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A Prevention Primer for Domestic Violence: Terminology, Tools, and the Public Health Approach

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In the past several decades, shelters and advocacy programs have proliferated throughout the United States to provide vital services to victims of domestic violence (DV) and their children. On a daily basis, DV advocates face the harsh reality that the number of women who experience DV far exceeds the availability of services, that women from diverse backgrounds face many barriers to accessing services, and that abuse has many long-term consequences. Consequently, advocates have expanded the scope of their work beyond direct victim services to include prevention. Advocates have been engaged in prevention through a wide range of activities including school-based curricula, community education, mass media campaigns, legal reform, and policy development.

Meanwhile, public health professionals have become increasingly aware that DV is a leading determinant of health and has a direct impact on most areas of service delivery ranging from reproductive health to injury prevention (Family Violence Prevention Fund, 2004). As a result, DV has been identified as a public health priority. The high prevalence of DV, the enormous cost to society, and the high rate of recidivism among perpetrators makes a strong case to focus on prevention. The public health approach emphasizes primary prevention and working with community partners to develop a coordinated response to violence (Graffunder, Noonan, Cox, & Wheaton, 2004).

The purpose of this paper is to provide an introduction to basic prevention concepts from a public health perspective. Following a brief outline of the public health approach to prevention, two classification systems for prevention are discussed along with examples of DV prevention strategies. These classification systems provide a framework to conceptualize how prevention can be designed to occur at different points in time (before, during, and even after an adverse event) to address different aspects of a problem and how strategies can be directed to different populations according to their levels of risk. A planning tool that can be used to develop more comprehensive prevention initiatives is introduced along with specific examples for preventing DV. The importance of understanding prevention terminology relative to grants and funding opportunities is emphasized throughout this paper, which concludes with an overview of a national partnership between public health and domestic violence coalitions that is supported through public health funding.

Finding Common Ground

It is important to acknowledge that prevention terminology and tools developed by public health practitioners will not be a perfect fit for DV. Public health has its roots in science and medicine and consequently places considerable emphasis on empirical evidence and structure. As part of the larger social justice issue of violence against women, DV brings together many disciplines and perspectives. Public health and DV practitioners have different philosophies and missions, and often use different terminology that can be confusing or even conflicting. Nevertheless, both of these fields have strong underpinnings in social equity. DV advocates are dedicated to ending social injustices against women. Public health is committed to reducing health disparities. Health disparities are factors that are associated with reduced access to health care and compromised health. DV, a well-documented barrier to health care, is associated with a myriad of health problems and health risk behaviors (Chamberlain, 2004). DV *is* a health disparity issue for adult victims and their children. The health disparities and social justice aspects of DV are inextricably interwoven, and this interface provides common ground for public health and DV practitioners to learn from one another and work together. The magnitude of DV as a social equity and public health problem, the limited

resources available to fund research, intervention, and prevention, and the potential for maximizing the effectiveness of prevention through collaborative leadership and teamwork provide the groundwork for promoting DV -public health partnerships.

A Public Health Approach to Prevention

Public health uses a systematic approach to prevention that has four basic steps as shown in Figure 1 (Lutzker, 2006). The first two steps of the public health approach to prevention are data-driven and research focused. In Step 1, surveys, surveillance systems, and other data collection methods are used to gather information that is used to describe the magnitude of the problem. In Step 2, more advanced research is conducted to identify the causes of a problem, factors that are associated with an increased risk of the problem occurring (risk factors), and protective factors that may prevent the problem from occurring. The information that is gathered during Steps 1 and 2 is applied during Step 3 to translate science into data-driven prevention strategies that are evaluated. Step 4 focuses on disseminating what has been learned and helping communities to adapt and implement proven prevention strategies.

