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An Integrated Framework for In-School Teen Dating Violence Program Evaluation

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## Abstract

### An Integrated Framework for In-School Teen Dating Violence Program Evaluation By Amelia F. Stagg

This study develops and demonstrates the use of an integrated framework for evaluating in-school teen dating violence prevention programs. Teen dating violence (TDV) is a public health concern that impacts 1 in 3 adolescents. However, research has shown that in-school prevention programs can lower rates of victimization and perpetration. Additionally, 22 states have implemented laws that mandate schools teach students about dating violence. Despite research and policy, it is unclear if or to what extent schools are implementing these programs. Therefore, the aim of this research was to develop a process for evaluation that could be used in a variety of settings and contexts.

Using insights from public health, public policy, and education, this project argues for thoughtful, practical evaluation of current TDV programs in order to improve prevention efforts. The framework for this process consists of Evaluation Development, Evaluation and Assessment. An evaluation with 7 critical components of effective TDV programs is developed through reviewing public health literature and public policy at a national, state, and local level. To demonstrate the evaluation in action, this project assesses 4 high schools in Peoria, IL. Drawing on course material, teacher interviews, and discussions with community organizers, this study identifies critical areas of need and facilitating factors for success in Peoria, IL. These insights can inform future action in Peoria, IL, and in other communities. Further research could apply this framework on a larger scale to assess statistical correlates of effective programs, or on a smaller scale to gain specialized insight into a specific program.

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## **Lily's Story**

Lily met Shawn at a friend's fall cookout celebrating the beginning of our senior year in high school. A short first encounter soon blossomed into Lily's first serious relationship, and she was immediately enamored by Shawn's frequent displays of affection. Shawn visited Lily whenever he could, even sneaking through windows when her parents were asleep to squeeze in time together. When they were apart, Lily would receive thoughtful letters from him that she would save in a box on her desk, envelope and all. The barrage of romantic gestures disguised Shawn's abusive tactics that began to strangle all aspects of Lily's life, making it difficult to parse out the warning signs. He was possessive, making her feel guilty for wanting to spend time with friends and family. He was manipulative, calling her phone in class repeatedly until she would step out in the hallway to answer him. Kind words of adoration quickly turned to disparaging remarks that made Lily question her sense of self and worth. As their relationship progressed, emotional and psychological abuse became a daily part of Lily's life that left her feeling paralyzed in the landmine of Shawn's unpredictability.

During this time, I remember having many conversations with Lily about her relationship with Shawn. Often, her vague descriptions of the trauma she faced were followed by a nonchalant dismissal of his abuse. "You know how guys are," she'd say. "Every relationship has its problems," I'd nod in agreement. When details of the abuse became more concrete, I struggled with knowing what steps to take. I was afraid of retaliation from him if I spoke up, or that she would withdraw even more from our friendship. When I finally was able to sit down with her alone after weeks



of rescheduling, I expressed my worry that their relationship was unhealthy. She explained that she wasn't being *abused* – he had never hit her before. Her response earned an undue sigh of relief from me, as I thought of abuse in terms of stereotypical images evoking black eyes and split lips.

Years later, when I talk with Lily about Shawn, everything seems so obvious and overlooked. Their relationship was a textbook example of teen dating violence (TDV), with escalating episodes of abuse in between periods of him begging for forgiveness and showering her with gifts (Coleman, 1997). After each of his outbursts, he would promise that it would never happen again, sometimes insisting that his abuse was her fault in the first place. Yet, true to the literature on TDV, the violence worsened over time, transitioning from verbal threats and psychological manipulations into physical abuse, property damaging, and stalking. Like many people in abusive relationships, Lily feared leaving him even though the abuse worsened, afraid of what he'd do when he had nothing left to lose. Indeed, her fears were not unfounded. As she carried her belongings from his house to her car, intending to leave him for good, Shawn threw a brick through her front windshield and assaulted her in the street. After this, Lily obtained a restraining order, and has not seen Shawn since.

### **Introduction**

Lily's story is close to me, and the details feel painfully, personally unique. However, her experience of TDV is not a rare phenomenon. TDV is a pervasive public health concern, impacting 1 in 3 adolescents nationwide (Arriaga & Foshee, 2004). The consequences of TDV are significant – experiencing abuse as a teen is associated

with substance abuse, depression, unintended pregnancy and low self-esteem (Ackard, Neumark-Sztainer & Hannan, 2002; Silverman, Raj, Mucci & Hathaway, 2001). Additionally, TDV victimization is correlated with adult intimate partner violence (IPV) victimization, suggesting that early abuse experiences can feed into a greater lifetime cycle of abuse (Exner-Cortens, Eckenrode, & Rothman, 2013; Arriaga & Foshee, 2004). While adult IPV has earned significant attention through awareness efforts and public health advocacy, the issue of TDV has historically been overlooked (Ackard et al., 2002). Dating violence was assumed to occur only in adult relationships, as researchers underestimated the frequency and seriousness of adolescent dating. However, statistics obtained since the late 1990's indicate that adolescents are dating. In a survey of four diverse U.S. cities, over half of 6<sup>th</sup> graders reported dating behaviors in the past 3 months (Simon, Gorman-Smith, Orpinas, & Sullivan, 2010). Additional research has shown the average age that adolescents first experience dating violence is only 15 years old (Arriaga & Foshee, 2004). With adolescents forming intimate relationships at an early age, and engaging in intimate violence at an early age, it is clear that IPV prevention efforts aimed at adults simply come too late.

The widespread, debilitating nature of TDV can seem overwhelming in terms of prevention and intervention. However, there is hope for improvement in school-based interventions. Generally, TDV prevention has been left to the community outreach sector; however, newer research is supporting broader implementation of school-based education (Mulford & Blachman-Demner, 2013). Indeed, according to the World Health Organization (WHO), school-based programs are the only TDV interventions that can be deemed empirically effective (Mulford & Blachman-Demner, 2013). In-school

intervention programs have been shown to reduce perpetration rates, as well as impact dating attitudes connected to relationship violence (De Koker, Mathews, Zuch, Bastien & Mason-Jones, 2014; Foshee, Bauman, Arriaga, Helms, Koch & Linder, 1998). The power in having these intervention programs in school, as opposed to general community outreach, lies in a school's ability to reach students within their peer groups and integrate key adult role models (De Koker et al., 2014; Weisz & Black, 2009). Beyond the studied benefits of school-based programs that support widespread inclusion of TDV education, schools have an inherent responsibility to teach such curricula, as well as to implement TDV specific policies (Carlson, 2003; Peace Over Violence, 2008).

Only within the past thirty years has TDV been formally recognized as a legitimate concern in the United States (Ackard et al., 2002). Prior to the 1980s, TDV statistics were not being collected, impeding progress in identifying the scope of the issue and prevention measures needed (Ackard et al., 2002). However, in the past fifteen years TDV education has made considerable progress in terms of research, legislation, and measurement related to TDV (Ackard et al., 2003; Mulford & Blachman-Demner, 2013). Currently, federal laws such as the SMART Teen Dating Violence Prevention and Awareness Act (2013) and state-level TDV education legislation in almost half the country demonstrate that the nation is increasingly supporting educating teens on healthy relationships (National Conference of State Legislatures, 2015).

While the mere presence of legislation that recognizes the need for TDV education is promising, a critical analysis of this policy is important in order to

adequately assess school-level progress (Carlson, 2003). For example, a policy that merely encourages TDV curricula without detailing what constitutes an effective implementation is unhelpful from a measurement and evaluation standpoint. Additionally, a policy that encourages TDV curricula without requiring accountability for such a program can seem like a mere suggestion. Analysis of policy can also identify gaps in existing legislation and reveal what characteristics are associated with success (Carlson, 2003).

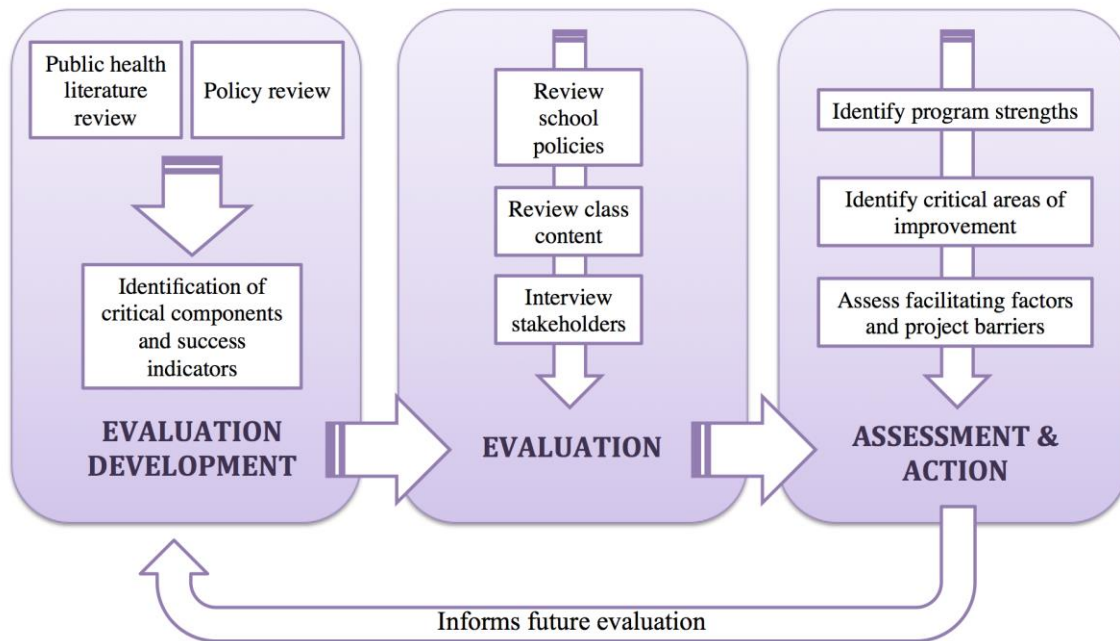
As important as the policies is the research that informs them. While the field of public health has established some best practices for TDV implementation, there is little evidence into how these practices are being implemented at a school system level. Previous research, although consistent in identifying key components of successful programs, has generally focused on evaluating program performance in a single school (De Koker et al., 2014). While this type of analysis has given considerable insight into best practices for TDV education, it does not represent everyday practices of educators. Representing the experiences of teachers attempting to implement TDV education is essential to understanding the facilitating factors and obstacles of prevention (Buston, Wight, Hart & Scott, 2002). Furthermore, as primary stakeholders, teachers' insights are necessary to include in research that contributes to educational policy.

The current state of TDV education has been impacted by both political and public health influences. However, often these fields have contributed to TDV education in isolation of one another. Political push for TDV education often occurs in response to publicized tragedies, also known as focusing events (Weisberg,

2013). Public health research on TDV is largely informed by previous research indicating alarming TDV prevalence, connecting these rates to negative impacts of TDV victimization across an individual's lifespan (Banyard & Cross, 2008; Wekerle & Wolfe, 1999). There is common ground between these arenas in a shared vision for TDV prevention. Yet, the nuances in motivation and methodology are critical to parse out since slight differences can lead to gaps in implementation and measurement of such programs. Indeed, statistical measurement of the issue's scope, as well as empirically evaluated prevention programs, is scarce (Mulford & Blachman-Demner, 2013; Simon et al., 2010).

In order to address the research gap between policies, prevention programs, and ground-level practices, this study proposes a framework for implementation evaluation of TDV school programs (see Figure 1). The framework emphasizes knowledge integration from public health and public policy to identify critical categories for effective programming (Chapters 1 and 2). Contributions from these fields are incorporated into an evaluation that provides an overview of a school's implementation of these critical categories (Chapters 3 and 4). Currently, there is no framework for conducting interdisciplinary evaluation in regards to school-based TDV programs. With a generalized framework for implementation evaluation, foundational understandings of the existing field are practically strengthened, forging an understandable entry point for conversation across disciplines.

