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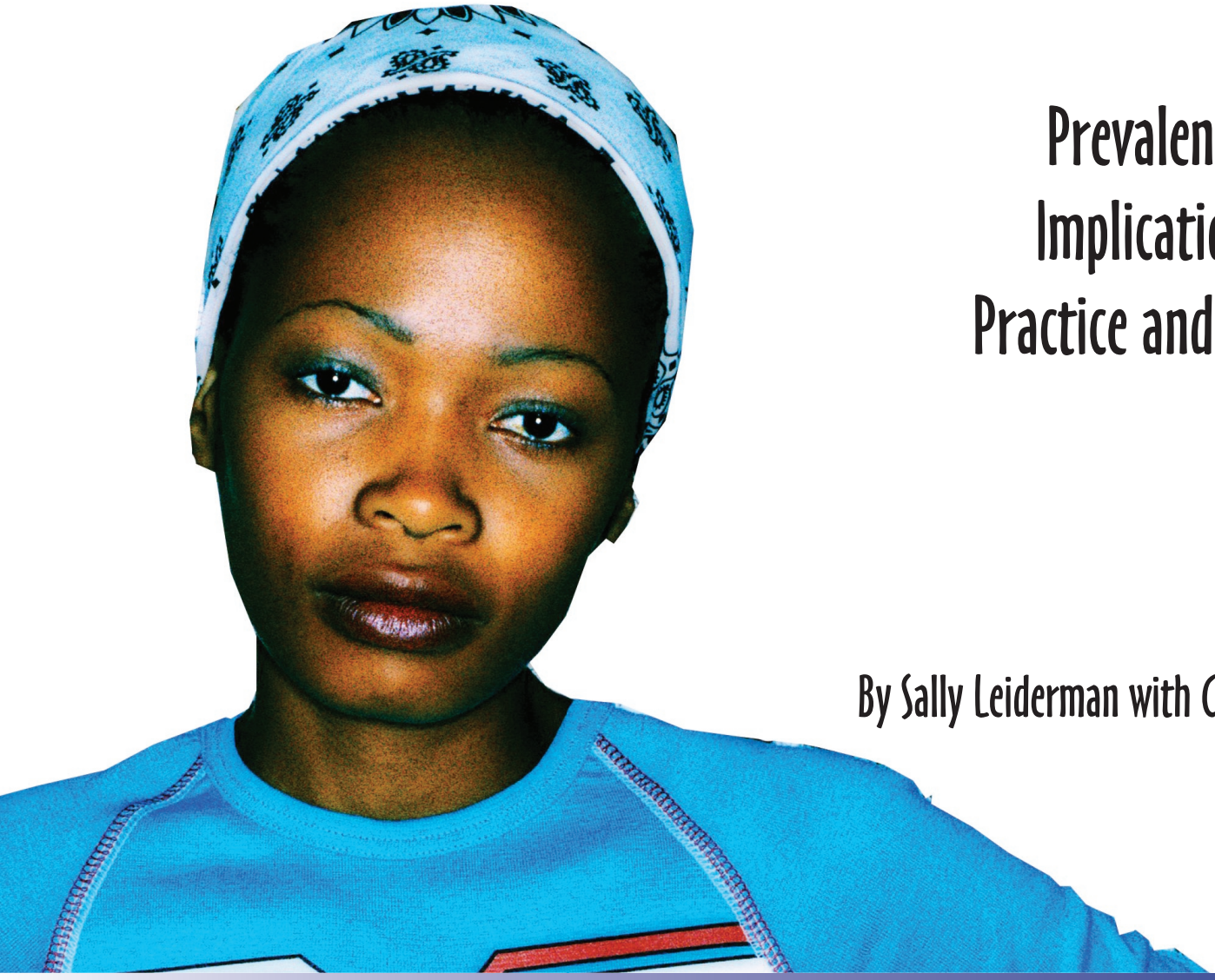
Interpersonal Violence and Adolescent Pregnancy



Prevalence and Implications for Practice and Policy

By Sally Leiderman with Cari Almo

Healthy Teen Network
MAKING A DIFFERENCE IN THE LIVES OF TEENS AND YOUNG FAMILIES

CAPD
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This report was produced in partnership between the Center for Assessment and Policy Development (CAPD) and Healthy Teen Network (formerly the National Organization on Adolescent Pregnancy, Parenting, and Prevention - NOAPPP) with funding from the Wendy C. Wolf Tzedakah Fund of the Shefa Fund.

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We would also like to thank the members of Healthy Teen Network's (formerly - NOAPPP) Policy Committee, Patricia Flanagan, Tom Klaus, Maria Guajardo Lucero, Hector Sanchez-Flores, Max Schilling, and Paula Van Straten, as well as Lynn Blinn Pike from the Center on Adolescent Sexuality, Pregnancy and Parenting at the University of Missouri, for their helpful and constructive review of the draft report.

We interviewed several persons from across the nation. They directed us to programs currently addressing the many aspects of this issue and offered us insights not only about practitioners, but also about victims, abusers, and the field in general. We would like to acknowledge especially Ellen Bassuk, Linda Bowen, Rick Brown, Janet Carter, Obie Clayton, Charlene Clemens, Patricia Eng, Patrick Gardner, Mark Green, Mary Hall, Deborah Horan, Lacinda Hummel, Susan Moskosky, Jodie Rafael, Maria Rincon-Dwyer, Carole Souza, and Jo-Ann Wells. Their thoughtful comments and suggestions are greatly appreciated.

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Foreword

Dear Colleague,

Our two organizations – Healthy Teen Network (formerly NOAPPP) and the Center for Assessment and Policy Development (CAPD) – are pleased to present this report as the first part of a collaborative project that will address issues of violence and teen pregnancy and parenting.

Since 1968, research has identified the unmistakable link between childhood sexual abuse and early teen pregnancy. Co-authors Sally Leiderman and Cari Almo bring together recent research and present findings that help define the extent of the problem, and further, outline program and policy implications. This report is designed to inform the work of practitioners, program planners, evaluators, researchers, youth advocates, legislators, and leaders of community-based coalitions and task forces.

Healthy Teen Network (formerly NOAPPP) members and constituents have long known about the prevalence and effects of physical, sexual, and emotional violence on the young women, men, and their children with whom we work, and about whom we care so deeply.

For many of us, there are faces behind the statistics and research … faces of children and teenagers we know with stories of lives that have been filled with violence. Perhaps you've listened to a disclosure of childhood sexual abuse, or current incest, or heard conversations about date rape, gang initiations, domestic violence and other forms of abuse. Perhaps you've awakened at night, fearing for their safety, wondering if you've done enough, done the right thing, could do more.

If we are ever going to rid our culture of violence against women and children, we must know about it, talk about it, promote community understanding about it, join with other local, state, and national advocates, and infuse our programs, policies, and laws with our combined knowledge. We must provide ample opportunities for all youth – and especially those who have experienced sexual and other forms of interpersonal violence – to learn new skills, gain self confidence, lead activities, create something new, and be an active part of something bigger.

Our combined intention is to provide you thoughtful, timely, and relevant information and tools for action in your programs and community groups, with the long-term goal of reducing – and eventually, eliminating – violence against children, teens, and women.

Sincerely,

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Note on the Second Edition:
In 2006, Healthy Teen Network re-released this report as a companion to *Boys Will Be Boys: Understanding the Impact of Child Maltreatment and Family Violence on the Sexual, Reproductive, and Parenting Behaviors of Young Men* to underscore the belief that, while interpersonal violence is detrimental to the development of healthy relationships, effective prevention can occur, and survivors can heal when this issue is tackled using a gender-inclusive approach.

Contents

Introduction

Interpersonal violence is intricately intertwined with adolescent pregnancy. Though there are substantial data gaps and limitations, the best available evidence indicates that interpersonal violence is prevalent among pregnant and parenting adolescents and may be one of the key challenges to reducing rates of adolescent pregnancy. Evidence also suggests that while practitioners may be aware that interpersonal violence is a factor in young people's lives, they may not be aware fully of its prevalence, consequences, and effects. An awareness of these issues also has considerable implications for practice, interventions, and policy.

A substantial number (no fewer than one-fourth and as many as 50-80%) of adolescent mothers are in violent, abusive, or coercive relationships just before, during, and after their pregnancy.

Many (as many as two-thirds) of young women who become pregnant as adolescents were sexually and/or physically abused at some point in their lives – either as children, in their current relationships, or both, according to several studies (2,9,18a,24,25,32,40). A substantial number (no fewer than one-fourth and as many as 50-80%) of adolescent mothers are in violent, abusive, or coercive relationships just before, during, and after their pregnancy, according to several studies (3,15,31,33,55a). Anecdotal and some emerging evidence suggest that the perpetrators of such violence are also disproportionately likely to have been sexually or physically abused as children.

Younger adolescents are even more likely to be victims of interpersonal violence than older adolescents (2, 12, 33). For example, one study found that younger teenagers are especially vulnerable to coercive and non-consensual sex. Involuntary sexual activity was found for 74 percent of sexually active girls younger than 14 and 60 percent of those younger than 15 (2). It is also important to remember that the actual prevalence of interpersonal violence in the lives of adolescents may be higher than these data indicate. This is because victims, partners, and families often do not disclose violence or abuse in their lives, so it is frequently under-reported (11).