Classifying Prevention Strategies

Two different systems for classifying prevention strategies are described below. The original classification system, referred to as the ìlevels of prevention,î categorizes a prevention strategy based on what point in time the intervention is implemented relative to when the problem occurs (Commission on Chronic Illness, 1957). This classification system has three levels of prevention: *primary, secondary, and tertiary* (Last & Wallace, 1992). The second classification system categorizes prevention strategies according to the population that is being designated for the intervention. For the purpose of this discussion, this classification system is referred to as the ìtargeted populationî approach. The three categories of prevention using this system are: *universal, selective, and indicated* (IOM, 1994). Grants and funding sources may explicitly state what types of prevention activities are eligible for funding. For example, the following statement appeared in a recent violence prevention grant announcement from the Centers for Disease Control and Prevention: ìonly proposals that evaluate a strategy, program, or policy that is focused on primary, not secondary prevention of perpetration of violence, and focuses on a target population that has not already engaged in the perpetration of violence will be considered responsiveÖî (U.S. Centers for Disease Control and Prevention, 2008). Because both of these classification systems are used in publications and grant proposals, sometimes simultaneously, it is important to understand the terminology.

Before the Problem Starts: Primary Prevention

The goal of primary prevention is to intervene before the health or social problem occurs by removing the cause or preventing the development of risk factors associated with the problem (Last & Wallace, 1992). A primary prevention strategy for DV is implemented before the violence ever occurs. To date, the vast majority of primary prevention initiatives for DV have involved some type of educational strategy which is often school-based. Safe Dates, an adolescent dating violence prevention program, is an example of an educational strategy that has been evaluated (Foshee et al., 1996; Foshee et al., 2000). Eighth and ninth graders who participated in Safe Dates reported less sexual and physical dating violence perpetration and victimization and the reduction in violence persisted four years after students had completed the program compared to students who did not receive the intervention (Foshee et al., 2004). The school-based, primary prevention strategies include a theater production performed by peers, a 10-session curriculum, and a poster contest (Foshee et al., 1998). The conceptual framework for Safe Dates is that changing norms associated with partner violence, decreasing gender stereotyping, and improving conflict management skills will prevent the perpetration of dating violence. It is important to note that primary prevention does not have to be limited to risk factors or problems that increase the risk of victimization or perpetration. Primary prevention strategies can focus on protective factors. In one study, parental monitoring reduced the likelihood of dating violence among African American girls and boys (Howard, Qiu, & Boekeloo , 2003).

In another study by Howard and colleagues (2005), having a stronger sense of self was protective against dating violence for Latina girls while spending weekly time with a mentor was protective for Latino boys. Culturally relevant, gender-specific prevention strategies for dating violence can promote development of the appropriate protective factors.

Once a Problem has Begun: Secondary Prevention

The goal of secondary prevention is to identify a risk factor or problem and take the necessary actions to eliminate the risk factors and the potential problem. While strategies at this point may sound more like intervention than prevention, the objective is to create opportunities to identify the problem before it becomes evident and to intervene as soon as possible to *prevent* the problem from occurring or progressing. Screening programs in the health care setting are an example of secondary prevention (Chrisler & Ferguson, 2006). By screening patients for DV, health care providers can offer support and referrals to patients who disclose abuse to reduce the likelihood of future victimization and prevent long-term health consequences. To date, there is very limited evidence to support the effectiveness of screening as a preventive measure. Two studies have shown that screening for DV and offering a wallet-sized referral card to patients who disclosed abuse was associated with reduced physical violence over time when compared to the level of violence disclosed at the time of screening (McFarlane, Soeken, & Wiist,2000; McFarlane, 2006). Home visitation services that are targeted to women with identified risk factors for DV is another example of secondary prevention. For example, the Nurse-Family Partnership home visitation program offers services to low-income pregnant women who are then screened for a wide range of risk factors, including DV. Women who disclose abuse receive additional support and referrals. Without this screening, home visitors may not become aware of the DV until much later when there is overt evidence of physical harm or the client chooses to self-disclose due to escalating violence. In one evaluation of the Nurse-Family Partnership, women who received home visits reported less DV two years after home visitation services had ended compared to women who did not receive home visits (Olds et al., 2004). Other examples of secondary prevention strategies for DV include self-defense training and community watch programs.