**Figure 1: An Integrated Framework for In-school TDV Program Assessment**



To illustrate the utility and impact of such a framework, this study considers the current state of TDV education within one metro area. Using the city of Peoria, IL, often referred to as “the average American city” this project demonstrates how policy analysis, public health insights, and teacher perspectives can create an interdisciplinary dialogue that gives insight into barriers and facilitating factors for progress (Forbes, 2014). The primary aim of this research was to demonstrate a process for developing an individualized TDV evaluation based on current public health literature and policies specific to the schools assessed. Additionally, this research aimed to outline what components of TDV programming are currently in place, and how well these components are informed by critical research. I argue that an integrated, targeted evaluation framework is necessary for uncovering localized needs and areas for improvement, as well as for creating a pathway to engage in cross regional comparisons. Using this

framework to assess Peoria, I identified the need for widespread staff training and improved school policies as critical areas for improvement. I identified the structure and content of TDV education as primary strengths of Peoria schools' programs.

While this study does not aim to extrapolate the state of Peoria's TDV education to the state of American TDV education in general, this research does put forward a repeatable evaluation approach that can be applied to any school system's TDV education programs. Having a repeatable evaluation process that can yield insight into strengths and weaknesses is a crucial step forward in expanding TDV education in a well-informed, effective manner. Having evidence that TDV education can be employed effectively in any school district is necessary now more than ever, as TDV education can be seen as a point of controversy in today's conservative political climate. TDV education often falls into the category of comprehensive sex education, a perhaps ill-fitting distinction that leaves it vulnerable to attack in the new Republican administration (Weisz & Black, 2009). United States Secretary of Education, Betsy DeVos, is poised to have a significant impact on the direction of sex education and has previously supported groups advocating against comprehensive programs (Stanton, 2017). Generally, the most relevant progress to TDV education has occurred on a state or local level, however, keeping the national political climate in mind is useful for thoughtful future recommendations (Carlson, 2003).

### **Chapter 1: Insights from Public Health**

The first step in my framework for developing a general implementation evaluation is to review public health research on TDV and identify which components of TDV education are considered critical to prevention by the field. TDV

can be considered the youth form of IPV, which is often still referred to by the outdated term domestic violence. While partner violence is often thought of as a social phenomena, or even a personal problem, the evidence on concerning prevalence, connection to negative health outcomes, and prevention possibilities clearly categorizes IPV as a public health concern (Mann, Gostin, Gruskin, Brennan, Lazzarini & Fineberg, 1995). TDV has faced even greater challenges in being established as a public health concern, with adolescent dating often dismissed as too immature or nonexistent to face issues of violence (Werkerle & Wolfe, 1999). Increasing recognition of TDV in the field of public health since the late 1990s has led to research that indicates school-based education as the most effective form of TDV prevention. Therefore, for TDV education the field of public health has been most important in terms of measurement and program development.

In this section, I outline the contributions the field of public health has made in defining the issue of TDV and developing TDV interventions. I assess how the nature of TDV, in logistical and theoretical terms, calls for school based interventions as opposed to other preventative measures. By giving an overview of prominent studies and facilitator viewpoints, I identify the key characteristics of effective TDV education. This discussion puts forward that TDV significantly benefits from public health research, but is hindered by the few number of empirical studies on TDV education. This public health overview will provide evidence for determining the best practices in TDV education to evaluate practices in Peoria, IL.

#### *A Brief Overview of TDV*

In order to contextualize the methods and results of TDV intervention



research, it is important to understand what TDV is, and how it impacts youth. Teen dating violence encompasses an array of unhealthy dating behaviors, and can include physical, emotional, sexual, and verbal abuse (CDC, 2016a; Mulford & Blachman-Demner, 2013). Physical and sexual abuses have historically received the most attention, as these forms of violence can be more severe, or at least more visible (Werkele & Wolfe, 1999). However, expanded definitions recognize that emotional and verbal abuse can be just as damaging to an adolescents' life, and are often more challenging to detect (CDC, 2016a). Emotional abuse, such as name calling or isolating a partner from family and friends, can be a precursor to physical violence or can exist alone within an unhealthy relationship (Werkerle & Wolfe, 1999). To reflect cultural shifts in technology usage, public health researchers are also now considering cyberstalking and cyber abuse to be included within TDV (Zweig, Dank, Lachman, & Yahner, 2013).

Nationwide, TDV is estimated to impact 1 in 3 adolescents (Arriaga & Foshee, 2004). More than 1 in 10 girls reported experiencing physical violence from a romantic partner in the previous 12 months, and 15.6% reported sexual dating violence (CDC, 2016a). Relationship abuse occurs at similar rates amongst teen girls and boys, although girls are more likely to experience severe violence or sexual violence (Ackard et al., 2002; Exner-Cortens et al., 2013; Werkele & Wolfe, 1999). The prevalence of TDV amongst all teens is notable as it justifies providing TDV education to all youth, not just girls. Therefore, TDV should not be thought of as solely a women's issue. The lack of significant differences between male and female TDV victimization is notable, since research on adult IPV has revealed consistent

gender differences in victimization (Werkerle & Wolfe, 1999). Rates of TDV haven't changed significantly since the late 1990s, perhaps demonstrating a lack of prevention success or attention to the issue (CDC, 2016c; Wechsler, 2011).

TDV is associated with a wide range of negative health outcomes beyond the experience of violence itself, including increased risk of smoking, truancy, and future abuse victimization (Banyard & Cross, 2008; De Koker et al., 2014; Exner-Cortens et al, 2013). Adolescents who have experienced TDV are twice as likely to report a suicide attempt, with 64% of victims reporting feelings of depression (Davis, 2008). TDV has also been linked to unintended pregnancy as both an outcome of abuse and a form of it, such as in reproductive coercion (CDC, 2016a; De Koker et al., 2014). Beyond consequences for the victim, TDV contributes to the broader financial burden of IPV, which costs America upwards of \$8.3 billion annually (CDC, 2003). These correlations clearly connect TDV to broader issues of personal health that can last far beyond adolescence.

### *Prevention Challenges*

TDV is especially challenging to address from a prevention standpoint due its intimate, sensitive nature that can impede help seeking from victims or open discussion of it by parents (Ashley & Foshee, 2005; Arriaga & Foshee, 2004). Of TDV victims, only 40% report seeking help, and the overwhelming majority of help seekers turn to a friend (Ashley & Foshee, 2005; Black, Tolman, Callahan, Saunders & Weisz, 2008). While peers are well suited to provide social support, youth may be under informed on available resources or appropriate advice to give victimized friends (Black et al., 2008). Further complicating the roles of parents and peers, TDV

victimization is connected to unhealthy perceived dating norms and observational learning from these groups (Arriaga & Foshee, 2004; Wekerle & Wolfe, 1999). Such research indicates that TDV may be a socially learned/modeled behavior, and this premise is supported by positive results from interventions that use Social Cognitive Theory (SCT) to reduce incidence (Taylor, Stein, Mumford, & Woods, 2013, Werkele & Wolfe, 1999).

Additionally, challenges to teaching teens about healthy relationships and dating violence can stem from parents. As issues around dating and sex can become entangled in issues of personal values, some parents may feel that teaching teens about dating is an inappropriate topic for schools to address (Weisz & Black, 2009). Instead, parents may feel this is an issue better discussed within the family. While personal agency in childrearing and instilling values is important, research shows that parents are often uninformed on the warning signs of dating violence (Weisburg, 2013). Parents may also neglect to have the discussion due to potential discomfort with the topic. Some parents may not discuss the issue because they do not believe their teens are dating, despite evidence that most teens do date in some respect (Simon et al., 2009). Finally, parents may be involved in unhealthy or abusive relationships themselves, preventing opening dialogue. With these considerations in mind, it is unfair to assume that parents will or can have this discussion with their children. While some parents may so do, implementing TDV education in schools better ensures teens receive the information.

#### *Learning from Experience: Past Examples of Successful Prevention*

The history of empirically evaluated TDV education programs can be traced back

to the first trial of the *Safe Dates* intervention, proposed by Foshee et al. and published in 1998. In this foundational program, Foshee et al. assigned 14 North Carolina public schools either a treatment or control condition to assess effects of the *Safe Dates* program on perpetration and victimization (Foshee et al., 1998). The results of this study indicate that TDV education has promising potential for reducing TDV incidence. At follow-up, there were lower rates of psychological abuse and sexual violence perpetration amongst the treatment group than the control group (Foshee et al., 1998). Additionally, Foshee et al. (1998) found that the treatment program positively impacted adolescents' ability to identify victim services and recognize harmful dating violence norms. *Safe Dates* has served as a hallmark case of the impacts TDV education can have in reducing dating violence, and the study design has been replicated with a variety of other programs.

An evaluation of *Safe Dates* and five other TDV prevention programs revealed that the most successful programs are implemented in more than one setting, for more than one session, and utilize key adults (De Koker et al., 2014). In this review, the two programs yielding the greatest reduction in TDV were *Shifting Boundaries* and *Safe Dates*. *Shifting Boundaries* taught students both on an individual level, and a community level through a safe/unsafe school 'mapping' project and showed improvements in self-reported healthy dating behaviors (Taylor et al., 2013). *Safe Dates* emphasized understanding dating violence norms and building conflict-management skills (Foshee et al., 1999). Effective program content strengthens students' abilities to identify warning signs of TDV and seek help if they are experiencing TDV (De Koker et al., 2014). Both interventions explicitly utilized social

learning theory, in addition to theory of reasoned action and feminist theory (De Koker et al., 2014; Foshee et al., 1999; Taylor et al., 2013). *Shifting Boundaries* and *Safe Dates* consisted of six sessions and ten sessions respectively (Foshee et al., 1998; Taylor et al., 2013). The broader review determined these two program lengths as effective (De Koker et al., 2014). While a prime program length was not identified, community practitioners have agreed that multiple sessions are most effective (Weisz & Black, 2009).

There is value in looking to successful programs for guidance, but there is also value in understanding the shortfalls of ineffective programs. Weisz & Black's 2009 interviews of 61 TDV education facilitators indicated short program length, lack of cooperation from school/school systems, and lecture based presentations as the most common barriers to effective prevention (Weisz & Black, 2009). In the previously mentioned review of six TDV interventions, the programs of shorter length with a curriculum-only focus failed to produce any impact on perpetration or victimization (De Koker et al., 2014). An additional struggle in TDV education is the overall lack of empirically evaluated programs, as well as the lack of appropriate measurement of program results (De Koker et al., 2014; Simon et al., 2010). The lack of empirically evaluated programs or holistically evaluated programs could be the result of a lack of attention to the issue of TDV. Additionally, lack of formal research could be related to the origins of TDV intervention as a community driven, advocacy-oriented field as opposed to an area of public health concern (Weisz & Black, 2009).

Since the origins of TDV education are in advocacy-based efforts, it is important to emphasize the appropriateness of considering TDV to be a public health issue, as

opposed to merely a ‘social ill.’ Advocacy groups ranging from key national non-profits such as Love is Respect to extremely localized women’s centers still play a critical part in providing TDV education and fueling awareness initiatives (Weisz & Black, 2009). Indeed, without specialized training of teachers on TDV, these advocacy groups are well suited to step in and provide TDV education themselves. However, the consequences of seeing TDV as only social problem and therefore tackling it with socially oriented groups include a lack of formal evaluation, a lack of empirically tested programs, and inconsistency in ideological frameworks (Weisz & Black, 2009; Wekerle & Wolfe, 1999). By considering TDV to be a public health concern, in addition to a social concern, the field is benefitted by structured evaluation and research funding<sup>1</sup>. In turn, the public health population based approach tracks strategy and data in a manner better suited to identify best practices and progress over time (Mulford & Blachman-Demner, 2013). Placing TDV within a public health framework can also result in the field being taken more seriously in a political climate where social justice efforts and ‘women’s issues’ can be cast aside as non-essential, or even antagonistic. Despite the relevance and value that a public health lens brings to this issue, local public health agencies are not a primary source of community programming (CDC, 2014).