How does interpersonal violence link to adolescent pregnancy? There are multiple pathways. Some women become pregnant directly because of interpersonal violence, through incest, sexual abuse, or through violence that includes birth control sabotage (12, 55a). Others become pregnant indirectly through correlating circumstances or conditions associated with prior sexual or physical abuse. For example, abused children may remain in an unsafe living situation where they are likely to be exposed to additional sexual advances (24a, 55a). They may experience emotional or psychological damage that makes them especially vulnerable to coercive or violent partners when they leave home (25,40b,43,66). As adolescents, they may be depressed and self-medicate with drugs or alcohol (8,9,40b,50,51,52). All of these circumstances and conditions put them at high risk of early pregnancy, compared to adolescents who were not abused as children.

Finally, children of adolescents are at high risk for difficulties stemming from the pervasiveness of violence and abuse in their parents' lives. They are at direct risk if they continue to be raised in abusive or violent settings or if the parents continue to form unhealthy partnerships and/or have few safe living alternatives (a serious problem for adolescents with children). Their parents' ability to provide for them can

be compromised by education or employment sabotage (where a controlling partner limits a parent's ability to go to school, look for work or keep a job), and/or by substance abuse, anxiety, depression, and other symptoms of trauma, violence, and abuse (6, 6a, 20a, 55a). (By way of illustration, 92% of very poor, homeless women are previous or current victims of domestic abuse, according to Ellen Bassuk, Director of the Better Homes Fund.)

There is increasing evidence that parents need to heal from their own violent experiences in order to support the healthy emotional development of their children (11, 20a).

In addition, there is increasing evidence that parents need to heal from their own violent experiences in order to support the healthy emotional development of their children (11, 20a). Without healing, it can be challenging for parents to attach, offer consistently nurturing interactions and respond appropriately to their children's needs and demands. In terms of risk, it is tough to be a child of an abuse survivor, even an aware and recovering one. It is not easy to be the child of an adolescent who is likely to be struggling to complete his or her own education, earn an income, and manage a family. Evidence suggests that it may be especially difficult to be both.

Some victims and survivors of violence or abuse, organizations, policymakers, and researchers, know this story well. They are working on particular practices, interventions, and policies that are sensitive to these issues and offer strategies that could reduce the rates of adolescent pregnancies and promote better outcomes for adolescent parents and their children. The implications of their work are discussed in the body of this briefing paper.

But our research suggests that experts in many relevant fields are not fully aware of the extent, nature, and links between interpersonal violence and adolescent pregnancy. This is true even within the fields of pregnancy prevention, domestic violence, sexuality education, youth development, child advocacy, and fields concerned with supporting pregnant and parenting adolescents.

Children of adolescents are at high risk for difficulties stemming from the pervasiveness of violence and abuse in their parents' lives.

Without this awareness, people often misunderstand adolescent sexual activity, and thus, adolescent pregnancy, as a freely made choice. They discount or do not know the role that violence, abuse, coercion, trauma, and victimization can play in the timing and nature of sexual activity. We generally understand that, for example, rape is violence – not sex. That same thinking might reasonably be applied to the sexual and contraception behavior of a substantial number of young adults in sexual relationships that lead to adolescent childbearing.

The prevalence, consequences and effects of interpersonal violence on adolescents have substantial implications for practice, interventions and policy. They imply that, for example:

- Myriad people who come into contact with adolescents could benefit from being made more fully aware of these issues, including, for example, pregnancy prevention educators and workers, teen parent workers, teachers, health care providers, people providing child care to adolescents and their children. They need this information to do their own work, to link young people to helpful supports and services, and so they can advocate for appropriate training, curricula, policies, and resources to better serve their target population.

- Policymakers and others (taxpayers, media, researchers) also need to be made more aware of these issues. This can encourage them to re-examine current

policies that intentionally or unintentionally trap adolescents in unsafe homes or unhealthy relationships, or that limit their ability to apply for and receive help. For some adolescents, income transfer policies that discourage independent living or promote marriage may be dangerous and counter-productive to society's interest in helping teen parents become self-supporting and responsible adults.

- We also have to change policy and practice to be sure we are giving young people tools that fit their real situations. Thus, while abstinence-only-until-marriage policies may be part of a comprehensive pregnancy prevention strategy, they would not be relevant for victims of incest, battering, and birth control sabotage. Similarly, shame and fear-based sexuality education runs the very real risk of re-traumatizing victims of child abuse or interpersonal violence. Such prevention approaches can be irrelevant and/or unhelpful to many adolescents, especially the ones that evidence suggests run the highest risk of early pregnancy.

- There are also key implications for those concerned primarily with the well being of children, including the children of adolescents. For example, evidence suggests we should be alert to their emotional well being as well as their safety. Responses might range from better identification and earlier treatment of the sequelae of child abuse to embedding generally helpful practices into all settings for children, particularly those that tend to include children of adolescents or abuse victims.

- In addition, for many of these children, we need to consider also how to support their parents' recovery and healthy emotional development. For example, parents who are involved in interpersonal violence will often need skills, supports, and opportunities for their own healing and recovery, so they can be more effective parents.

This briefing paper was prepared to highlight and stimulate further discussion on the links between interpersonal violence and adolescent pregnancy among the people most directly affected: practitioners, policymakers, advocates, and others. It was prepared by the Center for Assessment and Policy Development (CAPD), in partnership with Healthy Teen Network (formerly NOAPPP), through a grant from the Shefa Fund.

Findings are based on a review of literature and interviews with experts in several fields (see attached bibliography and list of people interviewed). These fields and disciplines include: pregnancy prevention and sexuality education; pregnant and parenting adolescents; fatherhood and male health; child development and parenting; youth development; sequelae and interventions to promote recovery from trauma, violence and abuse; domestic violence; dating violence; and child abuse.

Research and individuals working in each of these fields offer a deep understanding of different parts of the issue – for example, how to create developmentally-appropriate supports to adolescents; how to identify, treat, and begin recovery for victims of interpersonal violence; and how to create appropriate income transfer, paternity establishment, housing, or other policies to meet their particular needs, etc. At the same time, with some notable exceptions (e.g., the MAPPP program and resource materials, the SafeStart community initiative) there are very few publications, individuals, or organizations that pull all of these separate ideas into a comprehensive framework on which others can build conceptually or in practice.

Thus, this briefing paper has three goals:

1. To raise awareness among policymakers, advocates, and practitioners about the nature and extent of violence in the lives of adolescents and its links to adolescent pregnancy;

2. To advocate for more cross-disciplinary thinking that could lead to design of more sufficient strategies to prevent pregnancy and improve outcomes for adolescent parents, their partners, and their children; and

3. To point toward information that can help people create, enforce, and expand responsive policies, and implement, expand, evaluate, and learn from effective programs and interventions.

The remainder of this briefing paper is divided into the following sections:

- "Links Between Interpersonal Violence and Teenage Pregnancy" provides data about the relationship between violence and teen pregnancy, including prevalence, links between violence and early pregnancy, and connections among risk factors;

- "Interventions: Implications for Practice and Programs" focuses on implications for interventions, including best practices on which to draw;

- "Implications for Policy: Opportunities and Challenges" highlights some implications for policy, including challenges and opportunities in several areas; and

- "Possible Next Steps for the Field" poses some possible next steps for the field to consider, based on these findings and recommendations of several practitioners and other stakeholders.

Links Between Interpersonal Violence and Teenage Pregnancy

This section of the briefing paper looks at the extent and nature of interpersonal violence in the lives of adolescents. It reviews available evidence about the prevalence of violence in adolescents' current lives (including relationship, partner, and dating violence) as well as evidence about violence earlier in their lives (including sexual and physical abuse when they were children or in early adolescence). The section next provides data that help to describe the links between interpersonal violence and adolescent pregnancy and possible explanations for why those links occur. Together, this information begins to paint a more fully fleshed out picture of how and why victims of interpersonal violence are at high risk of adolescent pregnancy.

There are a few points that readers might want to keep in mind as they review these data:

- It is very important to remember that available data provide conservative estimates of the true extent of the problem. People frequently do not tell others about violence in their lives, so incidents may not be disclosed and thus go unreported. To illustrate the potential depth of under-reporting, a study by the Commonwealth Fund on women's health found that 31 percent of women reported ever having experienced violence or physical abuse from a spouse or partner and 21 percent reported ever having been raped or assaulted. Only eight percent of these women said they had ever discussed these issues with a medical professional (11).

- Findings on the same topic (e.g., the percentage of teen mothers who are victims of interpersonal violence) also vary a great deal across studies. There are several reasons:

  - Under-reporting may vary by research method. Surveys tend to report substantially higher levels of interpersonal violence (and other forms of violence or abuse) than administrative records. Anecdotal evidence suggests this is because the consequences for reporting interpersonal violence to public officials are far greater than for disclosing violence as part of a research or informal program data collection effort.

  - Data are not always comparable because studies use different definitions of interpersonal violence, and samples vary quite a bit. In terms of definitions, the studies we reviewed use similar definitions to capture the nature of violence, but they vary in, for example, whether or not current and prior abuse are considered as the same or different forms of interpersonal violence.[1] Our review suggests that these two factors alone could produce very large variations in findings on key indicators.[2] (For young girls in particular, it is not clear where the line between relationship violence and child sexual abuse should be drawn.)

These are particularly important issues for thinking about practice, interventions, and policy, since one's understanding of how to proceed is greatly influenced by one's sense of the pervasiveness of violence among the target population.[3]

The remainder of this section provides our best sense of the available evidence. It suggests that interpersonal violence is a real and pervasive problem for adolescents and one that is far more frequently a factor in adolescent pregnancy than is commonly understood.

