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TEEN DATING VIOLENCE: A MIXED METHODS STUDY IN FRENCH-SPEAKING BELGIUM

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SUMMARY

Backgraund: *"Teen dating violence" is a poorly studied issue in the literature. Several sociodemographic and psychiatric risk factors have been identified in the literature, and the consequences are numerous. The aim of this mixed study is to establish an initial inventory of the problem in French-speaking Belgium, to establish links with the socio-demographic and overall health characteristics of the population, and to issue recommendations for the future.*

Subjects and methods: *A study by questionnaire was conducted among 103 young people aged between 14 and 18 living in French-speaking Belgium and speaking French in particular. Qualitative and quantitative (descriptive and inferential statistics) analyses were performed.*

Results: *29.1% of respondents experienced violence. Significant links exist between the fact of having experienced violence and consumption as well as the presence of STDs. The combination of potential risk factors predicts a considerable part of the violence in the sample. A significant link exists between the fact of being subjected to violence and a high score on the scale of depression and violence suffered and committed.*

Conclusion: *The prevalence of teen dating violence is relatively high in Belgium. A link between these and a large part of the potential consequences studied could be highlighted through the study.*

Key words: *Teen dating violence - teen mental health - transition psychiaty*

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INTRODUCTION

Teen dating violence (TDV) is defined by the Center for Disease Control (CDC) as: "A form of violence that takes place in adolescent relationships, whether in person, online, or through technology. It includes physical, sexual, psychological violence, and harassment (Basile 2020), as well as cyberdating abuse which consists in using digital means to control, harass and threaten the other (Basile 2020, Zweig et al. 2013). Violence being itself defined by the World Health Organization (WHO) as being "the intentional use of threat, or the intentional actual use of physical force or power against oneself, another person, or against any group or community, which results in, or is likely to result in, injury, death, psychological disturbance, harm, maldevelopment or deprivation" (Quigg et al. 2020).

There are some differences between adolescent couple violence and adult couple violence, which is why a distinction is made between the two. Here we describe the three most important ones. First, there is a certain asymmetry present in the adult couple, which is not found in adolescent relationships: for example, there is often no financial dependence or children. Secondly, the adolescent couple is influenced by peers, unlike the adult couple: the social group generally has a non-negligible influence on the young couple and the behavior of the latter in front of peers may be different from that in private. Third, there is a lack of experience in romantic relationships: inexperience in communication can lead to using verbal or physical aggression as a defense mechanism to deal with complex situations (Mulford & Giordano 2008). We thus understand that the dynamic of an adolescent couple is relatively different from that of an adult couple, and that violence cannot therefore be approached in quite the same way.

TDV is a phenomenon with a significant prevalence, since it affects 1 in 8 students in the USA according to national surveillance data from the CDC (Basile 2020). 8.2% of students describe physical and sexual violence within the couple. It should also be noted that girls, homosexuals, bisexuals, and those whose sexual identity is uncertain are the most affected. However, there is extremely high variability between the various studies with regard to the prevalence of violence among boys and girls (Basile 2020, Jennings et al. 2017, Mulford & Giordano 2008).

The risk factors identified in victims of intimate partner violence are substance abuse, especially with regard to marijuana, being gay, bisexual, or transgender, as well as people who are unsure of their sexual identity (Basile 2020, O'Malley et al. 2020, Walls et al. 2019), pregnancy and post-partum (Harrykissoon et al. 2002, Thomas et al. 2019), having been sexually abused as a child (Hébert et al. 2016) and low social status (Dosil et al. 2020), as well as peers (Chen et al. 2017, Vézina et al. 2011).

There is a manifold of consequences of TDV, especially with regard to mental health. A positive association exists between experiencing violence and suffering from anxiety, depression, having suicidal ideation, attempting suicide, using tobacco, marijuana and alcohol, suffering from eating disorders, and having antisocial behavior disorder later in life (Baiden et al. 2021, Bonomi et al. 2013, Fletcher 2010, Foshee et al. 2013, Hill et al. 2019).

With regard to sexual health, the risk of STIs is increased as well as the number of screening tests (Bonomi et al. 2013, Decker et al. 2005, Hill et al. 2019). In general, there is an increase in the use of health care among victims (Fletcher 2010), which represents an additional cost for health care.