### *Why Schools?*

With TDV education established as a concern of public health, there remains the question of why such education should take place in schools. Later I’ll delve into the political implications, and the political responsibility, of including TDV education within school curricula. Yet, there is also support from the public health field. A commonly

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<sup>1</sup> Consider other issues, like drug addiction, obesity, and racism, that can fall into either category of ‘social issue’ or ‘public health concern’. By including these issues under public health, although are indeed social issues and have social implications, these issues receive more appropriate institutional attention.

cited reason for reaching youth in school settings includes the ability to reach all youth at once within their critical, formative peer groups (Arriaga & Foshee, 2004; Weisz & Black, 2009). Within schools, there are also structural benefits, such as the ability to involve key adults like teachers and coaches in the conversation (Werkele & Wolfe, 1999). Since TDV has been connected to shared norms and beliefs about acceptable dating behaviors, and since peers are heavily influential in perpetuating these beliefs, the school setting provides an opportunity to directly intervene in unhealthy discourse (Black et al., 2008; Werkele & Wolfe, 1999).

Alternatives to the school setting, such as presentations at community gatherings (like at a local church) or targeting at-risk youth specifically, are not preferred by community practitioners or recommended by leading health organizations like the CDC (CDC [1], Weisz & Black, 2009). Although the school setting is the most recommended, and has been considered the ‘natural’ setting for such interventions, there are some basic shortfalls worth mentioning. Education is not necessarily universal, and a school-based directive does not readily reach truant youth, students who have dropped out of school, homeschooled youth, or youth in the criminal justice system. The school setting can also create challenges in logistical planning, since schools often run on a tight schedule with little curricular time to cater to multi-session programming recommendations (Weisz & Black, 2009). Unless TDV education is a well-established concern of the school system, teachers and administrators may be under informed on how to handle sensitive issues of TDV without targeted training that emphasizes a unified response (Taylor et al., 2013; Weisz & Black, 2009).

### *Theory Behind Successful Intervention*

Beyond research identifying the practical strengths of school settings, and key structural components of successful programs, the field of public health has established critical theories for effective TDV education. The theories informing prevention efforts are foundationally related to three major theories describing TDV origins: social learning theory, attachment theory, and feminist theory. As previously mentioned, TDV is often considered to result through observational or social learning, known as the social learning theory (SLT). Indeed, SLT is currently thought of as critical explanation of TDV perpetration (Arriaga & Foshee, 2004). SLT proposes that teens learn to be violent through witnessing positive results that violence yields in relationships modeled by peers, close adults, or the media (Arriaga & Foshee, 2004; Werkele & Wolfe, 1999). Positive results, or consequences, in the case of TDV include a perceived gaining of control through violence and a false association of violence with intimacy (Werkele & Wolfe, 1999). The attachment theory explanation of TDV applies to both perpetrators and victims, and asserts a connection between previous relationships and future relationships (Werkele & Wolfe, 1999). Attachment theory argues that peers tend to choose partners that fit their ideas of what relationships should be, and having dysfunctional parental or peer relationships can lead to dysfunctional romantic relationships (Bell & Naugle, 2008; Werkele & Wolfe, 1999).

Finally, feminist theory is used to explain TDV by proposing that relationship violence is connected to gender, gender socialization, and gender norms (Bell & Naugle, 2008; De Koker et al., 2014). However, the relationship between feminist theory and TDV is complicated, and influences strategy of prevention more so than explains



epistemology of the issue. Feminist theory is well-suited to explain adult intimate partner violence, which is generally understood to exist within a system of power wherein women are overwhelmingly the victims (Werkele & Wolfe, 1999). Feminist theory, in this case, illustrates how systems of inequality that oppress can exist within intimate relationships to control women. In contrast, with TDV there is much less of a gender gap in victimizations. Therefore, gender may play less of a role in TDV, and feminist theory may be less helpful as an explanation (Werkele & Wolfe, 1999). However, research that shows strict gender norms are connected to increased risk of abuse indicates that feminist theory is still beneficial to consider and incorporate in prevention efforts (De Koker et al., 2014).

Although these theories have weaknesses that do not allow for a full theoretical explanation of TDV, they are extremely useful in developing effective interventions. Acknowledging SLT as a cause of TDV signals a need for a social-cognitive intervention approach. Insights from attachment theory highlight the need to address dysfunctional relationship models. Contributions from feminist theory call on programs to carefully consider how gender is addressed within their content. It is no surprise, then, that community practitioners have emphasized shifting social norms about dating and debunking common myths on TDV as critical components of their content (Weisz & Black, 2009). These components of curricula play into social cognitive theory (SCT) of intervention, which considers the power of culture in impacting health-oriented behavioral change (Bandura, 2004). SCT has been found to be a critical component of effective TDV education, with programs that incorporate it yielding more promising results compared to programs centered on an individual-based model of behavior change

(De Koker et al., 2014; De La Rue, Polanin, Espelage, & Pigott, 2014; Taylor et al., 2013). Additionally, programs that purposefully consider and include the role of gender in TDV have yielded more successful outcomes (De La Rue et al., 2014; Weisz & Black, 2009; Werkerle & Wolfe, 1999). Attachment theory is not usually explicitly named as the guiding theory behind an intervention, however, the response that an attachment theory approach calls for (acknowledgement that past relationships play into relationship expectations) is an additionally crucial component of effective programming (De Koker et al., 2014).

While SLT and feminist theory can be used to develop effective content for TDV education curricula, they do not necessarily dictate a specific approach. Research on effective youth development programs indicates that having a resiliency-based approach (strengths based) can improve intervention outcomes, as opposed to a deficit-oriented approach (Bogenschneider & Olson, 1998; Silbereisen & Lerner, 2007). A deficit-oriented approach to youth development targets the problems and risks individuals face, while a resiliency-based approach targets and builds upon strengths individuals have. Deficit-oriented approaches create low expectations, foster feelings of failure, and emphasize a need for outside resources (Kretzmann & Mcnight, 1993). Resiliency-based approaches emphasize supporting existing competencies and involving prevention participants in the process itself (Kretzmann & Mcnight, 1993; Silbereisen & Lerner, 2007). In terms of TDV education, a resiliency-based approach focuses on strengthening positive relationship skills and relationship problem solving, building community networks of support, and supporting parental dialogue.

### *Lack of Measurement*

A final critical contribution of public health research on TDV is the undertaking of thorough data collection techniques, including evaluation of studies and measurement of prevalence statistics. The power of this data is vast, determining what problems are deemed important, what programs deserve funding, and what progress has been made. Statistics on prevalence help us identify where resources are most needed, and what populations are most at risk (Ackard et al., 2002). Recall, for instance, the statistics demonstrating that boys are also at risk for dating violence (Ackard et al., 2002; Ashley & Foshee, 2005). Without this information, programs may rely on false portrayals of relationship hierarchies that conclude men *can not* be abused, subsequently making ineffective decisions on who the target population should be. Basic incidence statistics like these also help in identifying what types of dating violence are occurring. While the term “dating abuse” can seem synonymous with physical abuse in popular discourse, data shows that psychological abuse and cyberstalking are actually more prevalent among adolescents than physical abuse and can be just as life damaging (Mulford & Blachman-Demner, 2013; Zweig et al., 2013). Therefore, accurate data on the nature of TDV can help redefine stereotypes on what dating abuse is and how it is impacting youth.

Data collection is useful for determining the nature and prevalence of TDV, a powerful utility in itself. However, this data collection is actually critical for monitoring and tracking the problem from a logistical standpoint. In a 2014 report, the CDC listed a lack of local data as one of three significant gaps facing TDV prevention today. Without specific data on local prevalence rates and impacts of TDV, the issue can seem abstract or irrelevant to those making practical choices for resource allocation and programming.

Localized data allows communities to make more informed choices about where funding is directed and what initiatives to support. Additionally, local data improves accountability and engages communities in ways that national statistics do not (CDC, 2014).

Public health's emphasis on data collection when assessing interventions can also be useful in identifying *how* TDV education affects youth behavior, and in what ways. In this area, public health needs to improve. Most existing studies on TDV education have relied on action assessment scales, such as the Conflict Tactics Scale-2 (CTS-2) or the Conflict in Adolescent Dating Relationship Inventory (CADRI) (Bethesda, 2015; Mulford & Blachman-Demner, 2013). These scales are useful in measuring the prevalence of physical violence and psychological violence behaviors, however, they rarely measure sexual violence or address attitudes/norms about dating (Mulford & Blachman-Demner, 2013; Smith, Mulford, Latzman, Tharp, Niolon & Blachman-Demner, 2015). If a program focusing on changing *attitudes* about healthy relationships uses an ACT-based *behavioral* assessment to evaluate impact, there may be little change in pre-program vs. post-program results and the intervention may be deemed ineffective. However, if the same program assessed shifts in students' views and attitudes, there may be considerable improvement. Therefore, appropriate and thoughtful intervention assessment is necessary to make accurate conclusions about successes/failures of TDV education.

### *Concluding Remarks*

To summarize, the field of public health has contributed significantly, and appropriately, to the discussion on TDV and TDV education. Public health has well

established correlations between experiences of TDV and adverse health outcomes (Davis, 2008; Exner-Cortens et al., 2013). The field has also established a uniform definition of TDV, and has gathered data establishing TDV as significant, pervasive issue impacting adolescents of all ages and genders (Ackard et al.,; CDC[1]). Evaluation of previous interventions identifies several reliable structural and conceptual elements key for effective TDV education. Successful programs, in terms of structural basics, take place within schools, involve key adults, and are longer than one session (De Koker et al., 2014; Foshee et al., 1998). Key pedagogical components of successful programs include incorporation of both individual and community based components, as well as interactive activities (De Koker et al., 2014; Weisz & Black, 2009). Conceptually, effective education turns to SCT/SLT and feminist theory for guiding principles (Arriaga & Foshee, 2004; Bandura, 2004; Werkerle & Wolfe, 1999). Additionally, effective programs engage in thoughtful and consistent measurement of TDV (CDC, 2014).

Considering this literature review of public health research on TDV, I will highlight the following components as critical elements of effective programming:

*Structure:* Is the information on TDV presented in more than one session? Is the content presented in multiple learning styles? Does the program include an interactive component for skill building?

*Content:* Does the content cover emotional, physical, and sexual abuse? Does the unit discuss warning signs of TDV? Does the unit cover how to seek help for TDV? Does the unit promote and discuss characteristics of a healthy relationship?

*Theory:* Is the education presented in a resiliency-based format? Does the content emphasize social factors that influence TDV? Does the content acknowledge gender

differences in violence rates?

*Measurement:* Does the school measure rates of physical, sexual, and emotional abuse on a regular basis? Does the school measure TDV content mastery, and related attitudes towards TDV?

In considering these critical contributions, I outline these categories as guidelines for current best practices as identified by a variety of public health studies, experts, and organizations. The factors identified above represent what the ‘gold-standard’ in TDV education, according to current research, looks like. However, the key structural and conceptual elements cannot be ranked in terms of importance. For example, current research does not allow for priority comparisons between inclusion of key adults and inclusion of interactive activities. Rather, these elements can serve as a checklist for what programs should strive to include. Later, I take these factors into consideration when evaluating programs in Peoria, IL.

## **Chapter 2: Public Policy & Words Behind the Action**

In addition to being established as a public health concern, TDV education has also attracted attention from the public policy sector since the late 1990s. Federal laws such as the SMART Teen Dating Violence Prevention and Awareness Act (2013) and state-level TDV education legislation in almost half the country demonstrates that the nation is increasingly supporting educating teens about healthy relationships (National Conference of State Legislatures, 2015). While the mere presence of legislation that explicitly recognizes the need for TDV education is promising, a critical analysis of this policy is important in order to adequately assess school-level progress (Carlson, 2003). For example, a policy that merely encourages TDV curricula without detailing what

constitutes an effective implementation is unhelpful from a measurement perspective. Additionally, a policy that encourages TDV curricula without requiring accountability for such a program can seem like a mere suggestion. Analysis of policy can also identify gaps in existing legislation and reveal what characteristics are associated with success (Carlson, 2003).

