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Prevention of Partner Violence by Focusing on Behaviors of Both Young Males and Females

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Abstract Historically, the political context of partner physical aggression policy and research has focused on protection of physically victimized women and mandated interventions for male batterers. This emphasis is understandable when one considers the injuries and deaths of women by men. However, physical aggression against partners among teens is a very different phenomenon than battering. Intimate partner violence (IPV) in the form of physical aggression, the focus of this review, often starts in junior high school, and approximately 35% of male and female senior high school students report engaging in IPV. The specific trajectory of IPV varies by sample, but IPV appears to decrease in the late teens or early 20s. IPV is generally reported by both males and females, and not attributable to self-defense. IPV is significantly stable in couples who remain together, but stability appears lower if partners change. Given the importance of physical aggression by both males and females, prevention and early intervention programs need to address relationship factors, and targeted prevention and early intervention would be prudent with young high-risk couples. Decades of intervention programs for batterers have not proven very successful, and IPV appears easier to prevent than treat. Thus, emphasis on prevention of IPV seems both timely and promising. This review is intended for diverse audiences including educational administrators, policy makers, and researchers. It reviews issues such as who and when to target for IPV prevention programs, and it summarizes data relevant to these issues.

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Intimate partner violence (IPV) typically includes four types of behavior: physical violence, sexual violence, threats of violence, and emotional abuse (Centers for Disease Control 2011). This review focuses almost solely on physical violence against a romantic partner ranging from slapping or pushing to beating. Physical aggression among young males and females occurs at rates much higher than had been imagined when such aggression was hidden behind closed doors (Straus and Gelles 1990). Sexual violence against an intimate partner is far less common than physical aggression among teens (Muñoz-Rivas et al. 2007; Wolfe et al. 2001), and adolescent sexual IPV has been far less studied than physical violence. Thus, this review focuses on physical IPV.

Approximately 10–12% of adults in nationally representative samples report that they engaged in IPV during the past year (Schafer et al. 1998; Straus and Gelles 1990), and IPV is more prevalent among younger men and women (O'Leary and Woodin 2005). Unfortunately, interventions with batterers have been disappointing (Babcock et al. 2004). In contrast, IPV prevention efforts for youth are much more promising (e.g., Foshee et al. 2000; Wolfe et al. 2009), and prevention seems imperative to ultimately reduce IPV. We now describe intended audiences for this manuscript, the importance of addressing developmental and dyadic/mutual aggression issues in IPV, and note the political context that has driven IPV policy with an emphasis on reduction of male IPV.

Our intended audience is diverse. It includes policy makers, most of whom have had a primary focus on the protection of women, as well as educational administrators from elementary to university levels. Using this review,

educational administrators, policy makers, and researchers hopefully will better be able to make informed decisions regarding the development of aggression, the age at which prevention programs should start, and the extent to which behaviors of both males and females, as well as dyadic or mutual aggression factors receive focus.

Fortunately, there is empirical support for prevention aimed at both middle and high school students (e.g., Foshee et al. 2000; Wolfe et al. 2009), but several dyadic and developmental issues warrant consideration. To date, empirically supported universal programs worked with one member of a couple. And, as discussed by Avery-Leaf and Cascardi (2002), some of the early IPV prevention programs were based on feminist models with interventions for same sex groups to "ensure the comfort and safety of participants and to deliver messages appropriate to each gender" (p. 96). However, they concluded that such programs did not change attitudes regarding IPV, and argued that programs in which only males are seen as perpetrators and only females as victims seem ill-advised. When considering severe IPV, this portrayal with males as perpetrators is often the case, but these extremes do not provide a full picture of IPV, particularly among teens where IPV is often mutual and dyadic factors need to be taken into account.

Programs and policies exist within a political context that influences research directions. At the national level, aggression by males has received primary attention. This attention is understandable when one considers two points on the 2011 fact sheet of the website of the Centers For Disease Control Injury and Prevention Center: (1) "Each year, women experience about 4.8 million intimate partner related physical assaults and rapes. Men are the victims of about 2.9 million intimate partner related physical assaults," and (2) "IPV resulted in 2,340 deaths in 2007. Of these deaths, 70% were females and 30% were males." In short, males sexually assault and kill partners more than females. However, as noted above, the extremes do not characterize teen IPV, and we now address the following four questions that have relevance to the prevention of IPV in teens and young adults:

(a) At what point is the prevalence of partner aggression the highest?
(b) Is the physical aggressive behavior of *both* partners important?
(c) Is IPV of both young males and females stable?
(d) Is there evidence that IPV is easier to prevent than treat?

