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COMMUNITY GUIDE REVIEW

Intimate Partner and Sexual Violence Prevention Among Youth: A Community Guide Systematic Review

Ramona K.C. Finnie, DrPH,[1] Devon L. Okasako-Schmucker, MPH,[1] Leigh Buchanan, PhD,[2] Denise Carty, PhD,[3] Holly Wethington, PhD,[1] Shawna L. Mercer, MSc, PhD,[4] Kathleen C. Basile, PhD,[5] Sarah DeGue, PhD,[5] Phyllis Holditch Niolon, PhD,[5] Jennifer Bishop, ScD, MPH,[6] Tisha Titus, MD, MPH,[7] Samia Noursi, PhD,[8] Shavon Artis Dickerson, DrPH,[6] Daniel Whitaker, PhD,[9] Susan Swider, PhD,[10] Patrick Remington, MD, MPH,[11] The Community Preventive Services Task Force

Introduction: Intimate partner violence and sexual violence are widespread and often occur early in life. This systematic review examines the effectiveness of interventions for primary prevention of intimate partner violence and sexual violence among youth.

Methods: Studies were identified from 2 previous systematic reviews and an updated search (January 2012−June 2016). Included studies were implemented among youth, conducted in high-income countries, and aimed to prevent or reduce the perpetration of intimate partner violence or sexual violence. In 2016−2017, *Guide to Community Preventive Services (Community Guide)* methods were used to assess effectiveness as determined by perpetration, victimization, or bystander action. When heterogeneity of outcomes prevented usual *Community Guide* methods, the team systematically applied criteria for favorability (statistically significant at $p<0.05$ or approaching significance at $p<0.10$) and consistency (75% of results in the same direction).

Results: A total of 28 studies (32 arms) met inclusion and quality of execution criteria. Interventions used combinations of teaching healthy relationship skills, promoting social norms to protect against violence, or creating protective environments. Overall, 18 of 24 study arms reported favorable results on the basis of the direction of effect for decreasing perpetration; however, favorability for bystander action diminished with longer follow-up. Interventions did not demonstrate consistent results for decreasing victimization. A bridge search conducted during Fall 2020 confirmed these results.

Discussion: Interventions for the primary prevention of intimate partner violence and sexual violence are effective in reducing perpetration. Increasing bystander action may require additional follow-up as effectiveness diminishes over time. Findings may inform researchers, school personnel, public health, and other decision makers about effective strategies to prevent intimate partner violence and sexual violence among youth.
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From the [1]Community Guide Office, Office of the Associate Director for Policy and Strategy, Centers for Disease Control and Prevention, Atlanta, Georgia; [2]Cherokee Nation Assurance, Arlington, Virginia; [3]Office of Women's Health, Centers for Disease Control and Prevention, Atlanta, Georgia; [4]Office of the Director, Center for Surveillance, Epidemiology, and Laboratory Sciences, Centers for Disease Control and Prevention, Atlanta, Georgia; [5]Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia; [6]Office of Women's Health, Health and Human Services, Washington, District of Columbia; [7]American College of Preventive Medicine, Washington, District of Columbia; [8]Office of Research on Women's Health, National Institutes of Health, Bethesda, Maryland; [9]School of Public Health, Georgia State University, Atlanta, Georgia; [10]College of Nursing, Rush University, Chicago, Illinois; and [11]School of Medicine and Public Health, University of Wisconsin-Madison, Madison, Wisconsin

Address correspondence to: Ramona K.C. Finnie, DrPH, Community Guide Office, Office of the Associate Director for Policy and Strategy, Centers for Disease Control and Prevention, 1600 Clifton Road, Mailstop V25-5, Atlanta GA 30329. E-mail: vng7@cdc.gov.

Names and affiliations of the Community Preventive Services Task Force members can be found at: www.thecommunityguide.org/about/task-force-members.html.