In this section, I assess the role of TDV education policy at national, state, and local levels in terms of impact on prevention and shaping of current practices. This policy overview identifies the strengths and weaknesses of current legislation and describes the ideal implementation of TDV education from a policy standpoint. This discussion concludes that TDV prevention efforts can benefit significantly from policy-level recognition, and are hindered by the lack of strong multi-level policy. This policy review, as part of the evaluation development portion of my framework, adds to ongoing discussions in public health arenas to understand and evaluate through an integrated lens the implementation of TDV programs in Peoria, IL.

#### *Policy as a Signal of Priority*

With so many community organizations, advocacy groups, and research studies tackling the issue of TDV, why is legislation a relevant field to investigate? It is important to first understand the importance of having TDV policies at the federal, state, and local level in order to evaluate the practical implications of these policies. For TDV education, policy is critical for awareness, funding, and action (Brindis, 2006; Nelson, 1984). That is, legislation can signal national and local priorities, determine resource allocation, and provide guidelines for program implementation. Of course, legislation serves these generic purposes, among others, in all instances of the law. However, for an

issue with growing social awareness, TDV education can benefit most by legislation that identifies TDV as a priority, allocates resources to prevention, and provides guidelines for implementation (Nelson, 1984; Carlson, 2003).

In the Social Change model, policy change is an important component of broader social change (Christoffel, 2000). Policy, influenced by advocacy, can create material change in individual lives (Christoffel, 2000; Nelson, 1984). Additionally, the large effective impact of policy is derived from its inherent public commitment to solving a collective action problem (Start Strong Initiative). The Policy Change model presents policy as a way to address problems, as defined by public prominence, via legislative change (Christoffel, 2000). Such problems are continuously socio-politically redefined, and recognition of a problem can be the initial step in setting an agenda (Christoffel, 2000; Nelson, 1984). For example, Congress took rapid actions to include child abuse legislation on its agenda after the issue was pushed to the forefront of national consciousness by a nationwide advocacy push in the early 1970s (Nelson, 1984). The move to include it on the congressional agenda in 1973 emboldened a conversation on addressing child abuse, providing critical awareness at a national level that led to ground-level action in areas of education, protective services, and community resources (Christoffel, 2000; Nelson, 1984). Given the similarities between the two issues, the increase of political focus on child abuse could serve as a roadmap for improving TDV policy and raising national awareness (Carlson, 2003).

Beyond the power that comes from declaring something a legislative priority, TDV education laws can also have direct resource implications for local schools. For example, the 2001 No Child Left Behind Act specifically allocated some funding for



training school administrators on TDV, and the development of TDV programming (Carlson, 2003). Funding can be a critical motivator for intervention implementation in public schools that are resource scarce, so the power of providing funds to further TDV education is significant. Additionally, policy makers have the power to take away funding, which can be just as powerful a motivator (Peace Over Violence, 2008). The Safe and Drug-Free Schools and Communities Act mandates tracking of incidents of violence, and annual reporting of this data to the Department of Education (Futures Without Violence, 2012). Funding programs that prioritize violence reduction and require reporting can provide critical opportunities for schools to begin addressing violence on an individual level (Peace Over Violence, 2008).

Drafting of legislation also provides an opportunity to include empirically based guidelines and benchmarks for local implementation. Well-intentioned school districts may attempt to implement TDV education to adhere to newly implemented state standards, however, if their programs do not meet several empirically based guidelines (identified in Chapter 1), the programs may be ineffective (Mulford & Blachman-Demner, 2013). Although the research community is still in the process of assessing best practices, it is clear that programs that improve TDV outcomes included multiple educational components (beyond one classroom setting), training/involvement of key adults, and explicit school-wide TDV policies (Mulford & Blachman-Demner, 2013; Taylor, Stein, Mumford, & Woods, 2013). Space in both classroom curricula and professional development, especially in health classes, is limited (Brindis, 2006). Therefore, it is essential to look to evidence-based approaches when developing new mandates to ensure programs are efficient and effective. Schools may not have the

resources to hire a community partner to develop a program, or may be located in rural areas without access to TDV specific community allies. Passing legislation provides an opportunity to do this research and draft guidelines for school to implement and adjust as they see fit on a local level (Futures Without Violence, 2012; Start Strong Initiative). This style of legislation allows for administrative discretion that is helpful for effective, localized implementation (Weisz & Black, 2009).

TDV education legislation and related policies have been implemented on the national, state, local, and school level (Carlson, 2003; Weiz & Black, 2009). These levels of government have very different roles in the on-ground implementation of TDV education programs (Carlson, 2003). What role the federal government should play in education has been contested over the years, with legislation like No Child Left Behind, and the creation of Common Core (Carlson, 2003). However, it is clear that the federal government has the opportunity to use its supreme legislative status as a means for awareness at best, with recommendations for implementation guided by leading national organizations like the Centers for Disease Control (Carlson, 2003; CDC, 2016a). State input into education is the most powerful, relating to a state's culture and priorities for its own constituents (Guthrie, Louie, David & Foster, 2005). Indeed, the majority opinion of the Supreme Court in the case of *Brown v. Board of Education 1954* declared education as 'the most important function of state and local governments'. Community TDV practitioners also cite local school districts as the most powerful decision makers in regards to mandating and creating TDV programs (Weisz & Black, 2009). These levels of government also interact in terms of reporting and accountability, generally moving upwards (Futures Without Violence, 2012). Therefore, the levels of government need to

be seen as operating together, and the ways in which this collaboration is carried out is important to understand when discussing ways to improve existing legislation (Futures Without Violence, 2012; Peace Over Violence, 2008). Additionally, this collaboration needs to be understood as neither non-linear or uni-directional, with levels of government operating on different timelines and different priorities (Carlson, 2003).

### *Current TDV Education Policies*

#### A. Federal Law: Supreme Law of the Land

Federal law, as previously described, has the potential to play a significant role in TDV education through mandates and funding (Carlson, 2003). Additionally, as the supreme law of the land, the federal government is in a powerful position to signal national health and education priorities, including TDV (Carlson, 2003). In this section, I explain the current ways in which the federal government engages with the conversation on TDV education. Currently, the federal government engages with this issue through CDC research, legislative recognition of TDV, and federal mandates against violence in the school setting (Carlson, 2003; CDC, 2016a; H.R. 3515/S. 1920, 2011).

Recent work by the CDC, under the U.S. Department of Health & Human Services, has played an important role in federal recognition of the importance of TDV research and education. The Youth Risk Behavior Surveillance System (also known as the Youth Risk Behavior Survey [YRBS]) is an annual school-based survey that is used to determine CDC priorities and areas of greatest concern (CDC, 2016b). It is a tool that provides nationally representative data on adolescent behaviors that informs critical decisions by policy makers and educators concerning improvement of health-related policies and interventions (CDC, 2013). Since 1999, the CDC has included at least one

question concerning TDV on the YRBS, with additional questions introduced in 2001 (CDC, 2016c). The CDC's rationale for inclusion of these questions is consistent with public health's stance that TDV is widespread, and monitoring is essential for guidance on prevention strategies (CDC, 2016d). As an internationally respected institution, the CDC's inclusion of TDV on the YRBS signals that the issue is a relevant area of interest for adolescents that should be taken seriously and studied statistically. The CDC supports TDV efforts not only in statistical measurement, but also includes TDV as a priority in their Division of Adolescent and School Health (CDC, 2016d). Their support of programming is backed up not only by words, but by the numerous studies they provide funding for and evaluate each year (CDC, 2016d; De Koker et al., 2014; De La Rue, Polanin, Espelage & Pigott, 2014).

While the CDC plays the biggest role of a federal agency in terms of promoting awareness and research on TDV, the issue has been recognized explicitly in legislation as well (H.R. 3515/S. 1920, 2011). The most explicit example is the SMART Teen Dating Violence Prevention Act, introduced by Representative John Lewis and Senator Sheldon Whitehouse in 2011. Influenced by the 'focusing event' of an increase of youth abuse in Fulton County, GA, Congressman Lewis signaled a need for federal input into the TDV conversation (Office of Congressman John Lewis, 2011). The act, supported by a variety of national organizations, including Futures Without Violence and the National Centers for Victims of Crime, encourages the creation of educational programs addressing TDV (H.R. 3515/S. 1920, 2011). Additionally, it establishes partnerships with middle schools and high schools to include healthy relationships education within school curricula (H.R. 3515/S. 1920). Congressman Lewis also worked to endorse Teen Dating Violence

Prevention and Awareness Month at a national level, with the resolution passing in 2010 (Office of Congressman John Lewis, 2011). These are the pieces of federal legislation most explicitly calling for inclusion of TDV education in schools nationwide, however, they have weaknesses that will be explained later on.

Additionally, there are more general federal laws and Supreme Court cases that indicate schools' duties to implement TDV education programs. The main laws of concern include Title IX and 42 U.S.C. § 1983 (Carlson, 2003; Peace Over Violence, 2008). Additionally, Supreme Court cases like *DOE v. Petaluma City School District* and *Hackett v. Fulton County School District* hold schools accountable for on-site harassment, which can include TDV. Title IX prohibits discrimination on the basis of sex in federally funded education programs (Carlson, 2003). Many theories of intimate partner violence cite gender as a significant factor, and girls experience TDV at a significantly higher rate than boys (Ackard et al., 2002; Wekerle & Wolfe, 1999). Therefore, a school could be civilly liable for TDV occurring on school campuses if it is improperly addressed (Carlson, 2003; Start Strong Initiative). For similar reasons, 42 U.S.C. § 1983, which states a right to be secure in person, indicates a school's duty to address issues of TDV (Carlson, 2003). Additionally, the two Supreme Court cases listed above involved school districts improperly responding to harassment in the school setting (Carlson, 2003). Although these cases did not deal with TDV specifically, the rulings can be extrapolated to apply to TDV as well (Carlson, 2003; Mulford & Blachman-Demner, 2013). These examples, tied with a broad understanding of the nature of TDV, all suggest that TDV education is included within the duties of school systems' requirements to give students a safe learning environment.

## B. Prairie State Policies: A Spotlight on Illinois

Narrowing the focus down a level, state policies in Illinois are an excellent example of the fast spreading national trend of state-level TDV recognition, with rapid progress on the TDV education front in the past four years. Illinois is especially apt to encourage TDV prevention, as it has a high prevalence of TDV. Of the 37 states that participated in the full version of the 2016 YRBS, Illinois had the 4<sup>th</sup> highest rate of female physical dating violence victimization and the 5<sup>th</sup> highest rate of physical dating violence victimization overall (CDC, 2016a). The rate of physical TDV in Illinois has increased slightly within the past 10 years (NCSL, 2015). Additionally, in the past several years there have been a number of prominent TDV focusing events in Illinois with several high-profile murders of Illinois teens by their romantic partners (Braun, 2016; Bullington & Zerzulewicz, 2013; Rowland, 2016). Despite Illinois' high ranking in terms of prevalence, the state has been highlighted by respected TDV organization Break the Cycle for its inclusive domestic violence protection order laws that extend filing rights to minors (Break the Cycle, 2008). With these protections in place, Illinois was one of only 5 states to receive an A rating in Break the Cycle's 2009 State-by-State Report Card (on an A-F scale) (Schaidle, 2009). Beyond legal protections for minors, Illinois has also made significant progress in passing legislation regarding TDV education in the past 5 years, namely the passing of the 2013 House Bill 3379 that amended health education standards to include teen dating violence content.

House Bill 3379 (amending the Critical Health Problems and Comprehensive Health Education Act) marked a significant shift in TDV education endorsement in Illinois (Illinois HB 3379). The bill states that health education in IL “may include...teen

dating violence [content] in grades 7 through 12.” (Illinois HB 3379). This phrase was also included in the 2009 update of the Health Education Act (Illinois HB 973). However, the 2013 amendment is significantly more specific in highlighting the issue of TDV. The 2013 update adds a new section (3.10) titled ‘Policy on teen dating violence’ that clearly defines “dating” and “teen dating violence” in terms that adhere to the CDC’s definition. Beyond including definitions, the new section also states that public school district school boards “shall adopt a policy” prohibiting TDV, as well as incorporate education on TDV into school employee training. The section goes on to say that school boards shall also establish formal procedures for responding to TDV reports, and must notify parents of new TDV policies.