Although young age is recognized as a risk factor in intimate partner violence (Jewkes 2002), this problem is not well known and addressed in Europe, specifically in Belgium (Glowacz & Courtain 2017), resulting in a paucity of specific interventions provided at both primary and specialist care levels. This lack of targeted interventions is explained in particular by a lack of Belgian epidemiological data.

The aim of this work is therefore to attempt to establish an initial inventory of the prevalence of this problem among young people in French-speaking Belgium. For this, three objectives are set in this study. First, to survey young French-speakers in Belgium using known mixed-type tools (quantitative and qualitative) used to assess the problem. Second, to make links with sociodemographic and global health data. Third, to make recommendations for the future.

METHODS

Data collection

This study is cross-sectional, monocentric, of the survey type by anonymous questionnaire. The study protocol was submitted and approved by the Comité d'Éthique Hospitalo-Facultaire Erasme-ULB on 09/23/2021.

Participants between the ages of 14 and 18 living in Belgium and speaking French were selected. The survey was distributed in the form of a self-administered questionnaire, including the Short Conflict in Adolescent Dating Relationships Inventory (S-CADRI) scale for detecting violence among adolescents (Fernandez et al. 2012) and modified Patient Health Questionnaire-9 (PHQ-9) for adolescents for the detection of depression (Nandakumar et al. 2019). The questionnaire was distributed via social networks (Facebook® and Instagram®) and in high schools.

A power analysis was carried out a priori: a target number of 63.5 respondents was targeted in order to obtain a power of 0.8 in the bilateral statistical tests carried out (minimum 63.5 participants per group for a moderate effect size of 0.5 in the t tests. A total of 103 people answered the questionnaire, the data collection having taken place between 04/11/2021 and 23/02/2022.

Data analysis

For the statistical analysis of the data, the JASP 0.16.1 and JAMOVI 2.0.0.0 software were used. Descriptive analyses were first performed. For all variables, frequencies were calculated. For ordinal and discrete variables the median, the mean, the standard error of the mean, the standard deviations, the variance, the quartiles, and the IQR were computed. A Shapiro-Wilk test was performed to verify the conformation of each quantitative variable to a normal distribution.

A Chi-square test was performed to test the effect of variables classified as potential risk factors on the violence variable, as well as to test the link between violence and variables classified as potential consequences, with respect to all nominal and binary variables. The Chi-square test for the "pregnancy" and "abortion" variables was performed by studying only the subgroup of subjects identified as women. The effect size is assessed by the odds ratio (OR) between two binary variables, and the 95% CI is calculated for the OR. For tables including other variables, the effect size is calculated by Cramer's V.

To test the effect of violence on ordinal and discrete variables, classified as potential consequences, a Mann-Whitney test was performed. The effect size is assessed by the Rank-Biserial Correlation and the 95% CI was calculated. Regarding the qualitative data, they were analyzed and categorized.

RESULTS

A total of 103 responses were obtained. The average age of the population studied is 16.7 years (standard deviation: 1.26). There are 86 women (83.5%) and 17 men (16.5%). 30 respondents think they have already experienced violence (29.1%). In the qualitative analyses, the participants reported sexual violence, psychological violence (insults, belittling of the other, surveillance, threats, etc.), cyberviolence (broadcasting of photos, harassment), violence physical attacks, social isolation, destruction of objects, deception. Among the people who reported violence, 6 said they had never spoken to anyone (5.82%). Among all the respondents, 52 say that they would not want to talk about it with the doctor if they were subjected to violence (50.4%) and 46 answer that they would like to talk about it (44.6%). The results of the qualitative analyses show that those who answered "yes" to this question justified it with the following answers: "so that the person becomes aware of the seriousness of the situation", "to receive help and support", "for prevention", "for professional secrecy", "to have

someone to talk to". The “no” respondents justify it by: “a feeling of lack of interest on the part of the doctor”, “a feeling that the doctor will do nothing to resolve the situation”, “a feeling of lack of qualification”, “unease with to the doctor", "the fact of not wanting to stir up the past", "the fear of not being believed", "the fear of disturbing questions", "the impression that this will not change the situation", "the fear of blame", "a communication failure", and "the preference to talk to someone close".