Responding Afterwards: Tertiary Prevention

Tertiary prevention occurs after the adverse event or illness has occurred and interventions are designed to minimize the impact and restore health, wellness, and/or safety as soon as possible (Chrisler & Ferguson, 2006). It is sometimes argued that tertiary prevention should not be called prevention because the violence has already happened. However, a rapid, coordinated response and follow-up can reduce the impact of victimization, and prevent predictable, long-term consequences and revictimization. Tertiary prevention for DV encompasses all of the services directed to survivors and perpetrators once the violence has occurred, and it is important for first responders and care-givers to understand that they can have a role in prevention when prompt, appropriate services and follow-up are provided. These services may address immediate needs such as medical care for physical injuries, restraining orders, safety planning, and shelter services, long-term needs such as trauma counseling, support groups, employment assistance, transitional housing, children's services, parenting after domestic violence initiatives, and strategies to enhance the quality, coordination, and access to victims' and batterers' intervention programs. Legal advocacy programs to help victims navigate the legal system are an example of tertiary prevention. An evaluation of a legal advocacy program in Washington, DC found that women who worked with legal advocates reported significantly less abuse six weeks after contact with the advocate (Bell & Goodman, 2001). Tertiary prevention strategies are not limited to first responders and service providers. For example, the Mentors in Violence Prevention (MVP), a college-based empowerment program to prevent gender violence that focuses on primary prevention, also has a tertiary level ìbystanderî component to empower friends and students to be proactive when they witness or become aware of abusive behaviors among their peers (www.sportinsociety.org/mvp/mvphome.html). The MVP initiative is an example of multi-level prevention as described in the next section.

Multi-Level Prevention

Prevention initiatives can address more than one level of prevention by integrating strategies that intervene for DV at different stages or points in time such as before the violence has occurred (primary prevention), during (secondary prevention), or after the violence has occurred (tertiary prevention). For example, ExpectRespect, a school-based program developed by SafePlace: Domestic Violence and Sexual Assault Survival Center (NRCDV, 2002) to promote safe and healthy relationships for youth, combines strategies to prevent relationship violence from ever occurring while also providing support to youth who have or are currently experiencing abuse. ExpectRespect's primary prevention strategies include classroom presentations to educate youth in grades 6-12 about dating violence, sexual assault, sexual harassment, and healthy relationships. It also has a summer teen leadership program that provides intensive training on social justice and violence prevention to teen leaders through a paid internship. Counseling and support groups are offered to students who are currently in abusive relationships and students who have already experienced sexual, dating, or domestic violence (secondary and tertiary prevention). For more information about ExpectRespect, go to www.safeplace.org.

A Different Approach to Classifying Prevention

While the classification system for the three levels of prevention *(primary, secondary, and tertiary*) seems fairly clear -cut, there can be considerable disagreement when actually classifying prevention strategies. As science has advanced our understanding about risk and protective factors and the complex relationship between these factors and health, a new classification system was developed (Gordon, 1983; 1987). Referred to as the ìtargeted populationî approach, this classification system categorizes prevention strategies by the group or population to whom the intervention is directed and for whom it is most likely to be beneficial (IOM, 1994). There are three categories for classifying prevention strategies using the ìtargeted populationî approach: *universal, selected* , and *indicated*. Knowledge about risk factors is needed to use this classification system. While a discussion of risk factors for DV is beyond the scope of this paper, a review of the literature on risk factors for physical partner abuse perpetration and victimization by Stith and colleagues (2004) provides a comprehensive overview on this topic. This different approach to classification (*universal, selected, and indicated*) and how these terms related to the three levels of prevention (*primary, secondary, and tertiary*) are described below.

Universal Prevention: Everyone Will Benefit

Universal preventive measures are targeted to the general public, or all members of a specific group such as young boys or all adolescents, to reduce the likelihood of a problem ever occurring (IOM, 1994). The population is identified on the basis that the prevention strategy will benefit everyone in that group versus on the basis of a risk factor or problem. An example of a universal preventive strategy for DV is the Family Violence Prevention Fund's ìCoaching Boys Into Menî initiative. This public education campaign is directed to all men based on the belief that encouraging men to teach boys about healthy relationships and respecting women will benefit all boys. This campaign employs a wide array of strategies including public service announcements (PSAs), posters, awareness materials, leadership development, an interactive website, and event sponsorship with national sports and media figures who speak out on violence against women (www.endabuse.org). Over a four-year period during which the PSAs were aired, the percentage of men who had actually taken action and spoken to boys about violence against women increased from 29% to 41% (RMA Inc, 2005).