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INTRODUCTION

Intimate partner violence (IPV) and sexual violence (SV) are major public health problems that occur across every stage of life but often begin during adolescence.[1] IPV, including dating violence, is committed by a current or former intimate partner and includes physical violence or SV, stalking, or psychological aggression.[2] SV may be committed by a current or former intimate partner or by someone else; it includes sexual acts (e.g., kissing, touching, intercourse) committed or attempted without consent or against an individual who is unable to consent or refuse.[3] In 2019, a total of 10.8% of American high-school students reported experiencing some sort of SV; 8.2% of students who had dated in the previous 12 months reported experiencing sexual dating violence, 8.2% reported experiencing physical dating violence, and 3.0% experienced both in the past year.[4] Prevalence of IPV and SV was higher among female than among male youth, with 16.4% of female and 8.2% of male high schoolers experiencing any dating violence.[4] Lesbian, gay, bisexual, or questioning students reported a significantly greater prevalence of any dating violence and SV than heterosexual students.[4] Prevalence of any dating violence did not vary significantly by race or ethnicity[4]; however, some research suggests that racial and ethnic minority youth may be at higher risk.[5] Experiences of IPV and SV have consequences for youth, including physical injury, substance abuse, poor mental health, and low academic achievement.[6,7] Preventing perpetration (rather than general awareness, risk reduction, victimization response, and other types of secondary and tertiary prevention) has the greatest potential to reduce population rates of violence and its health consequences.[8−10] Thus, adolescence is a critical time to promote attitudes and behaviors that could prevent IPV and SV across the lifespan.[11]

The public health approach to IPV and SV is to prevent or reduce a person's risk of perpetrating IPV and SV.[10] Primary prevention interventions may be geared toward potential perpetrators or bystanders—those who can challenge violence-supportive norms by directly reducing risk (e.g., noticing a risky social situation and intervening) or by indirectly reducing risk (e.g., challenging hostile attitudes toward women such as offensive jokes or objectifying language)[12−15]—and may also reduce victimization (an act that makes someone a victim).[2,3] IPV and SV technical packages,[13,15] developed by the Centers for Disease Control and Prevention Division of Violence Prevention, compile and prioritize primary prevention strategies and actions to help states, local communities, and organizations reduce IPV and SV.[13,15] This *Guide to Community Preventive Services (Community Guide)* systematic review aligns with these technical packages and builds on 2 existing systematic reviews[16,17] to examine the evidence of effectiveness on perpetration, victimization, and bystander action of primary prevention interventions designed to reduce IPV or SV among youth aged 12−24 years.

Methods

Community Guide methods were used for this review.[18] The review coordination team (called the team in the remaining part of this paper) was composed of subject-matter experts in IPV or SV from various agencies and institutions along with systematic review experts from the Community Guide Office at the Centers for Disease Control and Prevention. The team worked under the oversight of the independent, nonpartisan, nonfederal, unpaid Community Preventive Services Task Force.

Conceptual Approach

The team defined interventions for the primary prevention of IPV and SV as those that aim to prevent or reduce the perpetration of IPV and SV and promote healthier relationships between peers and partners. Interventions must take place among youth aged 12−24 years.[19] The interventions included in this review provided educational information about how to recognize IPV or SV, the warning signs, or the consequences of IPV or SV. The interventions could also focus on ≥1 of the following strategies: teaching healthy relationship skills, promoting social norms that protect against violence, and creating protective environments (e.g., improving school climate and safety) (Appendix Table 1, available online). Interventions were implemented in schools, homes, or communities or in a combination of settings. They either targeted the general population or high-risk groups for violence, which may have included youth who previously experienced IPV or SV as a victim or perpetrator.

Interventions may modify social norms around violence by increasing awareness and knowledge of IPV and SV, improving attitudes toward gender equity, and decreasing acceptance of IPV and SV. Interventions implemented by policymakers may increase access to available resources and support within communities to create protective environments. Interventions may lead to improved relationship skills, increased self-efficacy, and improved conflict resolution skills, leading to decreased risk behavior. Through these pathways, primary prevention interventions may reduce perpetration and victimization and decrease morbidity, mortality, and disparities. In addition, these interventions may increase bystander action, which may also reduce

victimization and perpetration. Potential effect modifiers include peer influence, risk behaviors, structural factors (e.g., racism, poverty), and population characteristics, including race, age, sex, and SES. Primary prevention interventions may also have the additional benefits of increasing school achievement and decreasing peer violence, such as bullying.[13,15]

Search for Evidence

The search for evidence consisted of 3 steps. The first step involved searching for existing systematic reviews on the effectiveness of IPV and SV interventions. Two existing systematic reviews were identified: the Whitaker et al.[17] systematic review focused on IPV (search period through 2013) and the DeGue and colleagues[16] systematic review focused on SV (search period through 2014). The second step involved combining IPV and SV interventions into a single review because intervention strategies and outcomes of interest were in alignment. The third step was updating the search, merging the search terms used in both reviews. The updated literature search was from January 2012 to June 2016. Searches were conducted in PsycNET, PsycExtra, PubMed, ERIC, Sociological Abstracts, MEDLINE, Web of Knowledge, Dissertation Abstracts International, and Google Scholar. Reference lists in retrieved articles were also reviewed. The search is available on the *Community Guide* website under IPV/SV Supporting Materials.