The new section is significant for three specific reasons: first, it prioritizes TDV within the broader scope of health education in Illinois; second, this addendum clearly defines school board responsibilities for addressing TDV; and third, this section encourages a dialogue on TDV policy between districts and parents. Despite outlining these important goals, the impact of the bill is weakened by the absence of clear timelines within which these changes are supposed to occur, using the word “shall” to indicate a future responsibility that lacks chronological specificity. While the legislation is strong in terms of mandating school board action on school staff training and TDV response policy, TDV education is still presented as an option, not a requirement. With this emphasis, the intention of the legislation could be interpreted as a means to protect against lawsuits, rather than a means to prevent TDV. Indeed, staff training and formal procedures for addressing TDV are a great way to support victims, but these aren’t measures that actively prevent TDV from occurring.

Although the House Bill suggests, but does not require, including TDV education within health education curricula, the 2013 revised Illinois State Goals for Health Education include dating and dating violence education in performance descriptors for health education in grades 6-12. The Illinois State Goals for Health Education is a document that draws upon National Health Education Standards to create state focused learning goals for comprehensive health education. While the standards are not formally enforced, they indicate the state's priorities for ideal health education, and serve as a guide for district curricula development. The 2013 edition outlines that 6<sup>th</sup> and 7<sup>th</sup> graders should be able to "identify the signs and behaviors related to dating violence," that 6<sup>th</sup>, 7<sup>th</sup>, and 8<sup>th</sup> graders should be able to "identify criteria for acceptable dating behavior," and that 8<sup>th</sup>-12<sup>th</sup> graders should be able to "identify...dating limits." These standards make clear that education on TDV is part of the ideal comprehensive health education all students should be receiving.

While Illinois legislators should be commended for the significant improvements to the 2009 Health Education Act that clearly state action steps for school districts to take in strengthening TDV response, these policies still need improvement in regards to specificity, measurement, and accountability of programs. These weaknesses are discussed in detail in my policy analysis below. However, with only 22 states having some form of TDV education legislation, Illinois ranks at least in the top half of state efforts to address the issue formally (NCSL, 2015). Additionally, the state's clear adherence to nationally agreed upon definitions of TDV in the 2013 HB 3379 3.10 added section indicate careful consideration of language that reflects a conscious effort to include public health recommendations as part of state legislation.



### C. Making it Local: Efforts in Peoria, IL and Surrounding Areas

The final unit of governmental policy to highlight in this analysis is local school district policy. School district policy has the most significant impact on what curricula schools actually incorporate into health education (Weisz & Black, 2009). Peoria is the third most populated city in Illinois outside of the Chicago metro area, and the seventh most populated in the state overall (U.S. Census Bureau, 2010). The Peoria Metropolitan Statistical Area encompasses 5 counties – Marshall, Peoria, Stark, Tazewell, and Woodford – with Peoria as the principal city. The main school district this study highlights is Peoria District 150, which oversees 24 Peoria public schools. Additionally, this study includes neighboring District 310 (Limestone), District 325 (Peoria Heights), and District 309 (East Peoria). Schools in the main District 150 range in terms of academic performance, with 57% of Richwoods High School students meeting or exceeding state standards and only 9% of Manual High School students meeting state standards (no students exceeded) (Illinois Report Card, 2016).

Detailed information on school district curricula and policies is often challenging to find with a general lack of public transparency, possibly due to a lack of public interest in mundane details of school district governance. This section was informed by public reports put out by each school district, as well as local news reporting of initiatives.

Peoria District 150 is well positioned to address TDV education, with several Peoria non-profit and community organizations available to address the issue (Center for Prevention of Abuse, 2017). Peoria's Center for Prevention of Abuse is the primary community organization called on for in-school presentations, directing TDV programs in Peoria County, Tazewell County, and Woodford County. Additionally, Peoria's Hult

Center for Healthy Living offers a dating violence prevention presentation titled RUaTruFriend? (Hult Center for Healthy Living, 2017). The Center for Prevention of Abuse (CPA) is the primary TDV prevention provider for Peoria Public Schools, and Central IL schools in general, reaching 33,000 students in 105 schools during the 2015-2016 school year (Newell, 2016). Although Peoria Public Schools have been a primary target for CPA, services are also utilized in the other districts in question (Limestone 310, Peoria Heights 325 & East Peoria 309). As the premier provider of TDV education services in the region, CPA is often included in conversations about education and called upon to present content.

In addition to non-school specific Peoria organizations endorsing TDV education, the district has also formally recognized TDV. In a 2016 school board policy update (7:185), District 150 clearly defines and prohibits teen dating violence. Additionally, the policy update calls for the school board to develop a program that addresses TDV, citing previous policy provisions concerning harassment and bullying as reference points. The formal policy also requires instruction on TDV for students in grades 7-12. Also notable, the policy makes several references to the 2013 Illinois House Bill discussed in the previous section, citing the Illinois Content Standards and State law on comprehensive health education as justification for the policy. District 150's Teen Dating Violence policy is specific and clear in its purpose and requirements, and seems to be exactly the kind of policy that the state law intended school boards to create in HB 3379.

Limestone District 310 also has a formal policy concerning TDV. The policy, also adopted in 2016, clearly states what TDV consists of, how it should be addressed, and requires TDV education (Limestone 310 Policy 7:185, 2016). The policy is strikingly

similar to District 150's, using much of the same language and citing similar existing policies as reference points for the district's stance on TDV. Like District 150's policy, Limestone includes language regarding the state health education content standards.

East Peoria District 309 also has an extremely similar policy in place (7:185), however, District 309 adopted their policy 3 years earlier than Limestone 310 or Peoria 150 (2013). The language in East Peoria's policy is nearly identical to Limestone's policy, clearly defining TDV, responses to TDV, and requiring TDV education. Additionally, District 309 sent out a letter to all parents of East Peoria public school students that informs parents on the policy update, as well as outlines the warning signs of teen dating violence. The letter refers to the CDC's webpage on TDV as parent resources. Additionally, the warning signs that the letter lists are consistent with the public health literature on TDV warning signs, indicating the informational accuracy of the letter. District 309's policy goes on to list "teen dating violence prohibited and reporting encouraged" as a mandatory topic for teachers to discuss with students and parents. The "mandatory" distinction is important, since the board indicates that mandatory topics are legally required, as opposed to "recommended" topics, which are suggested as a part of best practices.

The final local example is Peoria Heights District 325. District 325 has a clear TDV policy that is nearly identical to the policies implemented by District 150, District 310, and District 309. It clearly states the definition of TDV, the process for addressing reported incidents of TDV, and calls for implementation of TDV education. The policy was adopted in 2013, around the same time as East Peoria District 309. The school board policy also mentions TDV education as a required component of biennial staff

development.

To summarize, all four districts researched in this study (Peoria District 150, Limestone District 310, Peoria Heights District 325, and East Peoria District 309) have some sort of policy concerning TDV. All four policies clearly define TDV in a manner that reflects the formal public health definition of TDV, and all of the policies mandate a process for addressing TDV incident reports. Each of the policies also refers to the state law and state standards as reasoning for and a reference for the policy. Each of the policies requires TDV education be provided for students in grades 7-12. The consistency across these four policies is a promising sign of some uniform agreement across the Peoria metro area on what TDV is, how it should be addressed, and educational prevention measures to take. East Peoria District 309 and Peoria Heights District 325 both adopted their policies in 2013, while Peoria District 150 and Limestone 310 both adopted their policies in 2016. East Peoria's policy is the most comprehensive, legally requiring a discussion on TDV with students and parents, and outlining staff procedures specifically. Peoria Height's policy is comprehensive on the employee training side, requiring TDV content to be part of staff development.

### *Policy Review*

#### A. Strengths in Current TDV Legislation

In the overview of policy at the federal, state, and local district levels it is clear that significant strides have been made to incorporate TDV education into more and more schools. For an issue that was not even formally recognized by government institutions thirty years ago, TDV education implementation is progressing rapidly (Mulford & Blachman-Demner, 2013). Legislators should be commended for increasing commitment

to address this problem at all levels of government, especially at the national and state levels (Break the Cycle, 2010). The most significant strength of current and newly enacted legislation is the increased awareness about TDV they bring to the populations they concern (Guthrie et al., 2005; Weisz & Black, 2009). Currently, 81% of school counselors nationwide reported that they did not have a protocol on responding to TDV incidents (Start Strong Initiative). Parents can also underestimate the pervasiveness of teen dating violence (Mulford & Blachman-Demner, 2013). The policy changes discussed signal to schools and communities that they should be taking a closer look at the ways adolescents are dating (Start Strong Initiative).

One primary strength of these policies, from the federal level CDC initiatives to the local level school board policies, is that they all include an expanded definition of TDV (Mulford & Blachman-Demner, 2013). Historically, TDV has only been considered to consist of physical or sexual violence (Ackard et al., 2002; Davis, 2008). However, legislation is increasingly incorporating the more comprehensive definition that includes emotional abuse, as well as stalking and harassment, as part of TDV (IL HB 3379). The commitment to using the formal public health definition of TDV is clear, as IL House Bill 3379 and each of the four districts' TDV policies all used the expanded definition. Use of the appropriate language at both the state and local levels also demonstrates coordination across levels of government. Not only does this consensus show agreement, but it also protects against any loopholes in response to TDV. For example, if the state included emotional abuse in its definition of TDV but local policies did not, the responsibility of school districts to respond to reports of emotional abuse could be murky. Therefore, maintaining the same definition across levels of government also helps ensure

a uniform response to TDV.

Beyond consistency in definitions, there is also consistency in the requirements for TDV response and education between state and local policies. The HB 3079 Section 3.10 calls for school boards to establish processes for responding to TDV, as well as include age-appropriate education. All of the districts had provisions regarding these two requirements within their respective policies. East Peoria District 309 had the strongest policy in place, in terms of adhering to the state guidelines, since it clearly stated the response process for reported incidents, as well as legally required informing students and parents on TDV policies and content. Peoria Heights District 325 had the second strongest formal policy, as it outlined staff training procedures in clear language. In terms of education, national, state, and local policies are somewhat aligned, as the state policy refers to national health education standards, and the local policies refer to state health education standards. In doing so, each level of governmental policy regarding TDV education agrees with the standards set by the level above it, minimizing potential conflict concerning how teens should be taught about dating violence. Policies are also incorporating an understanding of TDV prevention that includes not only education on negative behaviors and warning signs, but also education on what healthy relationships consist of (Illinois Health Education Performance Standards; Wekerle & Wolfe, 1999). The move towards a resiliency-based prevention shift is significant, since it better reflects best practices understood in the public health community (Wekerle & Wolfe, 1999; Weisz & Black, 2009).

#### B. Room for Improvement

TDV education has certainly made strides in the past several decades, however, there

is still significant room for improvement at a policy level (De Koker et al., 2014). Primarily, improvements could be made in terms of specificity, coordination, and accountability. At all levels of policy, these areas have not been adequately addressed by the legislation in place. Specificity refers to explicit guidelines for effective implementation, including length of instruction and essential topics to be covered. (Hickman, Jaycox, & Aronoff, 2004; Peace Over Violence, 2008). This means looking across policy levels for guidance (i.e. state policies utilizing national examples), as well as identifying potential partners and allies at local, state and federal levels (Guthrie et al., 2005; Weisz & Black, 2009). For example, Congress drafting TDV education legislation should communicate with government branches such as the CDC's Division of Adolescent Health, or the National Task Force to End Sexual and Domestic Violence. Accountability must take on the form of formal evaluation of programs, which is not only useful for improvements in the policies themselves, but also provide guidance for implementation of new programs in other settings (i.e. effective measurement of policy impact in one state is useful for another state's legislation drafting) (De Koker et al., 2014).