The answers to the above questions are complex, and sometimes the evidence is based on a small number of studies. However, answers to these questions are needed to make decisions about who and when to target for prevention of IPV.

At What Point is the Prevalence of Partner Aggression the Highest?

The answer to this developmental question can inform the timing and design of prevention programming. With some notable exceptions such as Foshee et al. (2000), there are very few studies that followed a sample from the point at which IPV may start to a later point at which IPV might be expected to decline. Thus, it is necessary to estimate the age at which IPV rates are highest from cross-sectional data. Trajectory studies of middle and high school students that attempted to ascertain the specific peak rate of IPV are reviewed. Finally, we use a nationally representative high school sample study and a nationally representative sample of married individuals with data across a number of years to ascertain the age at which IPV rates are the highest.

Middle School

IPV often starts when the students are about 12 years old, but in some inner cities, it starts earlier. In rural Canada, the middle school IPV perpetration rates were only 5% (Connolly et al. 1997). On the other hand, approximately 21% of students in a rural North Carolina county middle school reported engaging in IPV (Foshee et al. 1996). In inner-city Philadelphia, over 45% of middle school students, who were largely African American, reported IPV perpetration (Cascardi et al. 1999). In short, the prevalence rates of middle school IPV vary widely across samples, but generally they are similar to those obtained by Foshee et al. (1996) and in the low 20% range.

High School

In high school, dating and IPV are more common than in middle school. For example, in three large high school samples, between 32% and 38% of the students reported IPV perpetration. In Madrid, 38% of 16-, 17-, and 18-year-old students reported IPV (Muñoz-Rivas et al. 2007). On Long Island, New York, 32% of students in grades 11 and 12 reported IPV (O'Leary et al. 2008). In a sample of 719 high school students from Long Beach, California, 38% reported perpetrating IPV (Malik et al. 1997).

Trajectories of IPV

Using data from a sample of 13–19 year olds in rural North Carolina, Foshee et al. (2009) showed that the rate of IPV increased to a peak and then declined. The peak rate for moderate IPV was obtained at 17.1 years of age and the peak of severe IPV was at 16.3 years of age. In an Italian sample of high school students aged 16, 17, and 18 years, Nocentini et al. (2010) found a marginally significant

finding for a linear decrease in physical aggression across time. In Madrid with students aged 16 to 20, Muñoz-Rivas et al. (2007) found that percentages of individuals reporting perpetration of IPV increased from a low of 33.6% at age 16 to higher rates at ages 17 (42.3), 18 (38.6), and 19 (41.8), and then decreased to 32.3% at age 20. In sum, based on studies from three different countries that evaluated trajectories of IPV, it appears that rates of IPV reach their highest among 16- to 17-year old students.

National samples paint a similar picture. In a national survey of students in grades 9–12, Black et al. (2006) assessed the prevalence of dating victimization with one question as follows: "During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose?" The percentage of females reporting victimization in grades 9–12 was 8%, 9%, 8%, and 10%; for males, the victimization rates across grades 9–12 were 9%, 8%, 8%, and 10%. These cross-sectional data show a very slight increase in the percentages of victimization with the highest percentage being 10% in grade 12 or approximately age 17–18 years.

Using data from the National Family Violence Study, O'Leary and Woodin (2005) showed that husband to wife IPV decreased across the age span studied (20–69). Using aggregate data with 5-year age periods, there was a negative correlation of −.82 between IPV and age. Based on these nationally representative studies, it appears that IPV rates may be highest at age 17–18 years, and that there is a decline thereafter. Moreover, there is an interesting parallel in what appears to be a high point of IPV rates at around age 17, the same age that is the high point for rates of criminal behavior (Moffitt 1993). Regardless of the exact inflection point of IPV rates, Foshee and Reyes (2009) concluded that the best time to begin primary prevention of IPV is approximately age 13 years. Given the tremendous variability in rates of IPV among younger samples, and paucity of longitudinal studies, it is clear that more developmental research would aid in the development of specific recommendations regarding the timing of interventions.

