Can Adolescent Dating Violence Be Prevented Through School-Based Programs?

EACH YEAR IN THE UNITED STATES, AN ESTIMATED 10% to 20% of adolescents experience physical forms of intimate partner abuse.[1,2] The costs of exposure to relationship violence during adolescence are high, with adolescents who are victimized experiencing higher rates of depression, anxiety, and associated social and health problems. Importantly, adolescent dating violence also predicts involvement in domestic violence in adulthood. Strong support for a causal link between exposure to relationship violence and poor health outcomes[3,4] suggests that relationship violence prevention programs may have the potential to reduce the adult-health burden and improve the lives and well-being of adolescents. As a result, the prevention of relationship violence among adolescents is now recognized as an important public health problem and a prime candidate for intervention efforts.

See also page 692

Parents, teachers, and those invested in the well-being of youth want to know how to best reduce the risk for relationship violence among children in their care. At the same time, researchers are beginning to synthesize the rapidly accumulating body of knowledge regarding the predictors of and precursors to adolescent dating violence, with hopes of translating science into effective intervention programs. Thus far, results have been mixed regarding whether universal interventions aimed at reducing partner violence can make a difference in the lives of young teens. Moreover, only a handful of intervention studies have used randomized controlled trials to address this important public health question.

In this issue of the *Archives*, Wolfe et al[5] present findings from a rare—and seemingly effective—randomized controlled trial of a schoolwide program designed to reduce dating violence among adolescents. They implemented a randomized controlled trial of a 21-lesson manualized curriculum delivered by teachers to grade 9 health classes. The intervention, referred to as the "Fourth R: Skills for Youth Relationships," integrated lessons on healthy relationships, sexual health, and substance use. In their article, Wolfe and colleagues provide evidence that teaching adolescents about healthy relationships in grade 9 reduced physical dating violence 2.5 years later: the prevalence of partner dating violence was 9.8% for control students vs 7.8% for intervention students.

This study contributes to what we know about the prevention of adolescent dating violence in 2 important ways. First, randomization of adolescents to an intervention condition provides support for the position that school-based interventions can have causal effects on adolescents' romantic relationships, although this may be true only for boys. At first glance, the intervention effects appear to be relatively small. However, a 2% reduction in dating violence at the population level has the potential to result in millions of dollars in long-term medical, mental health, and criminal justice savings. The intervention appeared to be particularly effective for boys, with a 7.1% vs 2.7% difference in the prevalence of partner violence observed between intervention and control groups, respectively. The relatively large effect of the intervention among boys is important considering that partner violence perpetrated by males is most likely to result in physical injury and may carry heavier costs. Second, this study provides proof of principle that effective classroom-based interventions targeting relationship violence can be delivered by leveraging existing resources (eg, teacher time and modifications to existing curriculum) and for the relatively low cost of $16.00 per student. In short, Wolfe and colleagues provide a compelling case that classroom-based interventions can provide value for money with respect to delivering relatively low-cost early interventions that hold the promise of reducing the long-term health costs associated with partner violence.

The results presented by Wolfe and colleagues also raise important questions regarding how future interventions can more effectively reduce partner violence during this key developmental window. Decades of research on the prevention of conduct disorder and violence among children and adolescents has demonstrated that a multisystemic approach that integrates the family is most effective. Indeed, many adolescents who engage in partner violence have been exposed to domestic violence within their own homes. Thus, it seems critical that future school-based interventions designed to prevent partner violence contain a familial component. On a broader level, media campaigns may be required to change peer and societal cultures that are accepting of violence within adolescent relationships, and indeed these campaigns are currently under way (http://www.prevnet.ca). Intervention research with conduct disorder has also taught us that adolescents rarely specialize with respect to involvement in different forms of antisocial and aggressive behaviors. Therefore, it will be important to assess the effects of future relationship violence prevention programs

on antisocial behavior and violence in general and also to assess whether a history of conduct disorder or other childhood psychiatric disorders may moderate intervention effects.