Federal governmental policies are somewhat strong in these three areas, likely due to increased budgeting in areas devoted to violence prevention in general, as well better access to established national research organizations like the CDC. Hence, legislation at the federal level has more input from a wide variety of geographical regions, therefore there are more opportunities for politicians from early adopting states to give insight into their efforts. Additionally, the federal government has evidenced a decent level of consistency in defining TDV across organizations like the National Institute of Justice

and the CDC (Mulford & Blachman-Demner, 2013; Davis, 2008). However, the federal government still has room for improvement in terms of guideline specificity. The lack of specific guidelines for best practices is likely due to lack of consensus and research on effective programs (Mulford & Blachman-Demner, 2013; Weisz & Black, 2009). There has been some success in terms of accountability, in the reporting provisions for schools receiving funding that specifically addresses school safety and violence prevention, as well as improving evaluation on federal organizational fronts (Ackard et al., 2002).

Illinois policies are somewhat successful in terms of specificity, with guidelines for effective comprehensive health education that includes education on some aspects of TDV (Illinois Health Education Performance Standards). Guidelines in place currently are consistent with aspects of effective TDV education, as identified by community partners and national experts (Weisz & Black, 2009). Additionally, Illinois has made strides in strengthening some aspects of accountability between the 2009 version of the Health Education Act and the revised 2013 version. The newest edition of the legislation states that school boards “shall adopt a policy” to address what TDV is, how it should be responded to, and how students should be educated about it. Although “shall” is a term without deadlines or repercussions, it mandates some form of future response that school boards must take. However, TDV education is still listed as a recommended, but not required, topic in the Health Education Act’s listing of required content for schools’ health class curricula. Therefore, Illinois’ latest policy is strong in terms of school boards’ responsibility to respond to TDV, but not as strong in terms of school boards’ responsibility to educate on TDV. This could be improved by requiring local school boards to provide proof of some district level policy or adoption of TDV curriculum,



instead of only encouraging it (Guthrie et al., 2005). Local expertise and control could still be maintained by not requiring all school boards to adopt a state determined curriculum or implement a specific program. Rather, the state should require local boards to provide some proof of efforts. Illinois' participation in the full version of the YRBS also shows commitment to accountability, as it allows for annual data on the state's rates of physical and sexual TDV. Another concern is the lack of funding attached to Illinois' new bill, forcing TDV programs to rely on donor funding.

Finally, the school districts of Peoria, Limestone, East Peoria, and Peoria Heights, have perhaps the strongest TDV policies in place of all the governmental levels. There are not obvious areas for improvement at the local level, at least in terms of policy. Limestone, East Peoria, and Peoria Heights would all benefit from more outward demonstrations of community coordination, as opposed to Peoria 150 which clearly lists CPA as a community partner for health education on their district website. Additionally, the districts could improve all improve in the area of specificity by outlining what aspects of TDV teachers are required to teach, and how this curricula could look. The current provisions in each of the districts policies that require TDV to be incorporated within health education are too vague, only stating that such education should be "age-appropriate," without detailing specific topics to be covered (i.e. 'warning signs of TDV' 'characteristics of healthy relationships'). Without such specificity, teachers unfamiliar with the topic may not know how to approach it appropriately or include the content essential to effective education as outlined by the field of public health. Such specificity would not be an unusual measure for these districts to take on, since several of them already have specific guidelines in place for topics such as child abuse, drug use, and sex

education (see Peoria District 150 DASH Sex. Ed Curriculum, 2016).

The districts could also improve in terms of accountability, namely measurement. The state level equivalent of the CDC's YRBS for Illinois is the Illinois Youth Survey (IYS). The survey can be useful for understanding rates of TDV, as it asks two questions related to physical TDV and emotional TDV. None of the high schools in Peoria 150 have participated consistently since the IYS was first administered in 2008. Limestone 310 only participated the first year. Peoria Heights 325 only participated in 2014. East Peoria 309 is the only district out of the year to have participated in the IYS every year. Taking part in formal health assessment surveys like this is important in terms of contributing to accurate state-wide data on TDV rates, as well as determining prevention priorities. For example, knowing that your students face higher levels of emotional violence than physical violence could help shape a school's TDV education content to emphasize warning signs of emotional violence. Schools can request access to their school's individual IYS data, making participation in the survey a powerful tool for shaping health education and school directives. A commitment to regularly participating in this survey, or another health assessment survey, would improve accountability in Peoria Heights 325, Peoria 150, and Limestone 310.

#### *Concluding Remarks*

In this policy analysis, the roles of the federal, state, and local governments were each represented as relevant to the broader conversation on increasing implementation of TDV education. The overview of policies at each of these levels gives insight into the rapid progress on the policy front of TDV education, as well as the forms that these policies currently take on. Further analysis of these policies indicates strengths in the areas of

broadened definitions, across level policy consistency, and required response plans. Analysis also indicates a greater need to address weakness in the areas of specificity, collaboration, and accountability. The local governments have succeeded the most in these areas, compared to state and federal governments. For all areas of government, specificity in terms of clearly stating what constitutes effective TDV education is most lacking in current legislation.

With this policy overview and analysis in mind, I considered the following factors in my later assessment of individual school's TDV education:

*Federal level:* Is the school receiving funding that requires violence reporting, and if so, is it adhering to these guidelines? Does the school include a broad, explicit definition of TDV in its school conduct code? Does the school recognize any nationally promoted awareness months or weeks? Does the school participate in the national YRBS?

*State level:* Does the school adhere to Illinois Health Education Standards? To what extent does the school follow these standards (minimum required, best practices comprehensive version)? Does the school have a designated resource for students experiencing violence? Does the school train staff on TDV?

*Local level:* Does the school provide TDV education to all students? Does the school have a policy defining, prohibiting, and providing resources for TDV? Are parents incorporated into the school's TDV program?

In assessing the local schools later on, and identifying characteristics of schools with the most successful implementation, these policy factors are considered in addition to public health guidelines and recommendations. The most ideal implementation in

terms of policy will have evidence of a ‘yes’ answer to all the above factors listed.

### **Chapter 3: The Study and Methodology**

There is a gap between public health research, public policy, and pedagogical practices concerning TDV education. These fields largely operate tangentially to each other, with points of connection but a lack of dialogue actively seeking to develop effective TDV education programs. This separation can lead to a lack of accountability and a lack of progress in terms of ensuring all students receive TDV education critical to prevention. Clear communication between researchers, policy makers, and teachers will allow for better identification of facilitating factors for and barriers against progress.

This study is an attempt to demonstrate how to bridge the gap between these fields with a strategic framework for integrated implementation evaluation (See Tables and Figures for framework visual). Too often public health initiatives fail to actively communicate with primary stakeholders when giving recommendations, or developing programs (Salabarria-Pena, Apt & Walsh, 2007). Or, this communication only occurs during needs-assessment stages of intervention development. The same is true of policy development, with legislators creating laws concerning education without having conversations with the educators who will have to implement these changes (Weisz & Black, 2009). Therefore, this study assesses the state of TDV education within four schools in the Peoria, IL area. By assessing the current TDV education programs at these four schools, I demonstrate how the strength of a school’s TDV response can be evaluated with both public health and public policy in mind. In turn, I demonstrate how engaging in critical assessment is a crucial step in improving a school’s TDV response, as it allows for a systematic review of elements essential to prevention and policy

compliance.

### *The Evaluation*

I developed the evaluation method for assessing TDV education through the literature review of public health research and public policy analysis, the evaluation development portion of my framework. Through this literature review I identified three critical elements of effective TDV education as represented in public health research (structure, content, and theory) and three critical components of effective TDV education as represented in public policy (policy, education, staff training). I additionally identified measurement as a critical component of TDV, as referenced in both public health and public policy literature.

The basic outline for evaluating TDV education that I describe in this study was developed using the CDC's *Developing an Effective Evaluation Plan* as a primary resource. The CDC's evaluation development resource identifies four attributes that define "good" evaluation: utility, feasibility, propriety, and accuracy. An evaluation that has utility provides information critical to intended users. An evaluation with feasibility is realistic and sensible. An evaluation with propriety operates legally and ethically towards those involved. Finally, an evaluation with accuracy is grounded in research.

The evaluation is an implementation (process) evaluation, and makes up the second portion of my framework, with the primary aim of determining whether programs have been implemented as proposed in legislation and as supported in the literature. The purpose of an implementation evaluation is to identify how well a program is operating, whether the program is accessible to the target population, and to what extent the program is being implemented (CDC, n.d.). Implementation evaluation is useful for

identifying warning signs of future problems that may occur in program implementation. Additionally, process evaluation is useful for monitoring the utility of program plans and activities. Process evaluation is also a critical step in identifying outcomes and impacts of processes, and the CDC recommends that a process evaluation is conducted prior to or in addition to outcome/impact evaluations. The justification for this is that if desired outcomes were not achieved through a program, it may be due to errors in implementation.

Considering the four attributes of good evaluation, and the purpose of an implementation evaluation, I identified 7 assessment categories (see Table1): School Policy, Staff Training, Community/Parent Involvement, Educational Structure, Educational Content, Educational Theory, and Measurement. These 7 elements of TDV education programs were consistently identified in the legislation and the literature as important, effective, or required. Evaluating a school's strength or performance in these 7 categories provides a foundational understanding of a school's TDV program that is useful to a variety of fields seeking to prevent violence, and can help inform conversations in public policy, education, and public health, among other arenas. With a generalized implementation evaluation, foundational understandings of the existing field are practically strengthened, forging an understandable entry point for conversation across disciplines.

**Table 1: Breakdown of Evaluation Categories**

<b>Evaluation Category</b>	<b>Implementation Questions</b>	<b>Success Indicators</b>	<b>Relevant Source(s)</b>
<b>Policy</b>	What are the school's policies on TDV?	-Policy that clearly defines and prohibits TDV; -Policy that provides school resources for addressing TDV incidents	Carlson, 2003; Illinois HB 3379; Futures Without Violence, 2012
<b>Structure</b>	What is the structure of the school's TDV education?	-TDV unit is more than one session; -TDV unit incorporates multiple learning styles; -TDV unit has interactive component	De Koker et al., 2014; Weisz & Black, 2009
<b>Content</b>	What content is covered in the school's TDV unit?	-Unit covers emotional, physical, and sexual abuse; -Unit covers warning signs of TDV; -Unit covers how to seek help for TDV; -Unit discusses/promotes healthy relationships	Foshee et al., 1998; De Koker et al., 2014; Taylor et al., 2013; Illinois Health Education Standards
<b>Theory</b>	What theories guide the unit on TDV?	-Unit takes a resiliency-based approach to TDV; -Unit addresses the role of gender in TDV; -Unit covers the role of peers (SLT)	Bell & Naugle, 2008; Werkerle & Wolfe, 1999; Kretzmann & McKnight, 1993; Weisz & Black, 2009
<b>Community Involvement</b>	Does the school involve community organizations or parents in their TDV program?	-Community organizations are involved in the development/delivery of program; -Parents are involved in the program	Weisz & Black, 2009; De Koker et al., 2014; Break the Cycle, 2009
<b>Staff Training</b>	Does the school train staff on TDV?	-Regular staff training by a certified organization on TDV	Weisz & Black, 2009; Illinois HB 3379
<b>Measurement</b>	How does the school measure TDV and attitudes around violence?	-Regular participation in a survey that measures TDV; -Measurement of acquired knowledge after TDV unit	Ackard et al., 2002; CDC, n.d.; Mulford & Blachman-Demner, 2013

Generally, implementation evaluations are a component of a specific program's development, informed by a specific program's goals and methods. The evaluation measures the implementation of a specific plan, developed in conversation with stakeholders. However, this evaluation was not created with a specific program in mind,

or to measure a particular school's success with implementing a forethought procedure. This note is important to keep in mind when considering the strengths and weaknesses of these four schools, especially in terms of categories heavily informed by public health. By not tailoring the evaluation to a specific program, this framework remains flexible for a variety of purposes. Despite my generalized approach, as discussed in the conclusion the framework could be used to develop a specific evaluation to assess one school's or one district's success with a particular program.

