stored on a password-protected computer and removable drive owned by the primary investigator (PI). Data analysis was done using SPSS and included descriptive statistics, Chi-Square Test of Independence, and logistic regression analyses.

Procedures

A team of key stakeholders was formed including the program service coordinators, executive, and PI to determine a process in need of improvement and plan for implementing change to improve the process. Anticipatory guidance for healthy dating and adolescent IPV screening during intake evaluations was identified as the process to improve. The intake process was dependent on the case manager initiating a conversation on healthy dating or adolescent IPV,

identifying those at risk, and finding resources for referral. This process involved variation between intake case managers, including knowledge about the topic and resources available to address the topic. To minimize the variation, the *Healthy Relationship Quiz* was selected as the instrument to be used for standardizing the process between providers, including accompanying resources to facilitate education on the topic of healthy dating relationships. Three life skills seminars focused on healthy dating and adolescent IPV were offered to residents in the program from January to April. The outcome measures of interest were determined for study by the key stakeholders.

Results

A total of 19 retrospective intake record reviews were conducted ($N=19$) during the period of study. The age of the adolescent and young adult females ranged from 16– to 23-years, with a mean age of 18.84 ($SD=1.92$). The most predominant race/ethnicity was black ($n=16$, 84.21%), then other ($n=2$, 10.53%), and white ($n=1$, 5.26%) (Appendix A). All participants had the Healthy Relationship Quiz documented in the intake record ($N=19$, 100%). The majority were positive for IPV risk with a score from three to five ($n=18$, 95%), and only one (5%) scored between zero and two (a negative screen). No participants were identified as being in immediate danger ($n=19$, 100%). Anticipatory guidance regarding healthy dating was documented in the intake evaluation 68% of the time ($n = 13$), while 32% ($n=6$) did not have anticipatory guidance documented. Most

intake evaluations did not have a referral documented ($n=15$, 79%) but 21% ($n=4$) did have documentation for the recommendation of continued counseling services. No intake evaluations required the help line to be called.

A Chi-Square test of independence was conducted to compare an identified positive or negative screening with yes or no documentation of education provided. The results of the test were significant at the 0.05 level, $\chi^2 = 5.00$, $df = 1$, $p = .025$. A positive screening was likely to yield education about IPV. A second Chi-Square test of independence was conducted comparing an identified positive or negative screening with a yes or no referral to resources. The results of the test were significant at the 0.05 level, $\chi^2(1) = 14.00$, $df = 1$, $p < .001$. A positive screening was likely to be referred to additional resources.

A binary logistic regression was conducted to examine whether the score on the *Healthy Relationship Quiz* had a significant effect on the odds of being referred to resources. The model was evaluated based on an alpha of 0.05. The overall model was significant, $\chi^2(1) = 6.31$, $p = .012$, suggesting the score on the *Healthy Relationship Quiz* had a significant effect on the referral to resources. The McFadden R-squared value calculated for this model was 0.32. The regression coefficient for score was significant, $B = 0.06$, $OR = 1.06$, $p = .037$. A high score on the *Healthy Relationship Quiz* prompted referral to resources with the odds of being referred to resources increasing by approximately 6% per one unit increase in score. An additional binary logistic

regression was conducted to examine whether the score had a significant effect on the odds of the education provided. The overall model was not significant based on an alpha of 0.05, $\chi^2(1) = 0.08$, $p = .781$, suggesting the score did not have an effect on the education being provided.

Discussion

There were 19 intake evaluations conducted during the selected period of study with an average age of 18-years. All participants identified as female. During the study period from January 2020 – April 2020, 100% of all adolescent and young adult females who presented for an intake evaluation were screened utilizing the *Healthy Relationship Quiz*. The *Healthy Relationship Quiz* score ranged from 0-2 for negative (-) screening for IPV and 3-98 for a positive (+) screening for IPV. Of the screenings completed, 95% were identified as positive (+), however, no participants were identified as being in immediate danger and no helpline calls were placed. The majority of participants (68%) had documentation of education provided and 79% of those did not receive referral to additional resources.

The average score on the *Healthy Relationship Quiz* was 29 on a 0 – 98 scale. Scores of five or more were considered significant for more severe warning signs of IPV. The score on the *Healthy Relationship Quiz* was likely to prompt referral to resources ($p = .037$) with the odds of being referred to resources increasing by approximately 6% per one unit increase in score. The IPV education

provided was essentially unaffected by the score on the *Healthy Relationships Quiz* ($p = .781$).

A strength of this study was achieving a 100% screening rate for IPV during the intake process. Limitations included a small sample size and the beginning of a coronavirus pandemic during the time of this study. Due to social distancing and shelter in place orders, limited face-to-face anticipatory guidance and healthy relationship education was provided through group seminars. One of four group seminars were able to completed prior to the social distancing orders. The one group seminar conducted included seven participants who were currently housed in the shelter.

Recommendations for further study include a larger sample size, utilization of the *Healthy Relationship Quiz* as a screening instrument in other care settings including primary care practices, and assessing implementation of the *Healthy Relationship Quiz* for males and those identifying as part of the lesbian, gay, transgender, and bisexual, transsexual, and questioning (LGBTQ) populations. An implication for practice would be implementation of anticipatory guidance and healthy relationship education regardless of screening result. When positive screenings are identified, referral to resources should be utilized among practitioners screening adolescent and young adult females to include referral to community resources, referral to counseling services, establishment of a safety plan for those identified in immediate danger, and in areas of low or not easily

accessible resources, a referral to the national helpline for consultation is recommended.

Conclusion

In summary, almost all of the adolescent and young adult females presenting for intake evaluation to an urban Midwestern shelter for pregnant mothers and children had a documented positive screening for IPV. The implementation of the *Healthy Relationship Quiz* demonstrated a significant connection to anticipatory guidance through documented education and referral to resources for those screening positive. The identification of adolescent and young adult females who have experienced IPV enhances early intervention through education and referral to resources. Ideally, all adolescents and young adult females should receive anticipatory guidance and education regardless of positive or negative screening as a method of health promotion and IPV prevention. Also, all adolescent and young adult females identified with a positive screening should receive referral to internal or community resources by the agency or healthcare organization to provide early intervention, reduction of future risk, and ensure safety.

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Appendix A

Table 1. Demographics

Frequency Table for Nominal Variables

Variable	<i>n</i>	%
Gender Identity		
Female	19	100
Race Ethnicity		
Black	16	84.21
Other	2	10.53
White	1	5.26
Age		
16	2	10
17	2	10
18	5	26
19	4	21
20	4	21
21	0	0

	22						0	0
	23						2	11
	<hr/>							
	<i>M</i>	<i>SD</i>	<i>n</i>	<i>SE_M</i>	Min	Max	Skewness	Kurtosis
	<hr/>							
Age	18.84	1.92	19	0.44	16.00	23.00	0.71	0.27
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Note. Due to rounding errors, percentages may not equal 100%.

Appendix B

Figure 1. What Happened with Positive Screenings?