Inclusion and Exclusion Criteria

Inclusion and exclusion criteria aligned with those of Whitaker et al.[17] and DeGue and colleagues[16] so that studies were included if they evaluated the primary prevention of IPV or SV among youth aged 12–24 years. *Community Guide* methods include a range of study designs to better assess the effectiveness of public health interventions. For this review, studies were included if they had concurrent comparison groups. The team further restricted to studies that also met the following criteria: (1) reported ≥1 of the following behavioral outcomes: perpetration, victimization, or bystander action; (2) conducted in a very high human development Index country, as classified by the UN Development Program (for comparability to U.S. populations)[20]; (3) peer-reviewed manuscripts; and (4) published in English.

Studies that included interventions to prevent victimization but did not address perpetration (e.g., self-defense or other interventions to modify the potential victim's behavior) were excluded because they did not focus on changing the behavior of potential perpetrators, which is also consistent with the Whitaker et al.[17] and DeGue and colleagues[16] reviews. Studies that combined intervention groups or compared one intervention with another intervention without including an untreated control group were excluded.

Outcomes of Interest

Effectiveness outcomes were assessed using self-reported perpetration, victimization, and bystander action as measured below:

Perpetration and victimization were assessed using self-reported standard scales such as the Conflict in Adolescent Dating Relationships Inventory,[21] Peer Rejection Questionnaire,[22–24] Revised Conflict Tactics Scale,[25] Safe Dates Dating Violence Scale,[26] Sexual Experiences Survey,[27–29] and Sexual Harassment Survey.[30] A *decrease in perpetration and victimization* was defined as favorable.

Bystander action was measured using a variety of scales, including the Bystander Behavior Scale,[31,32] Sexual Social Norms Inventory,[33] and Reactions to Offensive Language and Behavior Scale.[34] An increase in bystander action was favorable.

Assessing and Summarizing the Body of Evidence on Effectiveness

Each included study was independently abstracted by 2 reviewers. Abstraction was based on a standardized abstraction form[35] that included information on study quality, intervention components, participant demographics, and outcomes. Disagreements between reviewers were resolved by team consensus. Threats to validity were used to characterize studies as having good (0–1 limitation), fair (2–4), or limited (≥5) quality of execution.[18] These included internal and external threats to validity such as poor description of the intervention, population, or sampling frame; poor measurement of exposure or outcome; poor reporting of analytic methods; loss to follow-up; or intervention and comparison groups not being comparable at baseline. Studies with limited quality of execution (≥5 limitations) were excluded from the analyses.

Calculation of the Effect Estimates for Qualifying Studies

Effect estimates were calculated for each study when possible.[18] The formula for calculating effect estimates was carried out using 1 of 2 methods, depending on study design and variability of the outcome. The preferred method included nontreated comparison (C) and intervention (I) groups, the basic units for the calculation, with measurements made before (pre) and after (post) the intervention. For studies with multiple inter-

vention arms meeting inclusion criteria and a single nontreated comparison arm, effect estimates for each intervention arm were calculated using the same comparison arm. The team calculated absolute percentage point difference using the following formula:

$$\left(I_{post} - I_{pre}\right) - \left(C_{post} - C_{pre}\right).$$

To pool data from studies reporting different measures to assess the same outcome, relative percent change was calculated using the following formula:

$$\left(\left[I_{post} - I_{pre}\right]/I_{pre}\right) - \left(\left[C_{post} - C_{pre}\right]/C_{pre}\right) * 100.$$

Interquartile intervals (IQIs) were calculated when independent effect estimates were available for at least 5 studies; otherwise, the range of estimates was displayed. For studies with multiple publications, the publication with the latest data point was used in the analysis. In addition, this review stratified results by short-term follow-up (≤6 months) and longer-term follow-up (>6 months). For studies with multiple follow-ups, the team looked at the latest data point in both stratifications. Effect estimates that could not be combined on a scatterplot were described narratively.