Is the Physically Aggressive Behavior of Both Partners Important?

Both Males and Females Engage in IPV

Many studies with community samples show that IPV is as commonly engaged in by women as by men (Archer 2000; Straus and Gelles 1990). Research across different labs with engaged and young married partners found that women were at least as likely as men to engage in IPV (Lawrence and Bradbury 2001; Leonard and Senchak 1993; O'Leary et al. 1989). Some qualifications about this conclusion are in order. The conclusion that women are as likely to aggress as men does not generalize to sexual IPV in community samples. Married males report perpetrating sexual aggression more frequently than females (O'Leary and Williams 2006; White and Kowalski 1994), and a full conceptualization of IPV should include sexual IPV. A second qualification is that males are more likely to inflict injury than females as evidenced with dating (Foshee et al. 1996), community (Stets and Straus 1990), marital therapy (Cascardi et al. 1992), and mandated treatment (Cantos et al. 1994) samples. Finally, as argued by Wekerle and Wolfe (1999), it is important to take into account the context of abusive acts, and the extent to which coercive interactional processes are involved.

The Majority of Partner Aggression is Mutual

When IPV occurs, it generally is engaged in by both partners. In reviewing four studies of IPV among college students, Gray and Foshee (1997) found that when IPV occurred, mutual IPV was reported by between 45% and 72% of the sample, depending upon the study. Partners' psychological and physical IPV have consistently been the most powerful predictors of physical IPV. Bookwala et al. (1992) found physical IPV from one's partner to be the strongest predictor of IPV for both college men and women. Among over 1,000 male and 1,000 female Navy recruits, White et al. (2001) found that partners' verbal IPV was the single best predictor of physical IPV and partners' physical IPV was the second best predictor of physical IPV. In brief, physical and psychological aggression are highly correlated in dyads.

Young Females Report as Much or More Perpetration than Victimization of IPV

Samples of young married partners show that relative to their partners, both males and females underreport their own IPV but males underreport more than females (Heyman and Schlee 1997; O'Leary and Williams 2006). However, even using only females' reports, they report more perpetration than victimization. With a sample of 2,300 high school students (O'Leary 2008) more females reported engaging in IPV (40%) than reported being victims of IPV (30%).

The strong association between male and female IPV is not due to self-defense. Self-defense was very infrequently endorsed as a reason for engaging in IPV by college females (Hettrich and O'Leary 2007). Instead, the primary reasons given for IPV were anger at partner, lying by partner, and poor communication. As expected, self-defense appears to be a much more common motivation among battered women (Hamberger et al. 1997) than in community

and non-clinical samples (Follingstad et al. 1991). However, among teens and in representative samples, IPV is not primarily perpetrated in self-defense.

Additional evidence that aggressive behavior is engaged in by females as well as males comes from data regarding partner selection. Studies examining assortative mating (e.g., Merikangas 1982), suggest that "birds of a feather flock together," and the overall evidence shows that partners chose partners with similar personality patterns (O'Leary and Smith 1991). Moreover, aggressive males and females seek out one another (Kim and Capaldi 2004). While couples with aggressive personality traits may seek each other out, andecdotally we have observed some female partners become more submissive across time as a function of consistent victimization.

The data reviewed above argue strongly for focus on the actions of both partners in prevention of IPV. Furthermore, these data suggest good reason to consider creative ways of delivering prevention services to couples, especially high-risk couples. For example, in a large Long Island high school sample, approximately half the teens who were engaged reported IPV (O'Leary et al. 2008). Engaged teenagers could well profit from varied prevention services, and although those services do not require a couple intervention, at a minimum there should be a focus on reducing aggression by both males and females in all prevention efforts.

It may, however, be easier to reduce or eliminate aggression in a mutually aggressive couple by involving both members of the couple in the prevention effort. The data on mutuality and dyadic relations suggest that partners shape each other, and if one partner engages in IPV, there is increased risk that the other will engage in IPV also (Straus 1993). Perhaps supplementing traditional school and new family-based programs that target individuals with focused programs for high-risk couples or couples at risk making a life transition (e.g., deciding to move in together, having a child) would be a viable strategy for enhancing the impact of IPV prevention.