Current Violence

Evidence suggests that no fewer than a quarter of adolescent mothers experience some form of interpersonal violence in the year surrounding their pregnancy, with some studies reporting rates of 50 to 80 percent (2,3,3a,10,12,14,15, 31, 33,55, 55a).[4]

- A state-specific survey of new mothers (PRAMS) found that 26 percent of women between 13-17 years of age experience violence before, during, or just after pregnancy (3).

- A small study of teen parents on TANF in Chicago, using a non-random sample, found that 55 percent had experienced domestic violence in the past twelve months (12).

- The Canadian Mental Health Association reports that 80 percent of teenage mothers are abused by their boyfriends, and, once the abuse starts, it usually becomes more frequent as well as more violent (10).

- Of course, pregnant adolescents are not the only adolescents to experience high and disturbing rates of partner violence. Summarizing many studies, the average prevalence rate for nonsexual dating violence is 22 percent among male and female high school students and 32 percent among college students. Females are slightly more likely to report nonsexual dating violence than males (68). Data from a study of 8th and 9th grade male and female students indicated that 25 percent had been victims of nonsexual dating violence and eight percent had been victims of sexual dating violence (28).

- A longitudinal study, just released in the October 2001 edition of the *American Journal of Public Health*, followed 7,500 adolescents in exclusively heterosexual relationships. It reports that one third of adolescents report some type of partner victimization, and 12 percent of adolescents report physical partner violence (34a).

Younger women, and particularly, young pregnant or parenting mothers, experience the most violence.

- For example, the same study that found that 26 percent of mothers age 13-17 experienced intimate partner violence in the three post-partum months also found that 12 percent of mothers older than 20 report some form of violence from their husband or boyfriend in the three months after the birth of their child (3).

- Other studies also found that adolescent mothers are much more likely to experience partner violence than older mothers, often twice as likely (3, 16, 34).

- One study of teen mothers on welfare reports that almost two-thirds (62%) of girls 11-15 were victims of partnership violence involving current boyfriends, compared to 56 percent of young women ages 16-19 and 47 percent of young women 20 and 21 (12).

- Younger teenagers are especially vulnerable to coercive and non-consensual sex. Involuntary sexual activity was found for 74 percent of sexually active girls younger than 14 and 60 percent of those younger than 15 (2).

- Among all women (not just adolescents or mothers), women ages 16-24 experience the highest per capita rates [19.6 per 1,000 women] of intimate partner violence (69, 70).

- By way of comparison, the Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior, released in June 2001, reports that eight percent of all women are abused by an intimate partner (74).

Violence in current relationships leads to adolescent pregnancy in different ways.

- Some young women become pregnant as a result of rape or incest, or through other coercive sexual relationships. One study estimates that 13 percent of births to adolescents are the direct result of sexual abuse (39).

- Many young women in abusive or violent situations experience birth control sabotage. One study found that 66 percent of adolescent mothers in violent situations experience birth control sabotage, as do 34 percent of adolescent mothers in partnerships that are not classified as violent (12). Anecdotal and survey evidence suggests some men believe that a woman who uses contraceptives must be "playing around;" some men believe that keeping their partner pregnant and/or caring for young children makes it more difficult for the partner to leave. Both of these are variations of control issues that dominate abusive and unhealthy relationships.

Prior Sexual Abuse

Prior sexual abuse (distinct from current partnership violence) also appears to be linked to adolescent pregnancy – many women who become pregnant as adolescents were sexually abused at some point in their lives (2, 9, 12, 18a, 24, 25, 33, 42, 55a).

- Up to 66 percent of pregnant teens report histories of abuse, based on a sample of 535 young women from Washington State who became pregnant as teens. Of these, 55 percent had been molested; 42 percent had been victims of attempted rape; and 44 percent had been raped (9).

- Another study conducted in the late 1980s found that 61 percent of teen mothers had experienced a coercive sexual experience and 33 percent had experienced unwanted sexual intercourse at some point in their lives (33).

- Still, another study found that 36 percent of women from a sample of 190 reported sexual abuse before the age of 18, and more than 26 percent were pregnant before the age of 18 (42).

- A 1996 study examining the incidence and effects of childhood sexual abuse experiences on the lives of Mexican American and African American teen mothers found that of 124 adolescent mothers, 44 percent were victims of childhood sexual abuse (25).

It's also important to remember that boys, as well as girls, experience damaging violence, including substantial childhood abuse.

A history of childhood sexual abuse has been linked to high-risk behaviors that increase the likelihood of teenage childbearing.

- The Children's Bureau estimates that 826,000 children (11.8 per 1,000) were victims of abuse and neglect in 1999, based on verified reports to state Child Protective Services systems. (As noted above, this number is most likely a substantial under-reporting of children who experienced maltreatment in 1999.) Of these, 21 percent were physically abused and 11 percent were sexually abused. Forty percent of these children were also found to be victims of other or additional types of maltreatment such as threats of harm or abandonment.

- These kinds of abuse are reported for both boys and girls. For example, 11 of every 1,000 boys were victims of abuse and neglect, as were 12 of every 1,000 girls. Rates of physical abuse, neglect, and medical neglect were virtually the same, though sexual abuse was reported more often for girls (1.6 for every 1,000) compared to boys (4 for every 1,000) (73).

Data Links and Possible Causal Explanations

Research indicates a link between exposure to sexual or physical abuse in childhood and a host of poor outcomes later. For example, a history of childhood sexual abuse has been linked to high-risk behaviors that increase the likelihood of teenage childbearing, including:

- Young age at initiation of sexual intercourse (9, 24, 52, 66);
- Failure to use contraception (9, 18a, 55a, 66);
- Physically assaultive relationships (9, 24, 52, 55a);
- Abuse of alcohol and other drugs (3a, 9, 52, 55a, 60a, 71a);
- Low self esteem, body comfort, academic confidence, and family rapport (25, 27a, 43, 55a, 60a, 66);
- Higher number of sexual partners (45, 60a);
- Prostitution (9, 66, 71a, 75); and
- Girls who have been the victims of sexual abuse have been found to have a greater desire to conceive and increased concerns about their ability to do so (9, 56, 64, 66).

These data suggest a link between exposure to sexual abuse or interpersonal violence in early life, a propensity to form or become victimized by unhealthy relationships in adolescence, and subsequent adolescent pregnancy. There are a number of possible explanations, often coming from different disciplines or professional perspectives. Several separate, but related, explanations are noted below.

- Children who are victims of sexual abuse, interpersonal violence, or other forms of childhood abuse become over-sexualized. They also have unmet needs that lead them to look for relief through sexual relationships. They tend to begin sexual activity at a young age, when their partners are often older men (9, 24, 52, 55a, 66). Older men who are involved with young women often practice birth control sabotage (12). These relationships often lead to early pregnancy (39).

- Child abuse is highly linked to running away and substance abuse, (Green, 1993; Brant and Tisza 1977; Benward and Denson-Gerber [4b]), both of which can lead young people to trade sex for housing and drugs.

- The sequelae of child abuse and similar early trauma typically include some combination of low-self-esteem, physical disassociation, autonomy and control issues, anxiety, and depression. These can be symptoms of post-traumatic stress disorder (PTSD) (27, 36a, 71). People with PTSD often form unhealthy attachments, are passive about their bodies and birth control, and self-medicate becoming substance abusers (4b, 9a). In addition, these sequelae can interfere with learning and school success (20a). They also help to explain why abused children run away from their families of origin, even when the families are not directly responsible for the abuse. Women and men with these symptoms and in these circumstances are at high risk for becoming pregnant or fathering children as adolescents (9, 27a, 40b, 51, 52, 55a, 66).

- The sequelae and circumstances of early childhood abuse can be healed (11, 27, 36a, 71), but children often do not have access to appropriate treatment and supports (20a). As a society, we are reluctant to interfere with childhood abuse, to identify or label victims, to continue offering support when it is rejected or resisted (as is often true for abuse victims), and to fund intensive supports of sufficient duration to work.

- Cycles of abuse are often intergenerational, for several reasons:

  - Male and female abuse victims often replay abuse – men often as perpetrators and females as victims, although the reverse happens as well (4b);

  - Domestic violence may involve partners and children living in the same house. For example, a review of several studies found that 32-53 percent of men who abuse their spouses also abuse their children (22);

  - Because children who are victims of interpersonal violence or abuse tend to go untreated, they may very well carry over the sequelae and consequences into their roles as parents; and

- Untreated victims of interpersonal violence and abuse can find it difficult to provide maximal parenting to their children. They are more likely to be poor and struggling to maintain adequate housing (43a). Depressed parents (many of whom have histories of domestic or childhood abuse) can find it difficult to attach and bond with their children and/or to provide consistent and responsive parenting, factors which are important to children's emotional well being (20a).[5]

Untreated victims of interpersonal violence and abuse can find it difficult to provide maximal parenting to their children.

People also point to underlying dimensions that contribute simultaneously to high rates of many forms of interpersonal violence, including child abuse, dating violence, domestic and intimate partner violence, and high risk of early pregnancy. These factors include:

- Stresses related to poverty, poor living conditions and exposure to neighborhood violence (5);

- The underlying dimension of oppression – including consequences of racism, gender and age oppression (43a, 48a). According to several practitioners who were interviewed for this paper, oppression is a common theme in efforts aimed at preventing dating violence; for example, many find that young people do not even recognize the extent to which they have internalized disrespectful or abusive behavior toward women.