Overall Determination of Favorability

Owing to the heterogeneity of outcome measures, effect estimates could not be pooled quantitively because they typically are for *Community Guide* reviews. For example, many studies reported standardized and unstandardized β-coefficients that could not be combined. Therefore, the team ensured a systematic synthesis process by employing criteria and decision rules for favorability and consistency. First, the team assessed all studies (both those summarized quantitatively and qualitatively) for direction of effect. The result was considered favorable if the effect estimate was either statistically significant at $p<0.05$ or approaching significance at $p<0.10$ in favor of the intervention. The same criteria were applied to results that were in the unfavorable direction. Summary of the outcome was considered consistent if ≥75% of the study arms were in the same direction. Overall direction was determined by team consensus regardless of statistical significance.

RESULTS

A total of 3,153 citations were screened: 2,996 from the database search, 18 from included studies in Whitaker et al.,[17] and 140 from those included in DeGue and colleagues.[16] Full-text screening was conducted for 44 publications; 31 studies[32,36−51,52−64] met inclusion criteria (Figure 1). Two studies were reported in 1 publication,[42] 1 study was reported in 4 publications,[26,52,65,66] 1 study was reported in 3 publications,[36,67,68] and 2 studies were each reported over 2 publications.[38,59,69,70] For the 4 studies that are represented by multiple publications, the publication with the latest data point was chosen as the main publication.[36,38,52,59] Summary evidence tables for all included studies can be found at https://www.thecommunityguide.org/sites/default/files/assets/SET-Violence-IPV-SV.pdf.

Appendix Figure 1 (available online) displays the quality of execution assessment for included studies. A total of 8 studies[38,42,47,52,61−63] had good quality of execution (≤1 limitation), 28 studies[32,36,37,39−41,42−46,48,49,53−60] had fair quality of execution (2−4 limitations), and 3 studies[50,51,64] were excluded owing to limited quality of execution (≥5 limitations). The most common limitations were for sampling (used convenience sampling, 16 studies)[32,39−41,44,46−49,52−54,57−60] and loss to follow-up (15 studies).[32,36−39,42,43,45,48,54,56,57,59,62,63]

Study Characteristics

Most included studies were conducted in the U.S.,[32,36,38−49,52−61] whereas 2 others were in Canada,[62,63] and 1 was in The Netherlands.[37] Almost half of the studies were implemented on college campuses,[32,36,42,43,46,48,49,54−57] and nearly half took place in middle schools,[38,45,47,60,62] high schools,[37,40,41,58,59,63] or both.[52] Two studies were implemented in the home,[39,53] and 2 were implemented in community centers or agencies.[44,62] Of the 17 studies reporting population density, most took place in urban areas[36,40,41,44,45,47,58,59,61,62] or a mixture of urban and suburban,[39,42,43,46,53,60,63] whereas 1 study[52] took place in a rural area.

Population Characteristics

Study participants in included studies had a median age of 15.5 years[32,38,39,41−44,46,47,49,52,54,58,62,63]; the median age of participants in studies implemented on college campuses was 19.4 years, and the median age of participants in studies implemented in middle and high schools was 13.9 years. A total of 17[32,36−47,49,52−63] studies included participants identifying as either male or female: 48.1% were male, and 51.9% were female. A total of 7 studies focused on 1 sex: 6 studies[37,49,54,55,57,59] included male participants only, and 1 study[44] included female participants only. Most study participants identified as White (median=69.9%),[38,39,41−46,48,49,52−54,56,57,59−62] whereas the median proportion identifying as Black or African American was 16.1%,[38,39,41−45,47−49,52−54,56,57,59−62] the proportion identifying as Hispanic or Latino was 12.6%,[38,40−43,45,47−49,53,54,56−62] the