Is IPV of Young Males and Females Stable?

In a now classic book, Walker (1979) argued that if one act of physical aggression against a woman occurred, it would continue, and the female would be best advised to terminate the relationship. This opinion has been shared by many, and it helped the development of a shelter movement to provide safe haven for battered women. For example, in 1981, Pagelow stated, "One of the few things about which almost all researchers agree is that batterings escalate in frequency and intensity across time" (p. 45). However, as will be reflected herein, desistance often occurs. The term stability has a broad meaning in ordinary English usage and it refers to constancy of character, dependability, reliability, and resistance to change whereas recurrence refers to coming up again for consideration and occurring again after an interval. In this manuscript, stability also has a broad meaning but will generally be referred to as assessments measured continuously, and recurrence and desistance will refer to measurements that are categorical (Lorber and O'Leary in press).

Stability appears to be affected by a number of methodological issues such as the number of items assessing aggression, time between assessments, number of assessments, base rate of aggression, and age of the sample. As might be expected, stability estimates of IPV are higher when aggression is measured with more items/measures (e.g., Capaldi et al. 2003; Whitaker et al. 2010). In addition, stability and recurrence are greater if participants are followed for longer periods (e.g., Fritz et al. 2003). Of course, samples also matter. Samples with very high rates of IPV or severe IPV also often show stronger evidence of stability (Chase et al. 1998; Feld and Straus 1989). Conventional wisdom suggests that stability ought to be developmental, with younger teens perhaps engaging in less stable and possibly more playful aggression, and older adolescents and young adults "settling in" to more high conflict styles. Indeed, Foshee et al. (2001) showed that about 10% of what is often reported as IPV by teens is of a playful nature and not in anger, and Fritz (2005) found that 20% of IPV incidents reported by college students were seen as non-aggressive by independent coders. Thus, methodological scrutiny with interview follow-ups of self-reported aggression would appear to be useful to triangulate on more precise evidence of prevalence and stability of IPV among teens and young adults. The stability and/or recurrence of IPV among older adults (40–50 year olds) in representative samples with the same partner across time is not yet clear. As later documented, the two major representative studies with the same 5-year time span between assessments show vastly different recurrence rates, likely due in part to the different base rates of aggression. Although stability of IPV appears higher in samples with the same partner across time, the evidence is not yet consistent on this point.

IPV Stability in Junior and Senior High School

IPV appears to be somewhat stable as early as junior high school. Based on a large study with participants followed across time, IPV for boys and girls had significant, moderate stability over a year (mean correlation of .28 for females and .17 for males), and stability did not increase with age (Fritz et al. 2003). The odds of IPV at some point in the subsequent 5 years, given the presence

of IPV at the first assessment, was .62 for males and .71 for females.

Stability was assessed in a large sample of high school students who stayed in the same relationship and for whom aggression was evaluated over 14 weeks (O'Leary and Slep 2003). The probability of IPV at a second assessment, given IPV at the first assessment was .47 for males and .78 for females. In a sample of high school students from schools with individuals having severe behavioral problems, there was considerable consistency of IPV reported across partners for males but not females; *r*s=.73 for males and −.03 for females (Chase et al. 1998). However, this sample was an extreme group expelled from their local high schools.

Stability and Recurrence among Young Adults

Using the representative National Longitudinal Study of Adolescent Health data, with individuals ranging in age from 18 to 26 years, Whitaker et al. (2010) assessed recurrence and IPV in relationships across the last 5 years in one of the largest studies of recurrence ever published. The respondents reported on the first important relationship (based largely on the length of the relationship) when they were 17.4 years old and the second relationship when they were 19.9 years old. They found lower rates of IPV (likely due to the brief nature of the IPV assessment included in the far-reaching study) than most IPV studies (11% for male and 24% for females), but still found evidence of significant persistence across relationships. That said, only 30% of people reporting IPV in the first relationship reported IPV in the second relationship. Rates of persistence for males and females were quite similar. As noted by Whitaker et al. (2010), these data are consistent with findings of Capaldi et al. (2003), suggesting that recurrence, although significant, seems to be lower when examined across relationships (although this has not consistently been found; e.g., Fritz and Slep 2009; Woffordt et al. 1994).