- A general culture in the United States that fails to sanction, tolerates, and/or promotes violence.

A general culture in the United States that fails to sanction, tolerates, and/or promotes violence may contribute to high rates of many forms of interpersonal violence, including child abuse, dating violence, domestic and intimate partner violence, and high risk of early pregnancy.

Interventions: Implications for Practice and Programs

This section of the briefing paper highlights some of the implications that emerge from a fuller understanding of the prevalence, consequences, and pathways of interpersonal violence and adolescent pregnancy. Our analysis is based on data presented in the prior section, discussions with experts, victims, and practitioners and the authors' prior work in these areas. These sources consistently lead to two major conclusions:

1. There are specific practices within the separate disciplines and fields of domestic abuse, male health, parenting, child development, trauma and recovery, violence prevention, and youth development that could be helpful to a broader range of practitioners; and

2. Practices from one area may not be widely known or incorporated into the thinking or practice of the others.

Our research indicates that, while many practitioners observe interpersonal violence in the lives of adolescents, there are very few programs – either aimed at pregnancy prevention or at supporting pregnant and parenting adolescents, young co-parenting families, non-custodial parents of children born to adolescents and/or their children – that take on this issue in a sustained fashion.[6] With the exception of the Maltreatment and Adolescent Pregnancy and Parenting Program (MAPPP) and the SafeStart Community Initiative, most people we spoke with were not aware of any that address all of the multiple aspects of interpersonal violence (e.g., current and prior violence, male and female perspectives and issues, coping and life skills, parenting, and recovery from trauma). Yet findings presented in this briefing paper suggest that insights and practices from all of these different areas need to be understood and considered to create fully sufficient pregnancy prevention strategies and to create adequate supports for pregnant and parenting adolescents and their children. Thus, we describe promising practices from a variety of fields in this section of the report.[7] Before doing that, however, we summarize implications broadly to indicate why the particular practices reviewed could be helpful.

While many practitioners observe interpersonal violence in the lives of adolescents, there are very few programs – either aimed at pregnancy prevention or at supporting pregnant and parenting adolescents, young co-parenting families, non-custodial parents of children born to adolescents and/or their children – that take on this issue in a sustained fashion.

Summary of Implications

Findings in the prior section have many implications for intervention, both to prevent adolescent pregnancy and to support pregnant and parenting adolescents, their partners, and their children. They imply that, for example:

- A fully sufficient strategy to reduce adolescent pregnancy would likely need to:

  - Incorporate curricula and strategies to help both males and females recognize interpersonal violence and abuse, oppression, and cultural tolerance for violence, so they can become consciously aware of the existence of these things and how they may personally be influenced;

- Offer comprehensive sex education including strategies to avoid STDs and unintended pregnancy in a coercive, violent or abusive relationship. As Moore et al., put it: "sexual coercion has been linked with early sexual activities among females; however, few programs take this into account in designing interventions. It is difficult to prevent pregnancy by increasing a female's knowledge and motivation to prevent pregnancy if the female is becoming pregnant as a result of a non-voluntary sexual experience." (50).

- Provide opportunities for males and females to disclose current or prior interpersonal violence and/or screen for histories of interpersonal violence;

- Have access to appropriate emergency and longer-term services such men and women may need, including but not limited to housing, health care, legal, and case management supports;

- Have access to appropriate resources to begin healing and recovery; and

- Offer ongoing and personal relationships to help adolescents follow-up, accept help, and negotiate the likely impacts of disclosure.

- Fully sufficient strategies to support parenting adolescents, their partners, and their children must also attend to the above issues. In addition, they might also need to:

  - Pay special attention to issues of depression, post-traumatic stress disorder, attachment, and other issues that may be especially important in the first few post-partum months;

  - Provide supports to foster the development of healthy co-parenting relationships and strategies where possible and safe because of the potential benefits co-parenting can have for children including children of an adolescent parent(s) (44a, 55a);

  - Link adolescent parents to ongoing parenting, educational, employment and training, healing and coping support, and respite. These services can support adolescents who are now having to simultaneously complete the tasks of adolescent development and take on the adult responsibilities of a family;

  - Advocate for, and provide, sensitive approaches to issues related to establishing paternity, child support enforcement, and other legal/administrative issues between parents and their partners – recognizing that these relationships are frequently violent, abusive, coercive, or unhealthy; and

  - Pay genuine attention to the developmental needs and progress of children in these situations (of the kind that would be appropriate for all young children).

- Finally, all strategies aimed at adolescent pregnancy, parenting, and prevention have to use age and victim-appropriate practices. Practitioners point out that interventions for violence victims are not always appropriate, safe, or effective

for adolescents (e.g., many domestic abuse or family shelters). Interventions and strategies for adolescents are not always relevant or effective for teens in violent, abusive or coercive partnership relations (e.g., abstinence-only-until-marriage approaches to sexuality education). Thus, interventions must operate within a sphere that encompasses both sets of understanding.

As noted earlier, our best understanding of the state of the art is that few interventions incorporate fully these elements, either as individual programs or through collaboration with others.

There are several barriers to implementation of more comprehensive approaches according to the people with whom we spoke. For example, few practitioners working with adolescents feel they have enough training to work with victims of sexual or other physical child abuse. Many are concerned about the lack of resources their program can offer to support these adolescents, either directly or through collaboration. Their sense is that communities lack adequate resources to address interpersonal violence coupled with teen pregnancy.

Some practitioners do not think adolescent pregnancy or interpersonal violence are appropriate subjects of their work, or they do not know how to make a link between the issue of most concern to them (male health, domestic abuse, dating violence) and adolescent pregnancy. Some are prohibited by local or federal policies, or institutional decisions, from talking with adolescents about the full range of issues. In addition, many just aren't aware of the possibilities to heal and recover from interpersonal violence or abuse, so they are reluctant to take on work they may consider hopeless. Finally, while some adolescents disclose interpersonal violence or abuse if the topic is raised, many do not. Experts point out that there is an art to developing the kinds of trusting relationships that allow adolescents to self-identify, seek, and/or accept help.

Interventions for violence victims must be appropriate, safe and effective for adolescents. All strategies aimed at adolescent pregnancy, parenting and prevention have to use age and victim-appropriate practices.

Thus, practice and program issues include:

- Developing comprehensive models likely to reduce pregnancy or improve outcomes for pregnant and parenting adolescents. Such models need to consider factors related to interpersonal violence and to adolescent pregnancy;
- Knowing best practices from a variety of fields and disciplines;
- Having the training, tips, and tools to implement these practices in developmentally appropriate ways;
- Having the training, tips, and tools to implement these practices in ways that are trauma sensitive;
- Having approval to (or at least not being prohibited from) implement necessary strategies; and
- Finding ways to engage and develop effective relationships with a tough target population – adolescents, including ones who are already victims of violence or abuse.

The good news is that there are lots of opportunities to move the state of the art forward. In addition, there are many resources within different fields that can be accessed by people both within and outside those fields, often via the Internet (e.g., from the National Health Resource Center on Domestic Violence, hosted by the Family Violence Prevention Fund). There are also examples of programs with experience in implementing important aspects of comprehensive programs that are willing to share their successes and challenges.

For example, Healthy Teen Network (formerly NOAPPP) highlighted some work in the field at its November 2000 conference (Orlando):

- There was a skill-building pre-conference workshop on working with teen survivors of sexual abuse, trauma and teen pregnancy, which drew in part of the work at Planned Parenthood in Naples, FL, and at St. Vincent Hospital in Green Bay, WI.

- Lynn Pike, of the University of Missouri, shared her findings and a training curriculum for the Maltreatment and Adolescent Pregnancy and Parenting Program (MAPPP), which provides comprehensive information about violence in the lives of young women prior to, during and after an adolescent pregnancy, including data about the effects on young women and their children.

- Other highlighted programs for traumatized youth, particularly adolescent mothers, included the Union Industrial Home for Children in Trenton, N.J.; Straight from the Heart developed by the Ounce of Prevention in Chicago; Project Equality, developed at Purdue University as rape and sexual assault curricula for teens; and Risk Upon Risk, developed by Virginia Commonwealth University and the Medical College of Virginia to explore the links among tobacco, alcohol and adolescent pregnancy.

Best Practices from Relevant Disciplines and Fields

This section describes relevant practices from several fields that could inform practice and/or enhance programs aimed at adolescent pregnancy, parenting and prevention.[8] The fields include health prevention and treatment; domestic violence; male reproductive health and fatherhood initiatives; parenting and child development; and youth development.

This section of the briefing paper only skims the surface of the available insights, practices and resources in these fields. It also does not summarize all of the fields from which practice insights might potentially come. Such detail and breadth of coverage are outside the scope of this briefing paper.[9] For more specific information, we encourage readers to review Lynn Pike's MAPPP (Maltreatment and Adolescent Pregnancy and Parenting Program) resource guide (55a), Douglas Kirby's Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy (40a) and to contact organizations such as Healthy Teen Network, the American College of Obstetricians and Gynecologists (ACOG) or the Male Advocacy Network (MAN). We also encourage readers to track resources that may soon become available from the National Youth Violence Prevention Resource Center and from the federal working group on Violence Against Women,

both of which have identified a need to draw together information and resources as major issues for the field (along with a collection of data to track prevalence and consequences).

Health Prevention and Treatment Practices

Potentially useful practices include:

- Adoption of protocols developed for emergency room treatment of rape or domestic abuse for use by primary care and other physicians and health care providers. Several experts mentioned that emergency room physicians now have many tools to help them identify, treat, and refer victims of interpersonal violence to follow-up resources. They do not believe these tools are being widely used in practices of other physicians and health care providers.