Finally, one of the most intriguing findings reported by Wolfe and colleagues was that their school-based intervention seemed to have no effect on the partner violence rates among girls. Face validity of the intervention protocol would suggest that the focus on promoting healthy relationships would lead to a *stronger* effect among girls. Relationships take center stage in the lives of girls, and when violence occurs among young women it is typically within the context of a close relationship. These findings raise several questions. Did the intervention begin too late for girls, who are at an advanced stage of social and emotional development as compared with their male counterparts? Or, are the proximal factors that trigger violence within relationship contexts for girls vs boys simply more powerful, making these dynamics more resilient to change based on an "ounce of prevention" 2 years prior? These types of unanswered questions emphasize the need to consider gender-specific—or perhaps gender-sensitive—intervention models and evaluation procedures in the prevention of adolescent partner violence. Future research will also be required to evaluate the mechanisms of change and active ingredients in school-based intervention programs. Despite these unanswered questions, findings from this study are encouraging. That is, the authors make a powerful case for the role of classroom-based interventions in helping to fulfill this important health objective. Perhaps most remarkably, they demonstrate that reductions in dating violence can be achieved for relatively little cost. This is a rare and positive message for those interested in promoting healthy relationships among young adolescents—a message with the potential to serve as a catalyst for developing effective evidence- and school-based interventions in this area. There is still much work to be done with respect to achieving the public health objective of greatly reducing or eliminating violence within adolescent relationships.

Candice L. Odgers, PhD
Michael A. Russell, MA

Correspondence: Dr Odgers, Department of Psychology and Social Behavior, University of California, Irvine, 3361 Social Ecology, Bldg II, Irvine, CA 92697 (codgers@uci.edu).

Author Contributions: *Study concept and design:* Odgers and Russell. *Drafting of the manuscript:* Odgers and Russell. *Critical revision of the manuscript for important intellectual content:* Odgers and Russell. *Administrative, technical, and material support:* Odgers and Russell.
Financial Disclosure: None reported.

REFERENCES

1. Silverman JG, Raj A, Mucci LA, Hathaway JE. Dating violence against adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. *JAMA*. 2001;286(5):572-579.
2. Olshen E, McVeigh KH, Wunsch-Hitzig RA, Rickert VI. Dating violence, sexual assault, and suicide attempts among urban teenagers. *Arch Pediatr Adolesc Med*. 2007;161(6):539-545.
3. Golding JM. Intimate partner violence as a risk factor for mental disorders: a meta-analysis. *J Fam Violence*. 1999;14(2):99-132.
4. Ehrensaft MK, Moffitt TE, Caspi A. Is domestic violence followed by an increased risk of psychiatric disorders among women but not among men? a longitudinal cohort study. *Am J Psychiatry*. 2006;163(5):885-892.
5. Wolfe DA, Crooks C, Jaffe P, et al. A school-based program to prevent adolescent dating violence: a cluster randomized trial. *Arch Pediatr Adolesc Med*. 2009;163(8):692-699.

The Family Is (Still) the Patient

In this issue of *Archives*, Silverman et al[1] present data from the 2004 Bangladesh Demographic Health Survey, revealing that more than 40% of Bangladeshi mothers with children younger than 5 years of age experience intimate partner violence (IPV) and that their children sustain significantly elevated rates of 2 leading causes of mortality in Bangladeshi children, respiratory infection and diarrhea. Although 2 in 5 mothers may seem to be an extraordinary prevalence of IPV to some, it is a value commensurate with those in neighboring Asian countries[2] and in some American states.[3] In the current study, younger Bangladeshi mothers and the mothers of very young children were more likely to have been assaulted, and IPV was more prevalent among households with lower levels of maternal education and without sanitary resources. Importantly, ascertainment of IPV was based on husbands' reports of violent incidents during the past year, while mothers independently described children's illnesses during the 2 weeks prior to the study interview. Although men's underdisclosure of IPV could have biased the reported association, such bias would operate in a conservative direction, producing an overestimation of childhood illness rates among families without IPV and obscuring the IPV-related differences. Furthermore, the association persisted after adjustment for many possible confounders, such as maternal age, education, household wealth and size, number of children, sanitation, cooking fuels, and crowding.

See also page 700

Such observations, emanating from a survey of health determinants and conditions in a resource-poor nation of South Asia, challenge several of the enduring shibboleths of pediatric orthodoxy, among them the conceptual and disciplinary division between mental and physical health; the separability of child health from maternal well-being; and the view that societal malaise lies outside the rightful perimeter of pediatric medicine's attention and concern. Nearly 30 years ago, pediatrician Bayard Allmond and colleagues[4] reminded us that, although