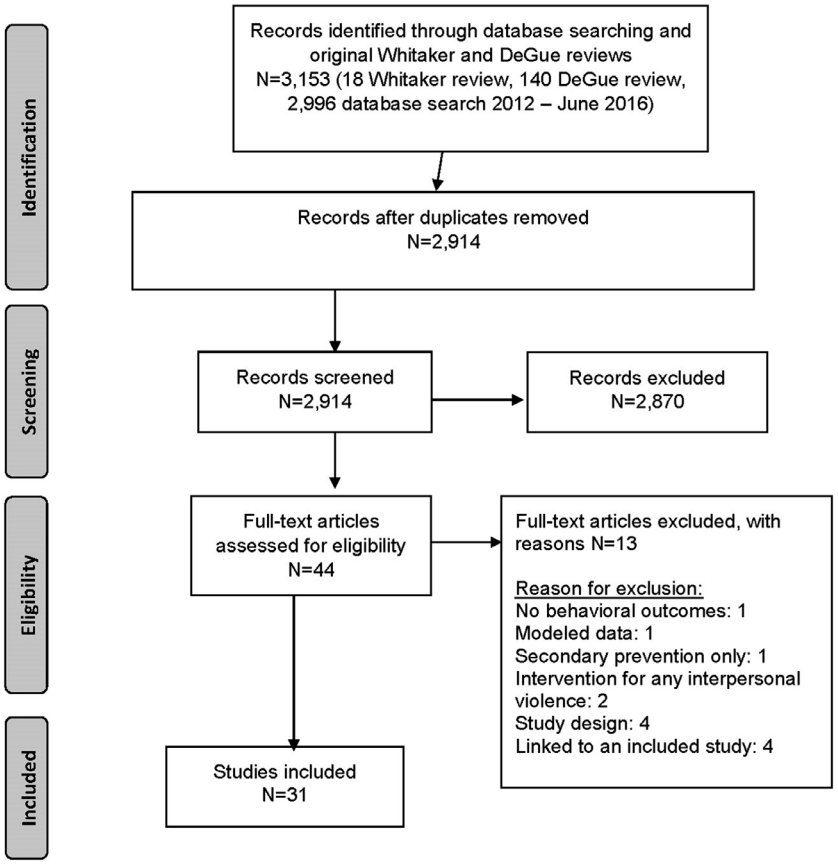

Figure 1. PRISMA flowchart.

proportion identifying as Asian was 6.9%,[41,43,48,49,54,56,59–62] the proportion identifying as American Indian or Alaska Native was 2.2%,[41,43,48,56,57,59] and the proportion identifying as other was 9.9%.[36–39,41–43,45,47–49,52–54,56–61] One study[40] had an exclusively Hispanic or Latino population.

Intervention Characteristics

All studies included strategies that provided information on IPV or SV. Two study arms provided information but did not include any additional prevention strategies.[58,60] In addition to providing information, 19 study arms in 17 studies[36–41,44,45,47,52–55,60–63] also taught healthy relationship skills, and 21 arms in 20 studies[23,25–39,56,59,60,64] also promoted social norms that protect against violence. Furthermore, 15 arms in 15 studies implemented bystander approaches.[32,36,40,42,43,45,46,48,49,54,55,57,59,61] A total of 3 arms in 2 studies[45,61] created protective environments (e.g., improving school climate by identifying hotspots and increasing staff presence).

Outcomes

Perpetration. A total of 24 study arms from 21 studies[36–41,44,45,47,49,52–55,57–63] reported perpetration. A total of 3 arms[40,44,57] reported a median absolute decrease of 6.7 percentage points (ranging from −7.3 to −5.2 percentage points). A total of 3 arms[52,54,59] reported a median relative decrease of 10.1% (ranging from −61.7% to 31.4%). A total of 10 arms from 8 studies[37,38,41,47,49,53,61,63] reported a median decrease in odds of perpetration (OR=0.6, IQI=0.4, 0.8). A total of 9 arms reported data that could not be combined to calculate a median: 5 arms[36,45,53,55,62] reported decreases in perpetration, 1 arm[60] reported no change, and 3 arms[39,58,60] reported increases in perpetration.