Among young married samples, IPV also shows significant stability. From pre-marriage to 30 months after marriage, self-reported IPV had correlations ranging from .31 to .41 for males and .31 to .55 for females, with a tendency toward increasing stability from pre-marriage to 30 months (O'Leary et al. 1989). Lorber and O'Leary (2004) examined a sub-sample of these couples in which the husband had engaged in at least one act of IPV during the engagement. Seventy-two percent of the men who engaged in IPV during the engagement engaged in IPV at one or more of the next three assessments. Another sample of engaged and young married couples found that 75% of husbands who engaged in IPV in the first year of marriage persisted in IPV at some point over the next 2 years (Quigley and Leonard 1996). Lawrence and Bradbury (2007) also had a newlywed sample and found that non-aggressive couples were likely to remain non-aggressive, and moderately aggressive couples remained moderately aggressive. Surprisingly, severely aggressive couples dropped in their mean levels of aggression, eventually looking more like non-aggressive couples. This latter finding is provocative, since as documented below, usually the more aggressive individuals are the most likely to remain aggressive.

Stability and Recurrence in Nationally Representative Samples

Feld and Straus (1989) selected aggressive individuals from the National Family Violence Survey and assessed 1-year recurrence. For men engaging in severe aggression initially, 57% continued to engage in severe aggression a year later and an additional 10% engaged in minor aggression. For the men engaging in minor partner aggression initially, 23% continued to engage in minor aggression at the second assessment and an additional 19% engaged in severe aggression. In short, severely aggressive men were most likely to persist in aggressive behavior.

Using married couples from the National Survey of Households and Families, Jasinski (2001) assessed recurrence of partner aggression across a 5-year period. To the surprise of the current authors, only 2.6% of the men who were physically aggressive to their partner at time one were physically aggressive at the second assessment 5 years later. Although the overall prevalence rate of male to female aggression was not reported by Jasinski, a study using the same NSFH sample (Benson et al. 2003) showed that the overall prevalence rate of male to female partner aggression in a sample that had two waves was 5.5%, and this relatively low base rate may have contributed to the very low recurrence rate.

Recurrence was also evaluated in a nationally representative sample across 5 years by Caetano et al. (2005). The prevalence of male to female aggression at the first and second assessment was 12% and 10%, respectively, and the prevalence of female to male aggression at the two assessments was 16% and 12%. In both cases, the decrease was significant but clearly small. With over 1,000 couples followed up, the investigators found the following 5-year recurrence rates of physical partner aggression, as broken down by race/ethnicity: 37% Whites; 52% Blacks; and 58% Hispanics.

In integrating information across studies with populations ranging from junior high school to older married partners, there is clear evidence of stability and recurrence of male and female IPV. Further, assuming some underlying aggressive style or trait, if one assesses aggression across more than two time periods, the likelihood of stability

increases (Lorber and O'Leary in press). Although there is some suggestion of stability even across different partners, re-partnering appears to result in lower stability than remaining with the same partner (e.g., Capaldi et al. 2003; Kar 2010; Whitaker et al. 2010), although not all studies examining the effects of re-partnering on IPV have found this to be the case (e.g., Fritz and Slep 2009; Woffordt et al. 1994). Finally, stability appears to increase from initial dating to early marriage, and to decrease again in later marriage. Of course, stability can be influenced by IPV base rates, which seem to increase over adolescence and peak in late teens (see Nocentini et al. 2010).

If prevention programs are to prevent IPV prior to its stabilization, efforts must be targeted at young people, certainly by middle school. On the other hand, different efforts could be targeted at helping teenagers already in aggressive relationships decrease their aggression through reductions in arguments, the single largest predictor of physical aggression. In addition, such teens could be helped to avoid new aggressive relationships by being careful in the selection of their next partners. Further, prevention efforts seem indicated throughout courtship to help stem the seemingly increasing stabilization of IPV that occurs until early adulthood.

Is IPV Easier to Prevent than Treat?