Selective Prevention: People at Higher Risk than Average

Selective preventive measures are directed to individuals or groups that have an above average risk of developing a problem (IOM, 1994). The Youth Relationship Project is an example of a selective preventive measure (Wolfe et al., 2003). This project recruits youth, ages 14-16, with a history of maltreatment to participate in classroom sessions designed to reduce gender-based violence. This intervention offers education on healthy relationships, conflict resolution and communication skills, and social action activities. Youth who received the intervention reported a significant reduction in perpetrating physical and emotional abuse against a dating partner over time.

Indicated Prevention: People with Early, Detectable Signs of the Problem

Indicated prevention strategies are directed to high-risk individuals or groups that have minimal but detectable signs of the problem (IOM, 1994). For example, indicated preventive measures could be directed to women who disclose early signs of emotional abuse in a relationship, immigrant women who are not allowed to apply for citizenship, and teens whose dating partners are tracking them by cell phone. Any identifiable risk factor or condition that makes it highly likely that these individuals are experiencing or perpetrating DV would constitute a population that is eligible for an indicated prevention measure. In a school-based survey of Latino youth, teens who reported recent fearful dating experiences reported less knowledge about abuse and less endorsement of nonviolent attitudes (Ulloa, Jaycox, Marshall, & Collins, 2004). Teens who disclosed fearful dating experiences could be identified as the population for an indicated prevention measure and be offered a culturally relevant intervention to enhance their knowledge about abuse and healthy relationships, improve their communication skills, and change their attitudes towards violence.

Making the Connection

As previously mentioned, terminology from both the ìlevels of preventionî and the ìtargeted populationî classification systems can be used to describe the same prevention strategy so it is useful to understand how the two systems are related to one another. While caution must be advised in making such broad generalizations, universal preventive measures are usually primary prevention strategies. For example, the Coaching Boys into Men initiative is a primary prevention strategy that is also a universal preventive measure since it is directed to all young boys. Selective prevention measures typically focus on secondary prevention strategies while indicated prevention measures usually involve tertiary prevention strategies directed to high-risk groups.

The classification systems described above illustrates how there are different approaches to prevention. The following section describes a tool that helps practitioners to recognize that there are many pathways to prevention. This tool facilitates planning and coordination of multi-level strategies that comprehensively address the problem to maximize our prevention potential.

Developing a Comprehensive Approach: The Spectrum of Prevention

Public health promotes multifaceted prevention strategies that address individual risk factors within the larger context of the sociocultural environment (Schewe, 2002). The Spectrum of Prevention provides a framework for developing comprehensive prevention initiatives (Cohen et al., 2003). The spectrum has six action levels as shown in Figure 2 (Cohen & Swift, 1999). The levels are not hierarchal or mutually exclusive -- that is to say that one level is not considered more effective than another and the levels are designed to overlap because they are inter-related. The relationship between the levels is synergistic and the potential for prevention is maximized by strengthening the linkages between the levels with multiple, complimentary strategies. When used as a planning tool, the spectrum promotes a systems approach that helps practitioners move beyond educational strategies to develop broader initiatives that address institutional practices (level 5) and policy development and legal reform (level 6). Reducing childhood exposure to violence against women in the media as a prevention strategy for DV is shown below as an example of how the spectrum can be used (see Figure 2).

Level of Spectrum	**Definition of Level**	**DV Example**
1. Strengthening Individual Knowledge and Skills	Enhancing an individual's capacity to prevent a problem and promote safety	Integrate information on media violence into parenting curricula, including strategies for reducing children's exposure to violence against women in the media and skills to talk to children about violence against women in the media
2. Promoting Community Education	Reaching groups of people with information and resources to promote health and safety	Develop mass media campaigns on the documented effects of media violence on children Develop a peer-to-peer teen program for kids to talk about violence in the media