Overall, for perpetration, 18 of 24 arms from 17 studies[36–38,40,41,44,45,47,49,52,53,55,57,59,61–63] reported favorable results on the basis of direction (i.e., decrease) of the effect estimate. There was no difference when stratified by length of follow-up time ≤6 months or >6 months or whether the intervention included a bystander approach. Table 1 lists the strategy combinations employed in addition to providing information (teaching healthy

Table 1. Summary of Strategy Combinations That Had Favorable and Consistent Results

Strategy	Result	Example
Teach healthy relationship skills	Perpetration: 5 study arms[37,44,47,61,69] 3 measures of effect, Favorable effects: 4 study arms[37,44,47,69] (80%) Victimization: 4 study arms[44,47,61,69] 3 measures of effect, Favorable effects: 3 study arms[44,47,69] (75%)	Exercises in social resilience aimed at body language, feeling, setting and respecting boundaries, intuition, making contact, standing up for oneself, and communication skills. Conflict management skills for dating.
Promote social norms that protect against violence	Perpetration: 3 study arms[49,57,59] 3 measures of effect Favorable effects: 3 study arms[49,57,59] (100%)	Web portal modules that include interactivity, didactic activities, and episodes of a serial drama Bystander education and empowerment.
Teach healthy relationship skills + Promote social norms that protect against violence	Victimization: 8 study arms[36,39–41,52–53,61–62] 3 measures of effect Favorable effects: 6 study arms[36,52–53,40–41,62] (75%)	Socioemotional learning programs to teach healthy dating skills (conflict resolution). Interactive activities that address dating violence norms, gender stereotyping, conflict resolution.
Teach healthy relationship skills + Promote social norms that protect against violence + Create protective environments	Perpetration: 2 study arms[45,61] 2 measures of effect Favorable effects: 2 study arms[45,61] (100%) Victimization: 2 study arms[45,61] 2 measures of effect Favorable effects: 2 study arms[45,61] (100%)	Identification of hotspots coupled with an increase in staff presence in those areas. Social marketing strategies. School-based teen dating violence prevention curricula to enhance skills and attitudes consistent with promotion of healthy relationships and reduction of teen dating violence.
Promote social norms that protect against violence	Bystander Action <6 months of completing the intervention: 8[a] study arms[32,42–43,48,57,59] 2 measures of effect Favorable effects: 7[a] study arms[32,42–43,57,59] (88%)	Protecting against violence through bystander education and empowerment Engaging men or boys as allies in prevention.

Note: Percentages represent the proportion of favorable studies for each strategy combination; favorable effects included studies with statistically significant effects ($p<0.05$).
[a]Studies included multiple study arms.

relationship skills, promoting social norms that protect against violence, and creating protective environments) that were favorable and consistent along with examples of interventions. Strategy combinations not included in Table 1 had inconsistent results across studies or too few studies to draw conclusions about perpetration. Effectiveness by combinations of strategies along with their corresponding approaches could not be determined.

Victimization. A total of 18 arms from 15 studies[36,38–41,44,45,47,52,53,56,58,60–62] reported on victimization. A total of 7 arms from 5 studies[38,41,47,53,61] reported a median decrease in odds of victimization (OR=0.9, IQI=0.3, 1.0). A total of 12 arms reported data that could not be combined on a scatterplot: 7 arms[36,40,44,45,52,53,62] reported decreases in victimization, 3 arms in 2 studies[56,60] reported no change, and 2 arms[39,58] reported increases in victimization. Overall, 11 of 18 arms[36,38,40,41,44,45,47,52,53,61,62] reported favorable results on the basis of direction (decreased) of the effect estimate. There was no difference by length of follow-up time ≤6 months or >6 months. Table 1 provides a list of strategy combinations that were favorable and consistent. Strategy combinations not included in Table 1 had inconsistent results across studies or too few studies to draw conclusions about victimization. Effectiveness by combinations of strategies along with their corresponding approaches could not be determined.

Bystander action. A total of 10 arms from 9 studies[32,42,43,46,48,49,57,59] reported on bystander action. A total of 8 arms from 7 studies[32,42,43,48,57,59] reported a median relative increase of 2.5% for bystander action (IQI= −5.5%, 22.3%). Two arms reported data that could not be combined to calculate a median. One arm[25] reported significant increases in the percentage of male undergraduate students who reported intervening behaviors (e.g., expressing disapproval when a peer is verbally abusive toward women, attempting to stop a peer who tries to be coercive or violent), and 1 arm[46] reported significant increases among first-year university students in helping behavior for a friend but no change in helping behavior for a stranger. Of the 10 arms, 6 arms[42,46,48,49,59] reported favorable results on the basis of increased bystander action, 1 arm[57] reported no change, and 3 arms[32,43] reported unfavorable results.