While schools are legally obligated to be informed about and implement laws like Illinois HB 3379, educators are not legally obligated to be informed about and implement the latest research in violence prevention. Therefore, schools are more likely to have succeeded in mandated components like having a written policy prohibiting TDV (as outlined in IL HB 3379) than in research-driven components like having a resiliency based approach to TDV education. Although it may seem irrelevant or even unfair to evaluate these non-mandatory components, like grading a paper on elements not on the rubric, the intention of forming this interdisciplinary dialogue calls for integrating knowledge across fields. While TDV intervention research does not have any legalistic power over what can and can not be included in TDV prevention, the considerable prevention strategies and insight developed in the field is critical to include in a measurement tool assessing such programs. In addition, viewing this evaluation like a rubric of any sort is inaccurate; this study does not aim to create a means for demarking failure or success, but rather creates a tool for identifying strengths, weaknesses, and next steps. It serves as an evaluative guide of currently accepted best practices and recommendations regarding TDV prevention.



### *Methodology*

I choose to study Peoria, IL largely due to personal connections to the city that made navigating the education system and teacher networks more feasible. Since I grew up in Peoria, IL and went to school there, I was already familiar with the histories and structures of school districts in the region. Nobody I spoke to in this research taught me personally, although some teachers I interviewed were teaching at a school while I was in attendance. I contacted health teachers at all seven high schools in Peoria District 150, East Peoria 309, Limestone 310, and Peoria Heights 325. Three teachers did not respond. Therefore, the remaining four schools self-selected their participation. I considered the implications of a potential non-response bias, but as this study does not aim to generalize the individual school's results, this did not concern me. While participation of the non-responding schools would strengthen this study in terms of breadth, my study of the remaining four schools still demonstrates the value of implementation evaluation.

To obtain information regarding the 7 elements of effective TDV education, I interviewed teachers on their practices pertaining TDV education and assessed respective content on TDV education they provided me. The interviews and content aided in assessing the structure, content, theory, education, and staff training components of my TDV evaluation. Some of the schools I researched utilized CPA as a community partner to facilitate their TDV education. Therefore, I also interviewed a representative from the CPA concerning the aspects of TDV education their staff presents.

The teacher interviews took place over e-mail or over the phone. The interviews were semi-structured, with a pre-written set of questions that I veered from for clarification or elaboration. This style was chosen in order to make data collection

somewhat systematic, while still allowing for flexibility to increase the relevance of questions. The questions concerned both the educator's general teaching experience and experience with TDV education. The primary questions were as follows:

1. Why did you choose to teach health, and how long have you taught it?
2. How have health classes changed since you began teaching?
3. Do you think health classes should teach students about relationships? Why or why not?
4. Do you teach about dating violence in your class? (If No, move to question 8)
5. How long is your unit on dating violence? (one class period, two weeks, etc.)
6. How is the material on dating violence taught? (style, theory)
7. What types of topics are discussed in the unit?
8. IF NO..Why don't you teach about dating violence?
9. Does your school have any policies on dating/dating violence?

My interview with a representative from the CPA was not formally structured, and took on a more conversational tone wherein I asked her about CPA's involvement in Peoria schools, the structure of their TDV presentations, and the theories guiding the content of these presentations.

I obtained the school's student codes of conduct through their respective school websites. Some schools provided me with class materials, so I included this in my evaluation as well. School names were changed to ensure teacher responses remained anonymous.

I applied for IRB approval for this study and received an exempt status because of the types of questions I asked, and the protection of anonymity of participants, pose little

risk to participants.

### Chapter 4: Schools Profiles and Results

For the final portion of this project, I present the results of my school assessments and subsequent analysis. This constitutes the final portion of my framework: Assessment and Action. The strength of TDV programs varied significantly amongst the four schools (see Table 2). Overall, schools had the strongest performance in categories concerning TDV education (structure, content, theory) and struggled most with staff training. First, I present the detailed school profiles to demonstrate what information an integrated evaluation provides on an individual basis. Then, I follow up with a discussion of common themes, as well as an assessment of program strengths, critical areas of improvement, and factors related to progress.

**Table 2. TDV Program Assessment Overview**

	Schools			
	Roseville	Sierra Ridge	Columbus	Highland
Policy	Some	Meets		Meets
Structure	Meets	Some	Some	Meets
Content	Exceeds	Some	Meets	Exceeds
Theory	Meets	Some	Some	Meets
Community Involvement	Meets	Some	Some	Exceeds
Staff Training				
Measurement	Meets	Some	Some	Meets

Legend:

(Blank) = No criteria met

Some = Meets some criteria

Meets = Meets minimum criteria

Exceeds = Exceeds minimum criteria

#### *Roseville High School*

Roseville has a formal policy prohibiting TDV, however, it is not easily accessible to students. It is not listed directly in the student handbook and can only be

found by typing in a link listed in the handbook as ‘more discipline details.’ At that link there is a full policy that defines and explicitly prohibits TDV. Additionally, no school resources are listed for students who need help or want to report victimization.

TDV education at Roseville is presented by CPA. It takes place over 4 sessions, and incorporates a variety of learning styles. Students are engaged by expert presenters, who utilize discussion, videos, and lecture to deliver content. Students also engage in interactive role-play activities, and engage in self-reflection activities that build skills for discussing expectations and boundaries in relationships. Although students complete CPA’s program in freshmen health class, there are annual school-wide presentations to reinforce the material.

In terms of content, the program truly exceeds minimum standards for effective education. CPA covers the primary topics: what TDV is (emotional, physical, and sexual abuse), warning signs of TDV, how to seek help, and what a healthy relationship looks like. CPA also includes information on same-sex relationships, experiences of violence as a transgender individual, and cyber abuse. Additionally, CPA talks about what it means to be a bystander, and how to seek help for a friend experiencing violence.

CPA’s program is explicitly theory based and evidence based, and draws upon guidelines for effective education by the CDC. Primarily, CPA’s program highlights the role of social learning. The content was delivered in a resiliency-based format, focusing on building students’ strengths instead of highlighting what puts them at risk. The role of gender in partner violence is also intentionally incorporated into the program.

With the involvement of CPA, Roseville’s TDV program is well integrated into the community. Beyond using CPA as a community partner, parents are also engaged

through outreach events where CPA presents, such as parent open houses. While these factors put Roseville into the 'meets' category for community involvement, the school needs to do more for parent involvement since not all parents can attend these types of outreach events.

There was no widespread staff training on TDV at Roseville. Several individuals, such as the school psychologist, are trained on dealing with TDV but more so as a result of their specific job title training than any effort by the school to train staff on TDV.

Roseville participates in two forms of TDV measurement. CPA gives students pre-tests and post-tests to measure attitudes around violence, knowledge of material, and skill development. Roseville has also participated in both of the Illinois Youth Surveys since IL HB 3379 passed, which measures rates of physical and emotional partner violence.

#### *Sierra Ridge High School*

Sierra Ridge has a strong formal policy on TDV. The policy defines, strictly prohibits, and lists school personnel for students to approach if they need help. The policy is printed in the student handbook, which is not only distributed to all students but also discussed in detail on the first day of school.

The structure of TDV education at Sierra Ridge could be improved. While TDV topics are discussed, there is no formal unit. Rather, material is integrated into sex education. Since it is sprinkled throughout, it is challenging to identify if the material meets minimum recommendations for TDV program length. Based on my interviews, Sierra Ridge's program does not meet minimum program length. However, the TDV topics that are discussed as a part of sex education are presented in a variety of learning

styles that incorporate interactive activities. Material is presented by Sierra Ridge's health teacher, with some involvement from the local Women's Pregnancy Center, which visits the school to present on sexual health.

Although TDV is not represented in a separate unit at Sierra Ridge, some critical topics on TDV are covered. In terms of content, Sierra Ridge meets some minimum criteria. Healthy relationships and respect are emphasized, as well as sexual assault/abuse. Warning signs in relationships are also discussed. However, a formal discussion on what TDV is, and how to seek help, is missing from content.

While components of resiliency-based programming are incorporated into sex education at Sierra Ridge, the teacher I spoke with didn't bring up any particular theories. Additionally, she incorporates some elements of Social Learning Theory (SLT) when discussing peer pressure and relationships.

Sierra Ridge somewhat fulfills community involvement with their partnership with the Women's Pregnancy Center (WPC). When WPC gives presentations on sexual health at the school, they provide some resources for students to contact. However, WPC focuses more on issues of sexual health, and isn't the best resource for students seeking safety from violence. Parents receive some information on what students are learning during the unit on sex education; there is no specific communication with parents about dating violence.

There is no formal staff training on TDV at Sierra Ridge.

Sierra Ridge has participated in the IYS once (out of two possible participation years) since the passage of IL HB 3379. Students take tests throughout their one semester of health, and some questions are related to relationships and respect. While this gauges

some aspects of attitudes and behaviors related to TDV, it does not provide enough information to track changes over time.

*Columbus High School*

There is no policy on TDV at Columbus High School. The teacher I spoke with said that issues of TDV would be addressed in accordance with school policies on bullying and harassment.

TDV material at Columbus High is teacher presented over 1-2 class periods within a broader unit on sexual health. Material is presented in a variety of learning styles, using discussion-based learning with interactive activities. The teacher I spoke with mentioned using unnamed outside presenters to supplement material, and the outside presenters sometimes discuss relationships as well.

The content of TDV discussions at Columbus emphasizes understanding what constitutes a healthy relationship, and personal violence prevention. Material on personal violence prevention addresses how to prevent sexual assault and date rape. There is also some discussion of gender roles, and how gender influences relationships. Formal discussions on TDV, such as what the cycle of abuse is, what warning signs to look for, are not discussed at Columbus.

While the unit on TDV at Columbus High is not specifically theory based, there are elements of resiliency-based approaches to prevention. For example, the teacher I spoke with mentioned that they strongly avoid scare tactics, which he says were commonly incorporated into health classes in the past. Columbus High also discusses gender roles in a manner that aligns with feminist theories of TDV.

Currently, community is loosely integrated into discussions on TDV at Columbus,

with some outside presenters who touch upon it. However, Columbus High and CPA have committed to partner together in the next year to deliver TDV education and parent outreach programming. Thus, community organizations have been formally integrated into future programming. Parents are integrated into the current programming at CPA, so they will likely be involved in the future.

There is no widespread staff training on TDV at Columbus High. The teacher who I spoke with was trained on issues of TDV while obtaining his health class teaching certification, however, it seems no other staff at Columbus have been formally trained.

Measurement on TDV at Columbus is largely informal. Columbus has not participated in the IYS since IL HB 379 was passed. Students are tested on the TDV material they receive, however, their tests are not intended to measure attitudes or behaviors on TDV specifically, but rather content mastery.

#### *Highland High School*

Policy on TDV at Highland is strong, defining what TDV and listing who students can turn to if they need help. The policy is printed in the student handbook, and a copy is also distributed to parents.

TDV education at Highland is presented by CPA. It takes place over 4 sessions and is presented to the entire school. CPA uses expert presenters to deliver content in a variety of formats, including lecture, discussion, and videos. CPA also uses role playing activities that encourage practical skill development and engage students to communicate the content in their own words.

Content of CPA's program goes beyond minimum criteria for effective TDV education. The program emphasizes understanding patterns of abuse, warning signs of



unhealthy relationships, and strategies for leaving unhealthy relationships. Particularly, CPA highlights the subtleties of emotional abuse and related warning signs. Additionally, CPA incorporates discussions on gender roles and same-sex relationship violence, and cyber stalking. Bystander training is also incorporated.

CPA's program is explicitly theory based and evidence based. Guidelines from the CDC are utilized for program structure and content development. The content is intentionally resiliency based, aiming to strengthen students' skills at identifying abuse and responding to abuse instead of highlighting areas of risk. Aspects of SLT are also intentionally integrated, as well as gender theories of violence.

Highland High successfully integrates community partners and parents into the school-wide discussion on TDV. CPA is an excellent community partner, giving students a direct resource for help if necessary. CPA also engages parents by presenting at PTO meetings and open house events on an annual basis. Highland also involved parents when their TDV policy was implemented, sending all parents a letter about the policy.