3. Educating Providers	Informing providers who will transmit skills and knowledge to others	Training for day-care providers and preschool teachers on reducing childhood exposure to violent media and how to talk to parents about this
4. Fostering Coalitions and Networks	Bringing together groups and individuals for broader goals and greater impact	Network with researchers conducting studies on exposure to violent media to evaluate how violence against women in the media affects children's attitudes, beliefs, and behaviors Form coalitions with medical associations that have issued statements on media violence to specifically address violence against women in the media in their recommendations
5. Changing Organizational Practices	Adopting regulations and shaping norms to improve health and safety	Work with schools to evaluate all media available in the classroom and remove media that is violent and denigrating to women
6. Influencing Policy and Legislation	Developing strategies to change laws and policies to influence outcomes	Lobby for regulation of violence against women in advertising and the media Strengthen policies on media ratings so that violence against women is not rated as acceptable content

Figure 2. Spectrum of Prevention (Cohen et al., 2003)

The Spectrum of Prevention does not directly address all of the issues or possible levels that may need to be considered in DV prevention initiatives but practitioners can adapt or modify the tool as needed to be more responsive. For example, issues on cultural sensitivity may need to be a separate action step to ensure that this issue is systematically addressed in a comprehensive DV prevention initiative. When designing prevention strategies or evaluating what is missing in their prevention agenda, advocates can use this tool to explore opportunities at each action level and add other levels as needed to develop a culturally relevant, comprehensive approach.

Building Public Health-Advocacy Partnerships

As previously noted, public health prioritizes primary prevention and working collaboratively with community partners. The U. S. Centers for Disease Control and Prevention (CDC) have partnered with domestic violence coalitions in fourteen states on a prevention initiative called DELTA (Domestic Violence Prevention Enhancements and Leadership Through Alliances). DELTA focuses on three key areas of violence prevention: leadership, capacity building, and partnership (Graffunder et al., 2004). Funded coalitions have created interdisciplinary work groups that are engaged in a wide range of activities which includes conducting needs assessments that will provide national baseline data on DV prevention activities, collecting and disseminating information on new prevention models, and providing education, technical assistance, and funding to evaluate DV prevention through local initiatives called coordinated community responses (CCRs). The DELTA initiative, which focuses on primary prevention, uses a social ecological model that identifies four levels of factors that can contribute to DV: individual, relationship, community, and society. By identifying risk and protective factors associated with these four levels, communities can then identify new pathways and comprehensive strategies that address prevention at all four levels. Lessons learned during this initiative will provide insight on collaborative opportunities and the challenges of integrating the diverse philosophies and practices of DV advocates and public health practitioners. More information about DELTA and the social ecological model can be found at www.cdc.gov/ncipc/DELTA.

Conclusion

The expertise of DV advocates and service providers is essential to develop safe and effective prevention strategies. The field of public health provides a systematic approach that prioritizes primary prevention, provides terminology to categorize strategies and tools to develop comprehensive initiatives, and promotes community-based partnerships. DELTA is an important step forward for comprehensive, primary prevention initiatives developed through the collective efforts of domestic violence and public health practitioners and other community partners.

There are many challenges and opportunities for collaborative approaches to DV prevention. The public health model, which has traditionally focused on diseases, must be adapted to accommodate complex social issues such as

DV. There are important lessons that have been learned from the public health approach that are transferable. The advantage of designing comprehensive prevention initiatives that address many different aspects of a problem is applicable to DV. To date, primary prevention for DV has focused almost exclusively on educational strategies, which limits our prevention potential. Another lesson learned in the field of public health is the importance of integrating evaluation into prevention to obtain the necessary data to determine and compare the effectiveness of different strategies. As government agencies and foundations place more and more emphasis on evidence-based practices, collecting and using evaluation data has become essential to compete for funding. Unfortunately, only a few preventive strategies for DV have been rigorously evaluated. These challenges should be viewed as opportunities for DV and public health practitioners to work together to adapt public health resources to address DV, to enhance the scope and evaluate the effectiveness prevention initiatives, and to advocate for more prevention funding.

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Suggested Citation: Chamberlain, L. (2008, March). *A prevention primer for domestic violence: Terminology, tools, and the public health approach*. Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence. Retrieved month/day/year, from: http://www.vawnet.org

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* The production and dissemination of this publication was supported by Cooperative Agreement Number U1V/CCU324010-03 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC, VAWnet, or the Pennsylvania Coalition Against Domestic Violence."