  - If such protocols are adopted, alter them to include attention to childhood interpersonal violence, sexual, or physical abuse. Emergency room rape or domestic abuse protocols tend not to ask about these things.

  - Different experts mentioned that protocols to screen for interpersonal violence might usefully be placed with people delivering sports physicals, particularly to young men; in well-baby clinics and with pediatricians who serve children of adolescents; and in school health clinics or with school nurses.

Protocols to screen for interpersonal violence might usefully be placed with people delivering sports physicals, particularly to young men; in well-baby clinics and with pediatricians who serve children of adolescents; and in school health clinics or with school nurses.

- Use of non-medical models for health service delivery to adolescents and adolescent victims of interpersonal violence. These models are usually offered in community, not clinical, settings; deliver services via peer support and trained para-professionals, not just health care professionals, place a priority on allowing time for participants to establish trusting relationships with others, including deliverers of service, and expect a participant to play a substantial role in setting goals and choosing among strategies (see, for example, the use of these kinds of models for health care delivery within the family support field). We believe these types of approaches to health care delivery might reduce some interpersonal and institutional barriers to disclosure and treatment.[10]

- Specific practices shown to help pregnant and parenting adolescents heal from sexual abuse or trauma. Bassuk, a psychiatrist, who is also Director of the Better Homes Fund, is an expert on domestic violence that leads to homelessness. She and her colleagues have published two very relevant reviews of effective practices, including a review of the implications for health care providers of post-traumatic stress disorder in extremely poor women (4a, 4b). The articles recommend, among other things:

  - Routine screening for violence and basic needs, including a readiness by the health care provider to housing, safety, money, and mobility (if a patient depends on a partner for transportation).

  - Recognition that for poor women, fears can include: "threat to public housing status, unwanted social service contact, loss of employment or financially

supportive partner, loss of social support or child care services provided by the assailant's family" and "although a trauma survivor may be distrustful, she is also likely to be greatly distressed and to desire help in some form."

- Validation of the experience, based on research that indicates that simply acknowledging domestic violence and agreeing that it is a serious problem "is a very powerful and therapeutic first step" (Flitcraft A., "Domestic Violence begets other problems of which physicians must be aware to be effective," *Journal of the American Medical Association*, 1990, 264 [4a[11]]).

- Explaining to patients the links between trauma and current medical and psychological distress. This reassures a victim she or he is not 'crazy.' Bassuk explains that "a cognitive framework may explain seemingly disparate symptoms by identifying a coherent theme that can be named and thus associated with hope for recovery."

- Treating underlying issues not symptoms. "Treating only the symptoms carries the risk of "increasingly severe and debilitating sequalae for the patient [and] exhaustion of resources for the system provide care (Browne, A. *Violence Against Women: Relevance for Medical Practitioners.* JAMA. 1992 267, [4a]).

- Making appropriate referrals. When doing so, consider:

  - Linking to case management services. Bassuk warns practitioners that case management is not a panacea though it can be very helpful to victims of interpersonal violence.

  - Choosing carefully among different treatment options, some of which may be better able to deal with basic needs. Many women are unable to work on psychosocial issues unless very basic needs (shelter, food) are dealt with; many will accept help on those needs before being willing to participate in specialized services.

  - Considering drop-in and local health clinics for women whose lives are unstable. Most mental or behavioral health services are based on a model developed for middle-class, mature women. They require regular attendance at periodic sessions (e.g., weekly therapy or support groups). Bassuk reminds practitioners that poor women (we would argue also adolescents) have transportation, living conditions, and survival issues, and experience chaos that can make these models irrelevant or harmful (if they reinforce a patient's belief that she or he is a failure).

- There are also two other practices for trauma and recovery that have been used specifically with adolescent populations around issues of pregnancy, parenting and prevention. Fields, of the Touch Institute, found positive outcomes for adolescent parents on approaches that incorporate attention to mood regulation via massage and other strategies – these approaches had positive effects on brain chemistry linked to depression, anxiety and other sequalae of violence. Similarly, Trad found that pregnant adolescents benefited from a technique called

previewing, which allows them to form positive images of their developing baby to replace often very negative images resulting from their own abuse or exposure to interpersonal violence (71).

Other Relevant Practices

There are also some other practices, from myriad fields, that could be added to the practice repertoire of programs working on adolescent pregnancy, parenting and prevention strategies. Practitioners and other experts noted several, including:

- From case management, the importance of recognizing the stages people are in on a continuum from crisis to stability, and providing supports appropriate to that stage. For example, several practitioners talked about knowing typical stages of response to interpersonal violence, and typical stages of response to adolescent pregnancy and then offering services that fit the intersection. One practitioner identified typical stages for adolescent victims of interpersonal violence as revealing, healing, developing skills to change situations and improve outcomes (in terms of, for example, parenting, education, or living situations), then action. Based on her experience, she raised caution about not trying to "rush the process" by trying to work with an adolescent parent on parenting issues when he or she is in crisis from domestic violence.

- From youth development programming, the importance of creating non-stigmatized and developmentally-appropriate activities that provide opportunities for youth to reveal personal problems, including histories of abuse. Practitioners believe that adolescents will not respond to stand-alone programs focused on interpersonal violence. Rather, they believe that work on interpersonal violence for adolescents has to be embedded in broader approaches that offer other reasons for adolescents to engage.

- Also from youth development, the importance of allowing adolescents to control the content and process of activities designed to affect them, giving them leadership roles in the governance of these efforts and treating them as resources not merely recipients of services. Practitioners say these practices are especially important when working with adolescents who are pregnant and parenting and who are victims of interpersonal violence and abuse, to offset low self-esteem and feelings of powerlessness.

- From early child development, the importance of modeling specific parenting techniques or providing supplemental parenting to children of adolescents who are depressed. For example, there are some attachment and bonding practices that are critical to a child's emotional well being which can be very difficult for traumatized parents to offer (20a, 71). Providers of early education and care to children of adolescents can embed compensatory practices into their work. They and others who work with adolescent parents can also work with the parents directly to encourage them to, for example, maintain appropriate eye contact, talk soothingly and otherwise respond to their children in ways that may not come naturally to them.

Youth development principles tell us that adolescents will not respond to stand-alone programs focused on interpersonal violence. Rather, violence prevention has to be embedded in broader approaches that offer other reasons for adolescents to engage.

- From male health and fatherhood programs, practices aimed at helping men acknowledge childhood violence or abuse and its links to their own current violent behaviors, when relevant. Some practitioners, who were otherwise pessimistic about the efficacy of programs designed to change the behavior of perpetrators of interpersonal violence, are observing some successes in programs that focus on young men beginning to heal from childhood violence and abuse.

- From male reproductive health and other programs aimed at helping young men make a transition to adulthood, practices that emphasize violence-free ways to "be a man." Some practitioners are developing specific practices around this issue. They had developed curricula to reinforce that, for example, "a really strong man doesn't have to have all the power in a relationship" and that "it is not okay to physically overpower somebody and force them to have sex. That manipulation and repeated badgering can be a form of social or psychological force." These practitioners say that these are often new ideas to young men in their programs.

- From child abuse work, practices that simultaneously support child victims and their parents (e.g., intergenerational practices). Child abuse practitioners recognize that parents need support to be partners in their child's healing and to deal with the consequences once child abuse becomes a public matter. These issues matter for adolescent parents whose child has been abused, and they are even more critical given the likelihood that the adolescent parent has also been abused, either in the current relationship or previously.

Practitioners and other experts from male health and fatherhood programs found promise in practices aimed at helping men acknowledge childhood violence or abuse and its links to their own current violent behaviors, when relevant.

Implications for Policy: Opportunities and Challenges

Just as the relationship between interpersonal violence and adolescent pregnancy touches many spheres of practice and intervention, it also has myriad implications for policy. Within the health area, for example, the issues of violence and its links to adolescent pregnancy can affect policy with regard to: services to pregnant and parenting adolescents; training of health care providers; maternal and child health; policies implemented through offices of adolescent pregnancy, parenting and prevention at federal, regional, state and local levels; offices of family planning (e.g., comprehensive sex education and abstinence-only-until-marriage) at all levels; male health; child health; mental and behavioral health; and acceptance of non-medical models as one treatment option and financing (to pay for sufficient services to improve outcomes). Other policy areas to be considered, outside of health, include: housing; income transfer and welfare (e.g., TANF); schooling and other education; and criminal justice, juvenile justice and law enforcement (e.g., child custody issues, child protective services, protection from abuse orders).

One advocate describes good policy as being "trauma sensitive," in that it takes account of the real lives and issues faced by those it touches, and thus, tries to remove barriers that make things harder and promote opportunities to make things better. This section of the paper provides some examples of policies that could be more trauma sensitive than they currently are. It provides a broad view of policy implications, by highlighting just a few examples in each area.

Good policy must be "trauma sensitive," in that it takes account of the real lives and issues faced by those it touches, and thus, tries to remove barriers that make things harder and promote opportunities to make things better.

Implications for Health Policy

As noted above, relevant issues are woven throughout health policy – at the levels of practice, training, service delivery, eligibility requirements, priority setting and financing. Some of the key issues people are working on include:

1. Creating training curricula and protocols to encourage physicians and other health care providers to screen for domestic violence and other forms of abuse: Several curricula have been developed and are being widely disseminated. In addition, questions about domestic abuse have been added to state licensing exams for obstetricians, gynecologists, and nurse midwives as one way to increase the likelihood that these subjects will be taught in medical schools and other settings. An expert with the American College of Obstetricians and Gynecologists (ACOG) estimates that about 30 percent of her colleagues now do such screening.