The more severe a problem is, the more difficult the problem is to treat. The adage is an old one that applies across many problems, and, IPV is no exception. Men in treatment who engage in severe, as compared with mild, IPV are less likely to cease or reduce IPV (Gondolf 2002; Woodin and O'Leary 2006). As noted earlier, a meta-analysis of batterer programs showed a very small effect of the intervention beyond that of monitoring by probation departments (Babcock et al. 2004). Recognition of the difficulty in successfully treating batterers has prompted recognition of the need for programs to address IPV before it ever starts or when it is in its early stages. Moreover, in reviewing lessons learned from criminal justice responses to IPV, Hilton and Harris (2009) argued that criminal justice interventions are ineffective or even counterproductive and that the best chance of reducing IPV "lies in improving interventions aimed at perpetrators' characteristics and relationships" (p. 232). Hilton and Harris (2009) came to the conclusion that relationship issues should be addressed after their analyses of criminal justice interventions, but similar conclusions have been reached by researchers who have evaluated multivariate models that address the dyadic nature of IPV in non-clinical samples.

There are data supporting dyadic models of IPV that address aggression and relationship issues of both males and females as well as mutual aggression with high school students (O'Leary and Slep 2003), college students (Riggs and O'Leary 1996), and married partners (O'Leary et al. 2007). In all three models, the psychological and physical IPV of both males and females is proximally related to the IPV of their partners. Further, neither men nor women view females' IPV as negatively as males' IPV, and the IPV of females is thus relatively discounted. Finally, on average, males and females select partners who are like them rather than unlike them; and the IPV of males and females is highly correlated. Results from these dyadic models are in accord with the developmental systems model of IPV by Capaldi et al. (2005) who examined family-of-origin risk factors, adolescent conduct problems, depressive symptoms, deviant peer associations, and a couple-risk context for IPV. In sum, these models portray IPV as a complex behavior with multiple risk factors (including family of origin, individual personality and psychopathology, and dyadic variables), and formulation of prevention and intervention efforts need to consider these risk factors. Couple-based treatment programs lasting 15–20 sessions have been specifically designed to reduce existing IPV and to prevent escalation of more minor IPV (Brannen and Rubin 1996; O'Leary et al. 1999; Stith et al. 2004). These programs have been successful in reducing both psychological and physical IPV. However, these programs are not appropriate for all aggressors; they are best utilized when the IPV is relatively infrequent, has not caused injury, and has not caused the partner to be fearful (O'Leary 2008).

As awareness of IPV has increased, a wider variety of men were mandated to batterers' programs. This increasing heterogeneity has led to the recognition by researchers and some intervention policy makers that "one size does not fit all." However, unfortunately, a recent survey of batterer intervention programs across 45 states revealed that 90% of the programs used a "one size fits all approach"; only 10% of the programs offered any kind of differential treatment (Price and Rosenbaum 2009). Research on heterogeneity in IPV suggests that it may not be optimal to place a man who has slapped his wife once into a program with other men who have repeatedly beaten their wives and who often have substance abuse problems (Whitaker and Noilon 2009). The recognition of the different types of IPV in older adults (O'Leary et al. 2006; Slep and O'Leary 2009) also suggest that prevention effects might be maximized by tailored programs aimed at different types of IPV rather than implement only a single approach.

Attempts to prevent IPV were first implemented in high schools, and dating violence prevention programs still are primarily school based (Morrison et al. 2003; O'Leary et al. 2006; Whitaker et al. 2006). The move to provide IPV education was prompted in the 1990s by the federal initiative Healthy People 2000 with a goal of violence and

drug free schools by 2000. IPV was not the central focus of the initiative because other forms of violence (e.g., against peers and teachers) had long been a major concern. Nonetheless, IPV came under the general violence rubric, and high schools often included some education about IPV in health-education curricula.

Despite the initiatives to widely institute IPV prevention programs, a recent review showed that there were only 12 such programs that were evaluated and results published (Foshee and Reyes 2009). Generally, these programs focused on knowledge about IPV and myths that surround IPV. Eleven of the 12 programs were school-based. Most targeted constructive communication and conflict management skills (Avery-Leaf et al. 1997; Foshee et al. 1996; Jones 1991; Macgowan 1997; Wolfe et al. 2003). Others also stressed strengthening communication and interaction among families, students, schools, and the surrounding community (Foshee et al. 1996; Jaffe et al. 1992). One focused on the above issues as well as the legal ramifications of IPV (Jaycox et al. 2006).