Highland has not incorporated widespread staff training on TDV into their current program.

TDV incidence and attitudes around TDV are regularly measured at Highland. The school has participated in both instances of the IYS since IL HB 3379 was passed, providing the school with data on rates of physical and emotional dating violence. CPA also gives students pre-tests and post-tests to assess content mastery and attitudes on TDV.

#### *Program Strengths*

The primary strength of TDV programs in all four schools was the positive

attitude towards TDV education exhibited by all four teachers I spoke with. All four teachers supported teaching teens about dating violence and saw the issue as valuable to discuss. The teacher I interviewed from Roseville High spoke of TDV education not only as a theoretical priority, but also a practical necessity, saying that “everyday in the halls you see students touching each other with force.” The strong endorsement of including TDV into school curricula from all four teachers is promising, as negative teacher attitudes are a significant barrier to effective education (Weisz & Black, 2009). These positive attitudes not only impact content delivery, but also posit these teachers as receptive allies for students seeking help (Werkele & Wolfe, 1999).

A critical program strength for Roseville High and Highland High was the integration of the expert community partner, CPA. Having CPA deliver content, as opposed to a teacher-delivered TDV program, ensured quality, evidence-based programming. Benefits of CPA’s involvement go beyond thoughtful programming, such as the practical advantage of exemption from mandatory reporting laws that teachers are subject to. If a student disclosed violence to a teacher, they would have to report the incidents to law enforcement, even against the student’s wishes. However, CPA’s presenters are exempt, allowing students a safe disclosure outlet. The schools that bring in CPA also had stronger TDV programs overall, scoring higher in categories not directly related to CPA. This demonstrates either that CPA has impacted non-education related aspects of a school’s TDV program, or that schools prioritizing TDV in the first place are more likely to seek out community resources like CPA.

Another strength of programs in all four schools was the positive, thoughtful delivery of content in a resiliency-based approach to prevention, even in teacher-

delivered TDV units at Sierra Ridge and Columbus High. None of the teachers I interviewed, or CPA, used any scare tactics or deficit-oriented approaches in their discussions about relationships. Two of the teachers I spoke with related their positive approach to Illinois' transition away from abstinence-only sex education (Sierra Ridge and Columbus High). Abstinence-only sex education hindered comprehensive conversations about relationships, they said, due to the "just don't do it" attitude of abstinence-based programs. Now that they are able to talk about the role of respect in sexual health through a more nuanced, conversational lens, they are better able to talk about respect in relationships in general. In fact, for the teacher at Sierra Ridge, discussing healthy relationships benefitted and segued into material on sex education.

A final primary strength of the programs was the consistent integration of interactive activities in all of the school's TDV programs. Interactive and role playing activities are not only critical for student engagement, but also for skill development (De Koker et al., 2014). By allowing students to practice difficult conversations and choices related to relationships and dating violence, students are better prepared to employ these skills in practical settings. Additionally, interactive activities engage students to make the content personal and relevant. For example, at Sierra Ridge students complete a "dating profile" activity where they list qualities they want in a partner and do not want in a partner, followed by a class discussion. This activity negates a 'one-size-fits-all' approach to dating, instead guiding students to make healthy decisions that still align with their individuality.

#### *Program Weaknesses*

The most glaring program weakness in all schools was the lack of formal staff

training. None of the four schools engaged in any widespread staff training specifically on TDV. The lack of staff training was disappointing and confusing, considering the ease of access some schools have to such training. For schools that partner with CPA, staff training is readily accessible, since CPA actively offers staff training. CPA is even accredited to certify teachers to present evidence-based TDV programming. CPA said that this was the most under-utilized program service they offered, and the representative I spoke with mentioned that some schools even have negative attitudes towards the proposal of staff training. Although the schools CPA partners with welcome the educational component, they have overall rejected staff training as unnecessary or irrelevant. This was also confusing taking into account local and state policies that mandate staff training, but list TDV education as an optional topic within health education. After assessing IL HB 3379, I expected schools to implement mandatory staff training and lag behind on the educational component. However, just the opposite seems to be the case. I attributed this largely to the lack of funding both within CPA and within the schools. If schools are making a choice where to allocate funding, providing students education rather than the staff may seem like a more impactful choice for prevention.

Policy was also a program weakness in three of the schools I assessed. Although Roseville High has a formal policy on TDV, it was not readily accessible, as it was not printed in the student handbook. The policies listed in the handbook are discussed on the first day of school, so excluding the policy from the physical handbook also excludes it from formal discussions. I find it unrealistic to believe that students are eagerly typing in links for more information on disciplinary policies, and it is likely many students are unaware the school has a policy. Sierra Ridge has a formal policy prohibiting TDV, and it

is actually quite detailed. However, the teacher at Sierra Ridge I spoke with was unaware that there was a policy. If staff are not up to date on school policies, it is unlikely that students are aware. Better communication between school policy makers and teachers is necessary at Sierra Ridge. Finally, at Columbus High there was no policy whatsoever. When I asked how issues of TDV would be responded to at Columbus, I was told that they would be treated as bullying or harassment. Bullying and harassment overlap with TDV, but the issues are not synonymous and this grouping could lead to inappropriate disciplinary responses.

#### *Facilitating Factors and Barriers*

The primary facilitating factors for effective TDV programming at the schools I assessed were positive teacher attitudes, use of appropriate community partners, and statewide/local policies. Positive teacher attitudes, as discussed in program strengths, stimulated positive discussions about relationships and provided students with responsive allies at the schools I assessed. Teachers at all four schools were truly excited about the material and their role in promoting healthy relationship skills that contribute to overall student well being. Additionally, they all really believed in the preventative power of TDV awareness. At Roseville, many students come from at-risk backgrounds that can exacerbate or contribute to negative beliefs about relationships, but the teacher I spoke with believed that TDV material can mediate these beliefs. Use of a community partner, primarily CPA, was an integral part of creating school-wide awareness of TDV. CPA not only facilitated student learning, but opened up opportunities for parent engagement and future options for staff training.

A final facilitating factor for effective programming was the recent changes in

policy at a state and local level. All of the teachers I spoke with referred to a variety of mandates as reasoning for including TDV education. The teacher at Columbus cited expansion of comprehensive sex education, as opposed to abstinence-only education, as a driver of conversation on healthy relationships. IL HB 3379 was referenced by the teacher at Highland High, as well as CPA, as a reason for including TDV material. The teachers at Roseville and Sierra Ridge, and CPA, discussed the role of Erin's Law, a high profile law implemented in IL in 2013 that mandates schools teach about child sexual abuse. Although Erin's Law does not include any mention of TDV or partner sexual abuse, it has opened the door for discussion of other stigmatized topics, like TDV. With these laws in mind, and the repeated mention of them during my interviews, it is clear that policy has facilitated TDV education.

Primary barriers of TDV programming are the lack of funding, the lack of training, and the lack of awareness. IL HB 3379 mandated a variety of responses to TDV, with widespread local policy response in all four districts I assessed during policy analysis. However, IL HB 3379 mandated program implementation without funding the legislation, burdening schools and community organizations to bear all costs associated with programming. Furthermore, the prevention/education arm of CPA is the least funded service they provide, relying almost entirely on donations. The lack of funding is a huge barrier to progress, and could explain the lack of incorporating staff training into existing programs at Roseville and Highland High. Without funding, underperforming or underfunded schools are further burdened by having to comply with a mandate they can not afford, which may prevent a school from seeking community partners. Unfortunately, this is unlikely to resolve anytime soon. Current federal educational priorities are leaning

away from comprehensive sex education, which can include discussions on TDV, and funding for these topics is unlikely to be a priority (Stanton, 2017). Agreement on an overall state budget in Illinois has been in a stalemate for over a year, and education in general is facing cuts (Finke, 2016). It seems programs will continue to rely on donations for the foreseeable future.

Lack of training and lack of awareness are additional barriers to program success. There was no widespread staff training in any of the schools I assessed, and this is a critical area for improvement. Staff training ensures appropriate, effective responses to TDV and helps create a culture against violence (De Koker et al., 2014). Schools that utilize CPA have ready access to such training, although they may not have necessary financial resources. As both state and local policies mandate staff training, this should be a primary priority of schools. Despite significant progress that has been made to increase TDV awareness, this is still a barrier to effective programming. Ineffective communication of policies with students and staff is one element that could be improved to increase awareness. Better parent communication about TDV could also impact awareness and support of programs. The positive teacher attitudes expressed during my interviews suggests that teachers, and the community, are generally receptive to promoting healthy relationships and recognizing the issue of TDV, so increases in awareness are likely to be generally well received.

### **Conclusion**

Through my framework for integrated evaluation of in-school TDV programs, I was able to create a repeatable process for critical, interdisciplinary assessment of a field still largely overlooked and under measured. Too often, research on TDV programs is

either theoretical or singular, assessing the effectiveness of a particular program in one school. There have been some broad policy assessments, such as state policies overviews conducted by Break the Cycle, however, these assessments do not take into account real-world implementation of policies. The value of an integrated, practical framework is clear: it allows for identification of areas of improvement, it recognizes the successes of schools and community organizations, and it provides pathways for action. Furthermore, this framework allows for these insights with ground-level examples, emphasizing the value of teacher and community experiences.

The framework I created can be repeated for any state, school district, or individual school. The practical utility of this framework is flexible. An individual school seeking to improve their TDV program could use the framework to perform a needs assessment. An advocacy group seeking to expand their community presence could use the framework to map critical areas of improvement. Legislators could use the framework to develop policy that responds to ground-level practices, strengths, and weaknesses. The framework is also flexible in terms of detail. For this study, I briefly assessed four schools for general adherence to elements of effective education, only looking at 2-4 elements for each critical category I identified. The framework could be expanded to include as many elements of effective education as desired by the evaluator, depending on what information they wish to gather. The evaluation could also be condensed for larger projects (say, assessing an entire state) with a short research timespan.

My assessment of four schools in Peoria, IL provided a wealth of knowledge indicating a variety of strengths and areas of improvement. Overall, I was pleasantly surprised to find that all four schools taught their students some aspects of healthy



relationships. This is a rapid shift from the state of TDV education less than four years ago when I graduated from high school in Peoria. Then, conversation on TDV in schools was practically non-existent, at least in my high school. Hearing the topics that teachers and outreach experts are speaking about now is promising, and leaves me wondering if there are now fewer experiences like my friend Lily's, or at least more support for students going through pain similar to hers. There is still progress to be made in these four schools, particularly in the areas of staff training and awareness. Yet, I can confidently say that in terms of TDV, students are in better hands today than when I was in school.

While my assessment of four schools in Peoria, IL does not provide enough data to make broad claims about TDV programs in general, it demonstrates a process that can be broadly used. Still, my assessments were limited by the number of teachers I talked to at each of the schools and the amount of material I reviewed. My interviews over e-mail were especially hindered (Columbus and Highland), and while I still had enough material from these exchanges to assess the school's performance in the seven critical categories, a phone or in-person interview likely would have given me a better picture of their programs. To get a truly detailed understanding of each school's programs, I would have liked to sit in on classes where content was presented and speak with more school personnel, such as principals or school counselors. For future uses of this framework, I encourage incorporating observational data into the assessment.

1 in 3 adolescents nationwide will experience emotional, physical, or sexual abuse at the hands of an intimate partner (Arriaga & Foshee, 2004). TDV is not an inevitable fact of adolescence, and can be prevented through in-school educational programs.

The focus of my research was to create a framework for integrated evaluation of TDV programs, and demonstrate what such an evaluation looks like, and what information it provides, by assessing schools in Peoria, IL. There is a great need for critical reflection and cross communication in the field of TDV prevention, and my framework is only a step in the broader need for progress. Such assessment needs to occur on a widespread basis in order to follow progress and improve outcomes for teens across the nation. Only by investigating ground level realities of these programs will advocates, teachers, and policy makers be able to make intentional, relevant change and foster a culture against TDV.

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