There are myriad opportunities to use similar techniques to focus the attention of health service delivery providers on the link between interpersonal violence and adolescent pregnancy, including the links among adolescent pregnancy, child abuse, depression, substance abuse, and post-traumatic stress disorder. There are also several challenges: reimbursement rates that discourage lengthy conversations between health

care providers and patients; lack of short and easy-to-administer screening tools; lack of training about how to deal with disclosure when it does happen; and few affordable resources to refer adolescent victims of interpersonal violence. All of these issues need to be addressed at the policy level.

2. Rethinking policies regarding abstinence and comprehensive sex education: It seems clear from the previous sections of this report that the prevalence of violence, its consequences, and what it takes to reduce or ameliorate its effects, has important implications for policy regarding pregnancy prevention – how it is taught; supports and services that are available to teachers, health educators, and participants; and funding priorities and what can or cannot be supported using federal or other government funds. The recent report from the Surgeon General (USDHHS, 2001) points out the value and necessity for comprehensive sex education to prevent pregnancy; findings from this report are consistent with his recommendations.

Once we know that no fewer than one-quarter of pregnant and parenting adolescents are victims of partner abuse, and as many as two-thirds were abused as children, it seems obvious that abstinence-only-until-marriage strategies are irrelevant for many girls. Victims of abuse and interpersonal violence are often unable to negotiate their sexual behaviors. Strategies that suggest they can, without providing them the full range of skills and healing support required, set them up for continued victimization, re-traumatization, and coercive sexual relationships. Even if one wished this were not true, it is. Therefore, such strategies are both counter-therapeutic and counter-productive to pregnancy prevention, the goal that all people concerned about teen pregnancy share.

In addition, abstinence-only-until-marriage programs do not offer young adults other options besides abstinence to protect themselves from STDs in coercive sexual situations. If we recognized that a substantial amount of sexual activity is not voluntary, particularly for the youngest adolescents, wouldn't we want to educate them about protection and treatment?

Effective policies would need to acknowledge and address the prevalence of violence in children and adolescent lives, and factor that into their proscribed strategies. Because funding follows policy in this area, new thinking might shift funds toward more comprehensive approaches and remove barriers that keep people from providing these services more broadly now.

3. Expanding access to adequate and affordable therapy and treatment using medical and non-medical models: It is very difficult right now for individuals and programs to access the kind of long-term but necessary supports to heal from childhood and domestic abuse and violence. Such healing seems necessary, however, to break the links between these things and early pregnancy for adolescents.

Many health care insurance policies, including but not limited to Medicaid and the state Children's Health Insurance Program (SCHIP), do not adequately cover behavioral or mental health services. Many providers refuse to accept these coverages at current reimbursement rates, and there are often long waiting lists for services from those who do. Even very good insurance policies won't cover the number of visits that would meet standards for healing. Thus, issues for policy include expanding the number of covered providers, increasing reimbursement rates, increasing the number of covered treatments,

and finding alternative strategies to see that victims of abuse (adolescents, children, parents of young children) can get the support and help they need at a sufficient level to make a real difference in their outcomes.

Some experts believe that managed care providers and insurers could readily recognize the potential cost savings from more effective prevention and healing strategies. They suggest that these organizations could be powerful advocates for appropriate policies, once they understood the prevalence and consequences of violence among children and adolescents and are given opportunities to analyze cost-benefit ratios for different treatments or interventions.

4. Creating regulatory and funding support to embed issues of interpersonal violence and adolescent pregnancy, parenting, and prevention in male health and fatherhood initiatives and maternal and child health programs and services (44b): There are myriad other opportunities at the policy level within health to address interpersonal violence in a way that might reduce initial or, especially, subsequent adolescent pregnancies in the short or long term. For example, fatherhood and male health programs, and maternal and child health programs could put more focus on healing from child abuse as well as identification of and intervention targeted to interpersonal violence, coercive sexual relationships, and birth control sabotage.

Federal funds could be directed toward these efforts, perhaps drawing on work of the Office of Family Planning, DHHS (which supports male reproductive health programs and demonstration projects), the Office of Adolescent Family Life, DHHS (which supports programs and projects for adolescent mothers) and the newly formed National Youth Violence Center, a collaboration between the Federal Working Group on Youth Violence and the Centers for Disease Control and Prevention. Standards could be built into policies to ensure that these issues of interpersonal violence are considered and addressed, rather than left to individual program discretion. Further, policies could require collaboration between maternal and child health programs, male health and fatherhood programs, and domestic abuse agencies. Confidentiality, reporting, and referral policies would need to be reviewed to protect the privacy of participants, but allow people to intervene when necessary. Home visiting programs, particularly those that are aimed at child abuse prevention, have developed standards, policies, and practices from which to draw.

Key policy issues include:

1. Creating training curricula and protocols to encourage physicians and other health care providers to screen for domestic violence and other forms of abuse
2. Rethinking policies regarding abstinence and comprehensive sex education
3. Expanding access to adequate and affordable therapy and treatment using medical and non-medical models
4. Creating regulatory and funding support to embed issues of interpersonal violence and adolescent pregnancy, parenting, and prevention in male health and fatherhood initiatives and maternal and child health programs and services.

Temporary Assistance to Needy Families (TANF)

Adolescent parents are an important subset of the TANF population. As noted throughout this paper, it is likely that a substantial portion of the TANF population have been victimized by interpersonal violence or abuse, either as adolescents or as children. States vary considerably in their approach to these issues. Policies that are sensitive to these issues are not necessarily known and enforced at the local level.

Several groups are working on TANF-related policy issues for adolescents (see, for example, the work of the Illinois Caucus and the work of the TANF re-authorization working group, organized by the Center for Law and Social Policy (CLASP). These groups and others are working from an awareness of the high levels of interpersonal violence among pregnant and parenting adolescents. Some of the issues they have identified are noted below:

- Adolescent parents may be required to establish their child's paternity to avoid sanctions (this varies by state). This is a serious issue for adolescents in abusive or violent situations. One practitioner illustrated the harm this regulation has done. She described two young mothers. One had left another state to get away from an abusive partner. She was extremely fearful, but reluctantly provided paternity information to TANF workers in her new location. She then dropped out of sight; workers believe her partner found out where she was living through the paternity establishment process and harmed her or caused her to flee again. Another young mother in a similar situation refused to provide paternity information and was denied benefits.

- The 1996 federal TANF law generally prohibits an unmarried, minor custodial parent from receiving federally-funded TANF benefits, unless she is living with a parent, legal guardian, or adult relative. There are five exemptions from this rule that may cover situations of interpersonal violence (4b).[12] However, many TANF workers are unaware of the exemptions. Anecdotal evidence suggests it is common for adolescent parents to be turned away or diverted from applying for TANF before they have a genuine opportunity to disclose interpersonal violence (for example, if they do not bring their parents, if the school or other referring agency does not forward information about prior abuse, or simply because the adolescent does not reveal the abuse or violence in the initial intake interview).

  Concerns about diversion have led some practitioners to use presumptive eligibility as a means to connect adolescents with a caseworker before declaring him or her ineligible for TANF supports or benefits. This gives the adolescent more time to disclose interpersonal violence, and allows a caseworker to link the adolescent to necessary housing, education, employment, and/or recovery or healing even prior to drawing down federal funds.

- Adolescents are generally required to attend school (or work) to receive TANF benefits. This presumes that the adolescents would otherwise be able to attend school or perform acceptably if not for the pregnancy. It used to be thought that girls drop out of school because they become pregnant, but more recent research indicates that girls who are already doing poorly in school are among those most likely to become pregnant as adolescents (25, 40b, 45, 51, 66). This makes sense given the high rates of violence and abuse in these girls' lives. Special consideration and support needs to be given to TANF-eligible young mothers with a history of interpersonal violence or abuse who are not attending school regularly. For example, the definition of acceptable schooling could be expanded to include specific programs for pregnant or parenting girls in crisis because of interpersonal violence, which are aimed at providing support to help them get to the point where they are able to attend school regularly and succeed.

Recent research indicates that girls who are already doing poorly in school are among those most likely to become pregnant as adolescents (25, 40b, 45, 51, 66). This makes sense given the high rates of violence and abuse in these girls' lives.

- Current and contemplated policies that promote marriage as the best option for young families may produce perverse effects for partners who have experienced interpersonal violence as children or in their current relationships (44a). For example, money is awarded to the five states that produce the greatest reductions in their rates of out-of-wedlock births each year. These kinds of policies encourage states to promote marriage among TANF populations. It is unlikely that people would urge marriage as the best option for adolescents in violent, coercive, or abusive partner relationships either for the sake of the partners or their children. These policies thus need to be re-examined given the prevalence of interpersonal violence among adolescent parents.

Housing and Homelessness

There are at least two major issues for housing policy: emergency housing for adolescents fleeing abusive situations; and longer-term access to safe living alternatives for adolescents, and particularly adolescent parents, who need long-term independent living arrangements (as is the case for some TANF-eligible young women, discussed above). Some of the key concerns are:

- Lack of emergency housing for adolescents, or adolescents with children, in crisis because of interpersonal violence. Few shelters accept adolescents, or adolescents with children. Further, adolescents are often afraid to stay in shelters or, when they do, find it difficult to follow rules set up for older populations. In addition, anecdotal evidence suggests that young women may refuse to disclose interpersonal violence, or fail to follow-up on referrals, because they are afraid their children will be taken from them to different safe living arrangements.