The majority of programs were successful in improving attitudes and at increasing knowledge about IPV. However, only two of three programs that assessed behavioral change reported that their interventions were effective in reducing IPV perpetration. In a universal program, Foshee et al. (2000) found reductions in perpetration but not in victimization. In more extensive evaluations across follow-up periods, Foshee and Reyes (2009) and Foshee et al. (2009) reported that the Safe Dates program, the most well evaluated program in the U.S., was associated with reductions in psychological aggression, moderate physical aggression, and sexual aggression. There was no overall reduction in severe IPV victimization at any of the four follow-up points. Wolfe et al. (2003) found that IPV perpetration and use of threatening behaviors decreased in a sample targeted for being at high risk for interpersonal violence. Jaycox et al. (2006) found changes in knowledge and attitudes but no changes in victimization or perpetration. Of interest is the fact that the two programs that were successful in changing both attitudes and behavior were also the longest. The Foshee et al. (2000) program, included ten 45-minute sessions, and Wolfe et al.'s program (2003) consisted of 18 120-minute sessions. The former program was universal whereas the latter program was targeted at high-risk students. The Jaycox et al. (2006) program was only three sessions.

A successful universal program published after the Foshee and Reyes (2009) review is that of Wolfe et al. (2009). This program was designed for students in the 9th grade in Canada, and it integrated dating violence lessons into a broader program focusing on healthy relationships, sexual health, and substance abuse. A 21-session program that comprised interactive methods of learning was delivered by teachers in a required health curriculum. This program addressed issues much more diverse than IPV, allowing one to cover IPV issues even though a significant percentage of the youth may have not have yet dated. The experimental program compared the active intervention, which involved role plays, lesson plans, videos, and handouts with control schools which addressed similar issues but without teacher training and program materials. A gender-specific approach was utilized with slightly different lessons for males and females to minimize defensiveness. Positive effects were seen on IPV 2.5 years after the program as well as increased use of condom use for boys.

Programs specifically designed to prevent or reduce IPV among engaged or young married couples have been relatively rare. However, there are scores of prevention programs designed to prevent marital discord and divorce, and one marital enrichment program assessed the extent to which IPV is prevented or reduced. PREP, a marriage enrichment program not specifically designed to reduce IPV (Markman et al. 1993), led to apparent reductions in IPV. A review of PREP programs by Foshee et al. (2009), however, raised cautions not to overinterpret this finding from a small sample and possibly results from one program variant.

A motivational interviewing (MI) approach is an effective means of preventing or reducing alcohol problems, and this approach was utilized with steadily dating college students with low-level forms of IPV (Woodin and O'Leary 2010). In just a single 2 h session, couple feedback was provided to them about their relationship, their psychological and physical IPV, and their alcohol use. A control group received feedback about their level of relationship satisfaction and how it compared to a normative group. The couples were assessed at 3-, 6-, and 9-month follow-ups, and MI recipients had less IPV and less harmful alcohol abuse at follow up.

Although the batterers intervention literature paints a generally pessimistic picture about reducing IPV (Babcock et al. 2004), the prevention literature provides reason for cautious optimism. Only a few programs have evaluated change in IPV, but the results of these evaluations are encouraging. The programs with some suggestion of promise were aimed at different ages of participants—from middle school students to young engaged couples. Some were universal and some targeted high-risk participants. Further, interventions with couples with lower-level forms of IPV can be successful. Thus, it would seem wise to build on these promising findings by systematically expanding and integrating IPV prevention and its evaluation. Reviews of prevention programs that have addressed multiple problems suggest that prevention programs that address multiple targets are likely to be more successful than those

that focus on single targets such as IPV (Nation et al. 2003). For example, as was the case in the Wolfe et al. (2009) program, addressing issues of substance abuse, sexual health, family relations, and IPV would potentially have greater impact than those with single focal targets.