When stratified by the length of follow-up, 8 arms[32,42,43,48,57,59] reported a median relative increase in bystander action of 17.9% (IQI=2.8%, 34.6%) within 6 months of completing the intervention

(Appendix Figure 2, available online). However, 4 arms in 3 studies[32,57,59] reported decreases 6 months after intervention completion. Interventions reporting solely on bystander action included strategies to promote social norms—specifically protecting against violence through bystander education and empowerment, engaging men and boys as allies in prevention, or both (Table 1).

Applicability. A total of 4 studies reported results by race or ethnicity,[40,44,47,58] 4 reported results for low-SES populations,[38,39,44,47] and 3 reported results for youth in high-risk settings.[44,52,62] Of studies reporting results by race or ethnicity,[40,44,47,58] 1 study[47] stratified results by race or ethnicity of the sample, 1 study[44] targeted Black or African American adolescent girls, and 2 studies[40,58] targeted Hispanic adolescents (1 study[40] was exclusively Hispanic, and 1 study[58] was majority Hispanic). None of the included studies stratified bystander outcomes by race, ethnicity, or SES. Interventions had favorable results for reduced perpetration and victimization among Black students[44,47] and mixed for both perpetration and victimization for Hispanic students.[40,47,58] A total of 4 studies[38,39,44,47] reported outcomes for low-SES populations measured as the majority of the population eligible for a free or reduced-price school lunch program, on public assistance, or with annual household income ≤$10,000. All interventions had favorable results for reduced perpetration and victimization among low-SES populations. A total of 3 studies targeted youth in high-risk settings (i.e., youth in foster care system,[62] pregnant and parenting adolescent girls,[44] or youth that had experienced violence as a perpetrator or victim[52]) and reported favorable results, whereas 1 study that targeted youth that had experienced violence[39] reported unfavorable results for perpetration and victimization.

Results were consistently favorable for decreasing perpetration among high-school–aged youth and middle-school–aged youth, and results were mixed for perpetration among college-aged youth. A total of 8[37,39–41,44,59,62,63] of 10 arms[37,39–41,44,53,58,59,62,63] among high-school–aged youth were favorable for decreasing perpetration; of these, 1 arm[59] also reported favorable results for bystander action. A total of 6[38,45,47,61,69] of 8 arms[38,45,47,60,61,69] among middle-school–aged youth were favorable for decreasing perpetration; none measured bystander action. One study arm[52] evaluated a program that started with middle-school students and followed them through high school. Results showed that the program was effective for decreasing perpetration and victimization at first follow-up (1 month) and remained effective as the students moved into high school (at 3-year follow-up). A total of 4[36,49,55,57] of 6 arms[36,49,54–57] among college-aged youth were favorable for decreasing perpetration; of these, 1 arm[49] also reported favorable results for bystander action.

DISCUSSION

Summary of Findings

This review found sufficient evidence that primary prevention interventions are effective in reducing the perpetration of IPV and SV among youth. Specifically, those interventions that used the following strategies were consistent and favorable across studies: (1) teaching healthy relationship skills, (2) promoting social norms that protect against violence, and (3) creating protective environments. Other strategy combinations had inconsistent results across studies or too few studies to draw conclusions about perpetration or victimization. In addition, interventions that promote social norms to protect against violence through bystander education and empowerment, engage men and boys as allies in prevention, or do both were found to be effective in increasing bystander action in the short term. Two studies in the review[49,70] that examined the effects of the intervention on both bystander action and perpetration reported favorable results for both outcomes, suggesting that increased bystander action may be associated with decreased perpetration. For studies that reported bystander action, intervention effects appeared to diminish over time, possibly indicating the need for booster sessions or extended interventions.