The average score of the S-CADRI scale violence done is 1.71 for the S-CADRI score violence received, the average is 3.37. (Each question on the scale having a value of 0 to 3 points depending on the frequency of the type of violence experienced, with a total score of 30) The average score of the PHQ-9 scale is 12.53 (Each question having a value of 0 to 3 depending on the frequency of each item, with a total score of 18.) With regard to the frequencies of the scores of the CADRI violence done scales, we observe that 44.7% of the respondents have a score greater or equal than 1 to scale. The same result is observed for the violence received category.

Regarding the analysis of potential risk factors, we were unable to demonstrate a link for any variable with the χ^2 test (p-values > 0.05).

The analysis of the potential consequences of violence using the χ^2 test shows a significant difference for the variables tobacco, alcohol, drugs, STDs. No link could be demonstrated for the pregnancy and abortion variable.

With regard to the potential consequences of violence, analyzed through the Mann-Whitney test, a significant difference is observed for the variables Score-PHQ9, S-CADRI score violence done, and S-CADRI score violence received. On the other hand, no significant effect could be demonstrated for the variables frequency of tobacco consumption, frequency of alcohol consumption, frequency of drug consumption.

DISCUSSION

The purpose of this study was to make an initial inventory of the problem of TDV within the Belgian population, as well as to relate the problem to the socio-demographic characteristics of the population studied, and finally, to issue recommendations for the future.

29.1% of respondents to the questionnaire think they have experienced violence in their couple. In comparison, we have 44.7% of people with a score greater or equal than 1 on the S-CADRI scale (violence received). Some young people in our sample therefore probably experienced violence and do not know it. However, these figures should be interpreted with caution. Indeed, the study population is not entirely representative of the general population (for example, more female respondents than men and a large proportion of respondents who are 18 years old). Moreover, this is a relatively privileged population compared to the rest of the Belgian population, since 29.1% of fathers and 41.7% of mothers have a university education, compared to 14% observed in the Belgian population (Dujardin 2021). Since the socio-economic level is a predictive factor of violence (Dosil et al. 2020), one can imagine that the frequency of violence observed in this study is underestimated. This hypothesis is supported by the results of a recent study in Belgium (Glowacz & Courtain 2017) which detected 90.5% of violence with the S-CADRI scale (all violence combined).

Furthermore, no significant difference could be demonstrated between girls and boys in relation to having experienced violence.

Contrary to what has been observed in studies (Basile 2020, Dosil et al. 2020, O’Malley et al. 2020, Walls et al. 2019), we were unable to demonstrate any significant link between the supposed predictive factors and the violence suffered, via the χ^2 test.

With regard to the potential consequences of TDV, we were able to highlight a significant increase in depression (measured by the PHQ9 scale modified for adolescents) on the fact of having suffered violence in the last 12 months (link between violence and S-CADRI score of violence received) and in the fact of having violent behavior in the couple (link between violence and S-CADRI score of violence done). There is also a significant association with having been subjected to violence and the addition to tobacco, alcohol and drugs, as well as having had an STD. These results are consistent with those observed in the literature (Baiden et al. 2021, Bonomi et al. 2013, Fletcher 2010, Glowacz & Courtain 2017). No significant association was observed with the occurrence of pregnancy.

We thus understand that the role of the healthcare professional is essential in both primary and secondary prevention. This role is all the more important when many adolescents are in a situation of violence and do not know it, as we have been able to observe from the disparity in frequency between the violence detected via the scale and the people who answered having experienced violence.

Even if a priori, one could believe that an intervention is not desired on the part of a large part of the respondents (50.2% would not want to speak about it to their doctor), in the light of the qualitative answers, one can see that most of the time these answers are not a refusal in principle but rather express an apprehension due to a lack of knowledge of the potential roles of the general practitioner, the latter having in principle to favor communication about all psychosocial issues.

CONCLUSION

Through this study, a relatively high prevalence of TDV in French-speaking Belgium could be highlighted. Through the importance of this problem and the many consequences highlighted, we can understand the important role of the healthcare professional in both primary and secondary prevention, and the need for an approach adapted to this young population.

Future research could be carried out, in particular to deepen the detection of violence using the S-CADRI questionnaire, to analyze the extent to which violence could be bidirectional, as well as purely qualitative studies in order to probe caregivers on their knowledge and to first on the subject.

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Contribution of individual authors:

Isaline Malherbe conceived the manuscript, collected the data and wrote the manuscript.

Giovanni Briganti contributed to the statistical analysis of data and reviewed the manuscript.

Nadine Kacenelenbogen conceived and reviewed the manuscript.

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