Conclusions

The behavior of both males and females can be dealt with in varied contexts; namely, universal or selected, targeting dyads or individuals. At the primary prevention level, the Foshee et al. (2000) universal approach has shown definite promise. It addressed gender-based expectations, and it has shown that changes in dating abuse norms and attitudes led to changes in dating abuse behavior that lasted across time. The Wolfe et al. (2009) universal prevention program demonstrated reductions in IPV in a program for ninth grade health classes in which IPV prevention was woven into a health curriculum addressing healthy relationships, sexual health, and substance abuse. Further, the Wolfe et al. (2003) program for maltreated children exposed to violence covered, among other things, abuse and power dynamics in relationships and this program also led to reductions in dating abuse behavior both at the end of the intervention and at follow up. Both these programs have had encouraging results. The next generation of universal, psycho-education programs might benefit from being developed with an eye toward integration across health outcomes rather than be IPV-specific. This integration is empirically justifiable in that IPV co-occurs with a variety of problematic health risk behaviors and might facilitate dissemination into already crowded health curricula. In addition, the development of effective IPV prevention messages and universal efforts that could be presented in modalities other than through schools would be a helpful addition. These could include media-based presentations and interactive web-based programs. These modalities have been effectively harnessed in other prevention domains and have promise for IPV as well.

For reduction of low-level IPV in long-term dating, cohabiting, and young married couples, dyadic approaches appear to have clear promise as exemplified by the Markman et al. (1993) marriage enrichment program and the Woodin and O'Leary (2010) motivational interview study. Furthermore, prevention efforts probably need to begin early, but this will be challenging as issues compete for attention in school health curricula and introducing IPV prevention material before teens begin relationships may be less effective. One approach might be to consider how IPV prevention can be integrated with prevention programs for associated adolescent risk behaviors such as early or unprotected sex, alcohol, and drug experimentation. Additionally, prevention with these couples at elevated risk will need to consider how to market IPV prevention and engage these individuals and couples. It could be that couples will be more open to prevention at particular milestones, but there may be other, currently untapped ways of marketing prevention and relationship education. Again, offering couples access through different modalities might increase the reach of IPV prevention beyond school-based programs. Furthermore, it could be that interventions that engage the couple, rather than individuals in their health classes, might be more efficacious.

For high-risk couples, such as high school-age couples who already have children or who already may be engaging in low levels of physical aggression, dyadically-focused prevention and intervention programs need to be developed and tested. Although universal prevention programs addressing IPV have their place, it is quite possible that high-risk couples have the greatest likelihood of eventually becoming the couples in which severe abuse occurs. Fortunately, marriage enrichment and MI approaches have already shown promise in reducing IPV, and MI approaches to reducing alcohol abuse have been very cost effective. Implementing such programs will require creative ways of engaging both members of couples who may not have their own transportation or attend the same school, if they are still attending school. Providing omnibus prevention services tied to physical care for mothers or well-baby care would be one possible avenue for service provision.

Given the relative nascence of dating violence research, additional data on some specific issues would enhance the field's abilities to develop more effective prevention approaches. First, we need to better understand the developmental course of IPV and how to optimally time interventions for young males and females with different developmental and risk trajectories for IPV and other problem behavior. For example, as noted earlier, there is an interesting parallel in what appears to be a high point of IPV at around age 17, the exact same age that is the high point for criminal behavior (Moffitt 1993). Also, we need to continue research on risk, course, and trajectories into adult relationships to help us understand how we can safely proceed with couple-based prevention activities for young at-risk couples in contexts that are not dependent on captive populations from high schools. We also need to understand what level of aggression can be successfully prevented and/or treated early before IPV escalates and traditional options like batterer programs are the only available choice.

Given the promising initial results of early trials of IPV prevention, especially when considered in light of the comparatively discouraging IPV treatment findings with only a 5% reduction in recidivism over arrest (Babcock et al. 2004), IPV prevention seems poised to make an important contribution to public health. By considering

how to address onset, stability, and development of IPV, as well as its dyadic nature in teens and young married individuals, the impact of these initial prevention efforts will likely be enhanced. As IPV prevention efforts grow, however, it will be important to adopt and adhere to an empirical orientation, and to stress the need to measure actual psychological, physical and sexual aggressive behaviors, not just assess change in attitudes.

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