Similar to this *Community Guide* review, previous reviews reported findings that were favorable but often did not reach statistical significance on the effectiveness of interventions to prevent perpetration and victimization. Previous reviews and this *Community Guide* review highlighted the need for more interventions focused on creating protective environments, changing social norms, and equipping young people to safely intervene when they witness behaviors that can result in dating violence or SV.[11,71,72] The *Community Guide* review differs because it systematically assesses heterogeneous data to identify effective combinations of intervention strategies that can help inform decision makers regarding the best intervention to implement for their population. In addition, the findings from this review provide the basis for a Community Preventive Services Task Force recommendation for primary prevention interventions to prevent or reduce the perpetration of IPV or SV among youth.[73]

The review team conducted a bridge search in November 2020 to identify studies published after this review's search period. Two systematic reviews that focused on bystander interventions reported similar results, although inclusion criteria differed slightly.[74,75] Two systematic reviews focused on dating violence prevention among adolescents in high- and low-income countries.[76,77] Findings from studies in high-income

countries aligned with this *Community Guide* review. Each review also reported the need for more research identifying the specific combination of strategies or components that work together to prevent or reduce dating violence. One additional study not captured in either review reported promising results for the effectiveness of a dating violence program on reducing any SV among middle-school youth.[78]

Evidence Gaps

Included studies consisted of various combinations of intervention strategies and their corresponding approaches, making it difficult to determine which combinations were the most effective, and many combinations included too few studies to draw any conclusions. Specifically, more studies are needed that evaluate interventions aimed at creating protective environments, such as policy change in health, economic, educational, and social sectors. The review also lacked studies that were conducted in rural settings or among youth identifying as 2 spirit, lesbian, gay, bisexual, transgender, queer, intersex, asexual, or questioning or youth with intellectual or developmental disabilities. Moreover, better consensus on the best scales to use to increase comparability across studies and increase the ability to synthesize evidence is needed.[79] More studies are needed that measure morbidity-related outcomes, which were reported by 1 study[62] in this review. Finally, participants in included studies in middle schools reported violence at baseline,[38,45,47,60,61,69] suggesting that some students are experiencing and perpetrating IPV and SV in or before middle school. Therefore, age-appropriate interventions for elementary school students may need to be developed and tested for immediate and later impact on IPV and SV outcomes.

Limitations

This review has several limitations. First, included articles were from peer-reviewed literature; therefore, there is potential publication bias. However, not all published studies found favorable effects. Second, outcomes are based on self-reported data; therefore, there is potential for recall bias and social desirability bias. However, the included studies used validated scales to minimize these biases. Finally, owing to the use of numerous different outcome measures for perpetration and victimization, many studies could not be combined into pooled estimates. Instead, systematic methods were developed and used to explore effectiveness across these highly heterogeneous, self-reported data by requiring 75% of studies for each outcome to show a consistent effect in the favorable direction, regardless of statistical significance.

Conclusions

Adolescence is a critical time to promote attitudes and behaviors to prevent violence. Primary prevention interventions to prevent or reduce IPV and SV can be effective ways to decrease the perpetration of both IPV and SV among youth aged 12–24 years as well as to increase bystander action in the short term. Findings from this review can inform researchers, school personnel, public health decision makers, and parents and other caregivers about effective strategies to prevent violence among youth.

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CREDIT AUTHOR STATEMENT

Ramona K.C. Finnie: Data Curation, Formal analysis, Investigation, Methodology, Validation, Visualization, Writing - Original Draft, Writing - Review & Editing. Devon L. Okasako-Schmucker: Formal analysis, Investigation, Methodology, Validation, Visualization, Writing - Original Draft, Writing - Review & Editing. Leigh Buchanan: Investigation, Validation, Writing - Review & Editing. Denise Carty: Investigation, Validation, Writing - Review & Editing. Holly Wethington: Investigation, Validation, Writing - Review & Editing. Shawna L. Mercer: Conceptualization, Supervision, Writing - Review & Editing. Kathleen C. Basile: Conceptualization, Subject Matter Input, Writing - Review & Editing. Sarah DeGue: Conceptualization, Subject Matter Input, Writing - Review & Editing. Phyllis Holditch Niolon: Conceptualization, Subject Matter Input, Writing - Review & Editing. Jennifer Bishop: Conceptualization, Writing - Review & Editing. Tisha Titus: Conceptualization, Writing - Review & Editing. Samia Noursi: Conceptualization, Writing - Review & Editing. Shavon Artis Dickerson: Conceptualization, Writing - Review & Editing. Daniel Whitaker: Conceptualization, Writing - Review & Editing. Susan Swider: Conceptualization, Supervision, Writing - Review & Editing. Patrick Remington: Conceptualization, Supervision,

Writing - Review & Editing. The Community Preventive Services Task Force: Supervision.

SUPPLEMENTAL MATERIAL

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