- Lack of services for domestic abuse victims at family shelters or other emergency housing (this is a general issue for people needing emergency housing, not limited to adolescents). People tend to be assigned to emergency shelter based on available space; the supports and follow-up services they receive are based on where they are assigned. People assigned to family shelters, as opposed to domestic abuse shelters, often do not receive domestic abuse services. Advocates for homeless women have identified this as a major issue for policy work. (Note: one survey found that of all homeless, very poor women, 92 percent were victims of domestic or interpersonal violence [4a]).

- Lack of access to public housing and other long-term alternatives to living in unsafe homes or remaining in unhealthy or violent partnerships. Many adolescents face the real choice between staying in an abusive situation in either their family of origin or current housing, or being homeless.

Homeless funding and services should be more routinely targeted to particular adolescents at risk of homelessness (including foster care children once they reach 18 and adolescent parents with histories of abuse).

Thus, there are opportunities to change policies with respect to access and eligibility for shelters and public housing, perhaps linked to changes in TANF teen living provisions, described above. The links between interpersonal violence and homelessness are, of course, considered in family preservation, foster care, and other services for abused children who cannot live easily or safely at home. But the data presented in this report also lend urgency to new thinking about the ties among adolescent pregnancy, interpersonal violence, and homelessness. The data suggest, for example, that homeless funding and services should be more routinely targeted to particular adolescents at risk of homelessness (including foster care children once they reach 18 and adolescent parents with histories of abuse).

Schooling and Other Education

As noted in the discussion about interventions, schools are one of the opportune places to identify and support adolescent victims of interpersonal violence, and to offer effective pregnancy prevention skills, information and supports. Early education and day care settings, elementary, middle and high school classrooms, and after-school or other recreational/educational programs are also prime places to implement trauma-sensitive policies. They can provide opportunities for students to heal without being stigmatized, and, one hopes, without being re-traumatized through counter-therapeutic or counter-productive strategies.

Below are examples of barriers or opportunities that could be addressed through educational policy:

- Information is emerging rapidly about fostering children's emotional well-being and resilience. This information points to practices that could be embedded in all early childhood education and child care centers to promote healthy emotional development. In addition, new information makes it easier to spot victims of child abuse, and to explain behaviors related to stress, anxiety and other childhood symptoms of exposure to violence. If one knows what to look for, one can spot these symptoms more easily in children and/or in parents; provide safe opportunities for disclosure and help them find appropriate support.

- Given that many children are at risk for interpersonal violence, educational policy could require that educators at many levels develop enough competency in these areas to promote better programs and more normal access to support – without necessarily having to identify and label any child in particular. In addition, policies could remove barriers to identification and treatment by educational professionals and para-professionals. Finally, policies could ensure that an adequate amount of funding is available for early education and day care facilities, and schools, to create trauma-sensitive settings and adopt trauma-sensitive practices as standard operating procedure.

- Pregnancy prevention education must start early, because victims of interpersonal violence tend to begin sexual activity earlier than non-victims, either through coercion, to meet previously unmet needs, and/or because of early sexualization. Many experts say that middle school is the absolute latest point by which some students need information, skills, and supports, and others say that pregnancy prevention efforts have to begin as early as fifth or sixth grade.

These facts challenge policymakers to permit appropriate intervention in earlier grades than many adults might find comfortable. They also challenge us to re-examine what "developmentally appropriate" information is, particularly for adolescents who are victims of violence or abuse. These issues have to be addressed to reduce adolescent pregnancy, which itself is highly linked to educational outcomes for adolescent parents, their partners and their children. Even though these are very tough issues for parents, educators, and policymakers to face, they cannot be avoided.

Criminal Justice, Juvenile Justice, and Law Enforcement

Relevant policy issues that involve the courts and law enforcement include child custody issues, protection from abuse, and enforcement of orders involving child protective services. People working on adolescent pregnancy and interpersonal violence note the following specific policy concerns:

- Adolescents have a difficult time getting law enforcement officials to take their complaints of partner or dating violence seriously. While law enforcement has dramatically improved its understanding of domestic abuse, this understanding has not reached down to issues involving adolescents. A young woman may find it hard to obtain a protection from abuse order, police officers may be slow to respond to her calls, and/or the system provides few supports to help adolescents, and particularly adolescent parents, when they are in abusive or violent situations.

- As noted above, there are numerous instances when adolescent mothers must establish paternity, or provide information to locate the other parent, to process TANF, child support enforcement agreements and/or for legal matters related to child custody. Many adolescent (and older) parents are then forced to choose between benefits to which they are entitled or risking their safety, or their children's safety, by giving information that could reveal their current location to abusive partners and/or parents.

- Adolescent parents in abusive living situations are sometimes afraid to come forward because they believe they will lose their children to child protective services. These fears can be well-grounded, particularly for adolescent parents who are substance abusers (one typical consequence of untreated interpersonal violence or untreated child abuse).

An increase in housing options, trauma sensitive supports and policies, and access to adequate and affordable treatments and supports would help address these issues as well. In addition, there needs to be a careful review of criminal and civil procedures to make sure they are appropriate for adolescents, parents, victims of interpersonal and child abuse, and those who fall into all three categories simultaneously.

Possible Next Steps for the Field

Many victims of interpersonal violence will experience consequences that can affect multiple aspects of their lives, including their ability to succeed in school, to be self-sufficient, to form healthy relationships, to avoid early pregnancy, and to parent children.

Findings presented throughout this briefing paper indicate that many adolescents who become pregnant have experienced interpersonal violence in their current partnerships, as children, or both. While some victims of interpersonal violence will thrive without special supports, most will experience consequences that can affect multiple aspects of their lives. Their ability to succeed in school, to be self-sufficient, to form healthy relationships, to avoid early pregnancy, and to parent children well may all be compromised because of psychological and material after-effects of untreated exposure to violence.

While there are promising practices and policies that could better support adolescents through these challenges, they are neither widely known nor typically incorporated in programs aimed at adolescent pregnancy, parenting or prevention. In addition, some policies and practices that promote marriage among TANF populations, that require adolescents to disclose interpersonal violence to be exempted from living at home, and that promote abstinence-only sex education are inconsistent with research and best practices in relevant fields. This may explain why we as a field may have had only limited success in reducing adolescent pregnancy or in achieving maximal, positive outcomes for pregnant or parenting adolescents.

Some next steps include:

1. Increase awareness of the prevalence and consequences of interpersonal violence among adolescents and their links to adolescent pregnancy
2. Collect more and better data to describe the magnitude of the problem
3. Develop and disseminate detailed understandings of best practices from relevant fields
4. Review policies in multiple areas to see whether they promote relevant cross-disciplinary work, exploit opportunities, and/or reduce barriers to working with at-risk adolescents
5. Create a stronger research base

Given all of this, there are a number of steps that could be taken by people working on adolescent pregnancy, parenting, and prevention. Some logical next steps, consistent with the findings in this report, are noted below:

- Increase awareness of the prevalence and consequences of interpersonal violence among adolescents and their links to adolescent pregnancy, as we now understand them. Highlight coercion and birth control sabotage and very high rates of child sexual and physical abuse in the lives of pregnant and parenting adolescents.

  - Increase awareness among advocates, practitioners, and researchers so they can embed this information into their work on behalf of their target population;

- Increase awareness among policymakers at federal, state, and local levels so they will be more receptive to the creation and enforcement of relevant practices, programs and policies; and

- Increase awareness among the general public.

    - Create messages that reframe public understanding of why and under what circumstances many young women become pregnant and the need for policies and programs that fit their actual situations and needs; and

    - Create messages that reframe men who perpetrate interpersonal violence in terms of their own exposure to childhood abuse, where appropriate.

- Collect more and better data to describe the magnitude of the problem:

    - Create a standard definition for "interpersonal violence" that can be used across surveys and administrative reports;

    - Create a standard age boundary to define adolescence;

    - Collect data on prevalence of interpersonal violence in current partner relationships and data on childhood interpersonal violence, sexual, and physical abuse using standard definitions of each; and

    - Collect data from randomized samples that include sufficient populations of males and females to make accurate prevalence estimates on which to base policy decisions.

- Develop and disseminate detailed understandings of best practices from relevant fields that could be brought to bear to prevent adolescent pregnancy, and to promote better outcomes for adolescent parents and their children, given high levels of interpersonal violence:

    - Investigate in depth and draw together practices from at least the fields of domestic violence, male reproductive health and fatherhood, youth development, early childhood, parenting, trauma and recovery, health prevention, and treatment;

    - Create or contribute to existing curricula, protocols, and other tools that can be used by practitioners in fields other than those in which these tools were developed;

    - Promote cross-disciplinary and cross-field training on these practices;

    - Share materials from one field (e.g., recovery from trauma) through websites, journals, and conferences aimed at practitioners in other fields (e.g., people working on male reproductive health and violence prevention; educators who work with adolescents who are behind in school or sexuality educators); and

    - Provide incentives and create new forums for relevant cross-disciplinary work.

- Review policies in multiple areas to see whether they promote relevant cross-disciplinary work, exploit opportunities, and/or reduce barriers to working with pregnant and parenting adolescents, or adolescents at high risk of pregnancy, who are also victims of current or prior interpersonal violence.

