Adolescent Dating Violence in Context

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The quality of our relationships lies at the heart of our health and well-being. The relationships we have with our romantic partners, our children, other family members, friends, coworkers, and even casual acquaintances shape our lives in profound ways. Romantic relationships are perhaps among the most central in shaping the contour of our lives. Violence, of course, severely undermines and, in many cases, can destroy these relationships that are so important to our health and well-being. Understanding and preventing adolescent dating violence (ADV) is critical because it represents the first outward manifestation of violence in the context of romantic relationships that a girl or boy directly experiences. As such, what we do as a society to address ADV sets the stage for the extent to which violence continues to be a part of teen romantic relationships as well as for future population levels of intimate partner violence Figure 1.

The Importance of Social Context

From a public health perspective, the ultimate goal is to advance programs and policies that are effective in reducing ADV at the population level. In service of this goal, the current theme issue includes five empirical studies that examine associations between family-, neighborhood-, and societal-level factors and ADV. Essential to having population impact are the use of interventions that alter the social context in which ADV develops. Interventions that address individual or personal characteristics (e.g., history of aggression or victimization, substance abuse, attitudes or beliefs) alone are unlikely to have population-level impact.[1] The experiences and attributes of individuals that contribute to ADV, however, are themselves socially conditioned. They are nested within and influenced by increasingly broader, "outer-level" social contexts, including the family, community, and society.[2,3]

Interventions that influence these broader social contexts, especially the community and societal levels, have several distinct advantages over those that focus on changing individual or personal characteristics. These advantages are well illustrated by the health impact pyramid developed by CDC Director Tom Frieden.[4] Programs or policies designed to address socioeconomic determinants (e.g., housing vouchers to reduce concentrated poverty) are at the base of the pyramid, followed by interventions designed to change the context for health (e.g., changing gender norms that promote violence); long-term protective interventions (e.g., early childhood interventions that promote safe, stable, and nurturing relationships between parents and children); clinical care (e.g., cognitive–behavioral therapy for victims of violence); and, finally, counseling and education (e.g., school-based programs to prevent violence). The interventions toward the base of the pyramid, typically policies implemented through laws or regulations, generally have greater population impact and require less individual effort.[4] Although it may be more difficult to evaluate the impact of these types of policy interventions using traditional rigorous evaluation designs (e.g., RCTs), which are typically used for interventions at the top of the pyramid, other designs are available that can be used to assess effects (e.g., interrupted time series).[5] The interventions at the top of the pyramid, typically interventions implemented through programmatic actions, are designed primarily to change individual behavior rather than have population impact. They have the potential to have population impact if "universally and effectively applied" or implemented as part of a comprehensive strategy, but, in practice, their reliance on sustained individual behavior change limits their potential impact.[4]

It's important to point out, however, that because these types of policy interventions at the top of the health impact pyramid may alter entrenched aspects of social structure and culture, they may also face greater political and social opposition.[4] Moreover, in the realm of violence prevention, laws are often more easily implemented than enforced.

The importance of understanding how the social context influences ADV is heightened by our desire to achieve population impact in reducing ADV. This theme issue sheds light on our understanding of this important relationship. In their systematic review of the association between neighborhood context and ADV, Johnson and colleagues[6] identify only 20 articles that examined this association. The limited availability of research in this

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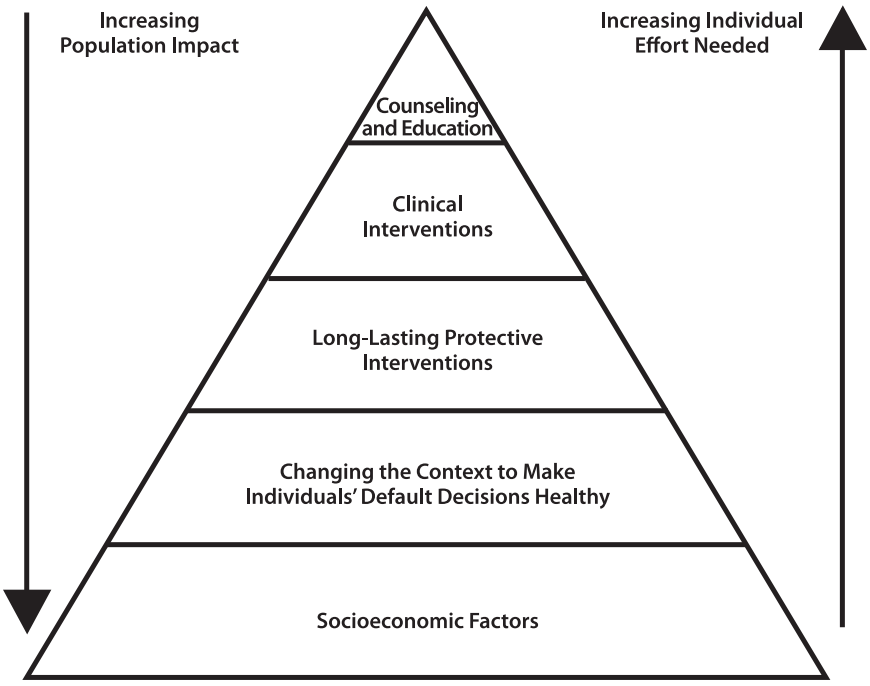

Figure 1. The health impact pyramid.
Note: Reprinted with permission from Frieden TR. A framework for public health action: the health impact pyramid. American Journal of Public Health 2010;100(4):590-595. Copyright American Public Health Association.

area constrains their ability to reach firm conclusions. Nevertheless, consistent with research on other forms of violence, they conclude that existing evidence supports that neighborhood disadvantage, as reflected by poverty, is associated with ADV; alcohol outlet density may be associated with dating violence among emerging adults; neighborhood disorder, as reflected by high levels of crime, may be associated with ADV perpetration; and that neighborhood social control of deviant behavior may be associated with lower levels of ADV perpetration. The authors also point out that most researchers that included neighborhood measures in their studies presented adjusted results. Consequently, in these studies, the true effects of these neighborhood characteristics could be attenuated by factors that intervene between them and ADV.

Gressard et al.[7] investigate the impact of another type of societal-level factor on ADV, namely, gender inequality, as reflected by state-level indicators. They find that the gender inequality index is associated with female physical ADV victimization at the state level. Interestingly, two components of their gender inequality index appear to account for the association of this index with ADV. The adolescent birth rate appears to be driving the association between the gender equality index and female physical ADV victimization, and the ratio of male/female educational attainment is strongly associated with female sexual ADV perpetration. It will be important to understand why these specific dimensions of the gender inequality index are associated with ADV.

Two other studies in this issue highlight how relationships between individual or family factors and ADV may vary by social context. Chang and colleagues[8] find that parental attachment is protective against physical ADV in residentially stable neighborhoods, but not in unstable ones. Similarly, Reyes et al.[9] find that the association between heavy alcohol and hard drug use and ADV was weaker in neighborhoods with high levels of social control. These findings, important in their own right, serve to emphasize more generally that we cannot assume that individual, family, and protective factors that have been identified for ADV will be similarly associated across all social contexts.

Implications for Prevention

The articles in this special issue raise a number of issues that have important implications for the future of ADV prevention.

First, we cannot ignore social context because there is sufficient evidence to indicate that our cultural and economic environment influences the population prevalence of ADV. Moreover, if we truly want to have population impact, modifying those aspects of the social context most highly associated with ADV will be essential.