  - Scrutinize policies within, at least, TANF and related legislation, adolescent family life and population planning, law enforcement and criminal justice (with respect to child protection, child support and custody, protection from abuse), behavioral health care delivery, and reproductive health care delivery, education, and child well being;

  - As noted above, raise awareness and provide at least minimal training on the prevalence, consequences, and links between interpersonal violence and adolescent pregnancy to workers at all levels within the systems that implement relevant policies; and

  - Advocate for and implement trauma-sensitive policies to reduce potentially perverse policy effects.

- Create a stronger research base on which to accomplish the tasks above, in addition to collecting comparable prevalence data. Build on the current interest in youth violence prevention, domestic abuse, and violence against women at the federal level to support this work:

  - Create a more fully comprehensive theory of change, based on available evidence, to articulate links between exposure to violence, consequences, and outcomes;

  - Evaluate promising programs, especially ones that embed a more comprehensive set of relevant practices, to create new evidence and further strengthen our knowledge of the relationships among consequences, practices, and outcomes; and

  - Disseminate findings broadly to practitioners, advocates, and researchers across multiple fields to stimulate new thinking and work.

Endnotes

[1] There is no standard definition for violence across relevant fields, a conclusion confirmed in a recent meeting at the Centers for Disease Control (CDC) on this topic. Most studies we reviewed use a variation of the definition found in *Technical Bulletin: Domestic Violence,* No. 209, American Academy of Obstetricians and Gynecologists (ACOG): "violent acts between partners have been categorized as verbally abusing the partner, threatening violence, throwing an object at someone, pushing, slapping, kicking, hitting, beating up, threatening with a weapon and using a weapon. Definitions of intimate partner violence may also include sexual assault, stalking, psychological abuse, enforced social isolation, intimidation and the deprivation of key resources such as food, clothing, money, transportation or health care."

[2] For example, at least two studies indicate that younger adolescent mothers experience more interpersonal violence in their current relationships than older adolescent mothers. So the age cut-off for a sample can substantially affect findings (e.g., a survey of adolescent mothers age 16 and higher is likely to report lower prevalence of current partnership violence than a survey that includes more younger adolescent mothers). Similarly, studies consistently show that adolescent mothers are about twice as likely to experience prior interpersonal violence (e.g., child sexual and physical abuse) than to currently be in violent relationships, though the rates of both are high. Thus, findings that separate these forms of violence will provide different estimates of interpersonal violence in adolescents' lives than studies that count both. (For young adolescents, in particular, it is not clear where the line should be drawn between relationship violence and child sexual abuse.)

[3] For example, early data from a survey of unmarried new mothers on welfare (the "Fragile Families" study) indicate relatively low rates of interpersonal violence and preliminary conclusions lean toward promoting family formation (29a). However, mothers under age 18 were excluded from initial data collection, until parental consent for their inclusion could be obtained. The study's findings, and its conclusions, may change once data from these youngest mothers are included.

[4] Different studies have estimated the prevalence of violence during pregnancy at 4% to 20% in the general population, with the majority of researchers reporting estimates of between 4% and 8% (31, 48).

[5] Adolescent mothers have disproportionate and high rates of depression compared to the general population. For example, one study found that 13 percent of adolescent mothers attempt suicide (71).

[6] There are many pregnancy prevention programs that touch on these issues, but not in a sustained way. They may, for example, have one session of many that discusses interpersonal violence, or bring in one or two speakers on this topic a year. Violence prevention programs tend not to focus on adolescents or adolescent pregnancy. This is also true for programs aimed at adolescent parents and their children, which often touch on interpersonal violence but are not set up to intervene directly or link adolescents to programs of sufficient intensity or duration to solve the problems.

[7] One of the original goals for this briefing paper was to summarize the state of the art in adolescent pregnancy prevention and programs for pregnant and parenting adolescents, and their children, with respect to interpersonal violence. We did not find any programs with a sustained focus on adolescent pregnancy and interpersonal violence, though there may be more than we uncovered. We found several programs focusing on a particular aspect of this issue (e.g., dating violence). We also found several practitioners who recognize this as an issue though they are not sure how to address it effectively and/or who believe it is outside their competency to address (without unintentionally doing harm). As noted in the text, we also found many relevant practices embedded in programs with different foci, which, if taken together, suggest best practices that could be incorporated into pregnancy prevention programs, programs for pregnant and parenting adolescents, and programs for children of adolescent parents. Thus, we have chosen to focus on best practices rather than reviewing the state of the art.

[8] As far as we know, there are no comparable reviews of findings from evaluations of programs aimed at supporting pregnant and parenting adolescents and their children. Only a small number of these kinds of programs have been subjected to rigorous evaluation; we know of no such evaluations that have found consistently positive effects on key outcomes, e.g., delay in onset of subsequent pregnancies. Research done for this briefing paper suggests that more effective programs will require more comprehensive approaches including attention to interpersonal violence and its consequences.

[9] For example, criminal justice and law enforcement with respect to protection from abuse and general violence prevention work with respect to exposure to environmental violence are not covered in depth here.

[10] For example, according to the Better Homes Fund, women report four barriers to disclosure: "fearing the perpetrator, but wanting to preserve the relationship and their families; feelings of shame, humiliation and low self-esteem; concerns about police involvement; and mistrust of providers." There are also "institutional" barriers within traditional health care delivery systems including "long waiting periods, brief appointments, and high costs."

[11] This quotation was taken directly from Ellen Bassuk, et al. article *Post-Traumatic Stress Disorder in Extremely Poor Women: Implications for Health Care Providers.*

[12] Minors can be exempted from the living arrangement rule if: the minor has no parent, guardian, or adult relative who is living or whose whereabouts are known; the minor has no parent, guardian or adult relative who will allow her to live in their home; a state agency determines that the minor or her child is being or has been subjected to serious physical or emotional harm, sexual abuse, or exploitation in the parent, guardian, or adult relative's home; a state agency determines that living with a parent, guardian, or adult relative presents a risk of imminent or serious harm to the minor or her child; or a state agency determines that it is in the best interest of the minor's child to waive the rule. (42 U.S.C.. 608(a)(5)(B)(i.i.) as cited in (4b of the Bibliography).

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Publications Available from CAPD on Teen Parents

Investing in Young Families: Some Thoughts on Advantages, Disadvantages and Possible Next Steps. Wendy C. Wolf, Sally Leiderman. March 2001.

Improving Outcomes for Teen Parents and Their Young Children by Strengthening School-Based Programs: Challenges, Solutions and Policy Implications. S. A. Stephens, Wendy C. Wolf and Susan T. Batten. April 1999.

Seeking Supervision: Local Implementation of the TANF Minor Teen Parent Living Arrangement Rule, Susan T. Batten and Stephanie L. Koenig. March 1999. (One of a 3-part series; companion documents produced by the Center for Law and Social Policy and the Social Policy Action Network).

School-Based Programs for Adolescent Parents and Their Young Children: Overcoming Barriers and Challenges to Implementing Comprehensive School-Based Services. Cynthia L. Snipe and Susan T. Batten with S. A. Stephens and Wendy C. Wolf. 1994.

School-Based Programs for Adolescent Parents and Their Young Children: Guidelines for Quality and Best Practice. Susan T. Batten and Bonita Stowell. 1996.

Working with Teen Parents and Their Children: The Importance of School-Based Programs and Guidance for Child Care Professionals in the Field C A Briefing Paper. Susan T. Batten. 1996.

Investigation of Credit-Accelerating and Competency-Based Academic Programs for Adolescent-Age High School Students. Michael Sack. 1996.

Adolescent Pregnancy Prevention: What We Know and Next Steps C A Briefing Paper. S. A. Stephens and Sally H. Leiderman. 1994.

Strengthening Young Families: Lessons Learned from the AT&T Family Strengthening Initiative. Sally H. Leiderman, Cheryl Smith Garrett and Wendy C. Wolf. 1994.

School-Based Programs for Adolescent Parents and Their Young Children: Community Assessment Workbook. S. A. Stephens. 1996.

Additionally, many of the following documents and short pieces regarding teen parents are available on the Web site http://www.capd.org:

- The potential of school-based programs to improve outcomes for teens and their children
- How to get a rough estimate of adolescent parents in a location that could potentially be served by such efforts
- The potential outcomes of these efforts and the necessary programmatic strategies to achieve them
- Common barriers to implementation of these efforts
- General lessons learned from the field
- Specific strategies used to overcome barriers
- Creative strategies used to overcome critical barriers
- Best practices in school-based programs for adolescent parents and their young children
- Overview of CAPD's Initiative
- Capacities needed by programs for adolescent parents and their children

Working with teen parents and their children; the importance of school-based programs and guidance for child care professionals in the field

- Providing services to all teen parents, both non-TANF and TANF
- Strategies to ensure that school policies are consonant with Title IX and protect the rights of pregnant and parenting students
- Making teen parents and their children visible
- Helping the education system work for teen parents and their children
- Providing critical services and supports to teen parents and their children
- Linking schools with TANF and resources
- Supporting young families: challenges to implementing contemporary welfare policy
- Summary of policy implications C addresses how to strengthen school-based efforts for adolescent parents and their children so that they can be more effective in meeting the needs and improving the outcomes of these young families
- Options for rapid credit accumulation using open entry/open exit computer assisted competency based instruction
- Reflections on early implementation
- Next generation issues confronting school-based programs
- Resource organizations and publications

Further information can be obtained by contacting Sally Leiderman at CAPD at (610) 828-1063.

Healthy Teen Network

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CAPD

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