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## Final Summary Overview

### A Brief Intervention to Prevent Adolescent Dating Aggression Perpetration

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Adolescent dating aggression (ADA) is a prevalent and consequential criminal justice and public health problem. Recent research suggests that 20% of U.S. high school-attending girls, and 10% of boys, experience physical or sexual dating abuse victimization each year (Vagi, O'Malley Olsen, Basile, & Vivolo-Kantor, 2015). Not only can ADA be deadly, but victimization can lead to serious and long-lasting problems including depression, revictimization, eating disorder, poor school performance, and trauma symptoms (Ackard, Eisenberg, & Neumark-Sztainer, 2007; Banyard & Cross, 2008; Exner-Cortens, Eckenrode, & Rothman, 2013; Shapio, 2014). There are a handful of evidence-based primary prevention programs that are designed to teach youth about healthy relationships (*e.g.*, Safe Dates, The Fourth R, Shifting Boundaries, Green Dot, and Coaching Boys Into Men) (Foshee et al., 1998; Miller et al., 2012; Taylor, Stein, Mumford, & Woods, 2013; Whitaker et al., 2006; Wolfe et al., 2003). However, there is a lack of secondary and tertiary prevention-oriented interventions to stop perpetration. In other words, once ADA has already occurred, we lack effective strategies for intervening with the perpetrators to reduce the likelihood of re-offense. Other noteworthy gaps in available strategies for dating abuse prevention are that many of them are relatively expensive to implement, designed for difficult-to-engage secondary schools, and have been tested primarily with samples of White youth (Rothman & Wang, 2016).

The Real Talk brief motivational interview-style intervention was designed to address these gaps. The theoretically-based intervention capitalizes on what is known about the effectiveness of both motivational interviewing (Rollnick & Miller, 1995), and the Screening, Brief Intervention, and Referral to Treatment (SBIRT) program endorsed by the Substance Abuse and Mental Health Services Administration, Center for

Substance Abuse Treatment (SAMHSA). The content of the one-session intervention was developed with input from experts trained in domestic violence offender reeducation, domestic violence victim advocacy, clinical psychology, adolescent behavior change intervention implementation, SBIRT, and with input from a small group of youth of color (*i.e.*, Black/African-American, Hispanic/Latino, and multiracial youth). The intervention was pilot-tested in 2012 in an urban, Safety Net, hospital emergency department to determine feasibility and preliminary efficacy, before the present trial began (Rothman & Wang, 2016).

The purpose of this NIJ-funded project was two-fold. The first aim was to test the three- and six-month efficacy of the intervention with a sample of urban-residing adolescents who were primarily Black/African-American, Hispanic/Latino and/or multiracial using an experimental design. The second aim was to evaluate the costs of providing the intervention relative to providing no intervention (*i.e.*, a cost analysis).

## **INTERVENTION CONTENT**

The development of the Real Talk dating abuse brief intervention began in 2011, and was originally called “Project READY.” In 2009, the PI was awarded a K01 grant from the National Institutes of Health (NIH, grant number K01AA017630) to study the relationship between underage alcohol use and dating abuse perpetration. One portion of that grant (2011-2013) was spent developing and pilot-testing a brief motivational interview-style intervention to prevent ADA perpetration and alcohol use. The process used to develop the content of that intervention is described in detail in Rothman & Wang (2016). The six-step intervention mapping protocol was followed including needs assessment, identifying behavior change goals; selecting a behavior change theory to

guide the development of the intervention, creating the program and preparing materials, implementing, evaluating and refining (Bartholomew, Parcel, & Kok, 1998). As described above, experts were included in the content development process and several youth gave input on intervention materials and interventionist language. An intervention manual was drafted and a social worker was trained to deliver the intervention by the PI and others. In 2012-2013, the team conducted a small randomized controlled trial (RCT) pilot test with 27 youth to test the feasibility, acceptability, practicality, and efficacy outcomes. The results of the pilot were encouraging and are published elsewhere (Rothman & Wang, 2016).

The NIJ project funding which is the subject of this report (2013-VA-CX-0001) was used to evaluate a refined version of the Project READY intervention, renamed “Real Talk.” Real Talk differed from Project READY in that it was focused on the reduction of ADA perpetration and did not also explicitly address alcohol use, and was tested with 15-19 year olds instead of 16-21 year olds. The Real Talk intervention entails nine steps, summarized in Table 1.

**Table 1. Summary of Real Talk brief intervention content**

Step 1	Introducing the purpose and rationale for the intervention and establishing ground rules for communication.
Step 2	Establishing a rapport with the patient, engaging them, and learning about their dating relationship.
Step 3	Assessing relationship aggression perpetration and victimization in greater detail
Step 4	Providing feedback about the use of violence in dating relationships and outlining five negative consequences of perpetrating dating abuse for the perpetrator. [Note: This step is not designed to instill victim empathy, though it does not discourage it. This step leverages the self-interest of the person who uses violence.]
Step 5	Assessing readiness to change using a readiness ruler graphic

Step 6	Eliciting a plan for behavior change using a healthy relationship strategies handout.
Step 7	Discussing the pros and cons of behavior change and potential barriers to implementing the change plan
Step 8	Reassessing readiness to change using the readiness ruler graphic
Step 9	Referral to any participant-identified resources that will support the behavior change, including (as desired) mental health counseling, employment assistance, housing assistance, sexually transmitted infection testing, primary health care, food pantry, youth development programs, fatherhood or parenting programs, etc.
Step 10	Booster calls: Up to three booster calls in the first six weeks following the intervention to ask how the behavior change plan implementation is proceeding and to offer affirmations and assistance.

**INTERVENTION SAFETY CONSIDERATIONS**

The safety of the intervention participants, their dating partners, and the intervention staff were carefully considered as the intervention was developed. Notably, there were also separate risk and data safety concerns related to the research that evaluated the impact of Real Talk. In this section, we briefly describe the safety concerns related to the implementation of the intervention itself.

Intervention participants: Because a large percentage of adolescents who report ADA perpetration also report victimization (Taylor & Mumford, 2014), there was a concern that our eligibility screening process could identify some individuals as perpetrators of ADA who were “actually victims.” This concern reflects a belief, held by some, that the majority of partner abuse is either unidirectional or almost always involves a primary aggressor. The concern for our intervention was that many “true perpetrators” might deceptively pretend to be victims and that many “true victims” would present to us as perpetrators because of self-blame—particularly if the perpetrator was female. The majority of our sample was female, and the majority reported that the ADA in their relationship was bidirectional. Therefore, we developed a method and protocol

for checking at several points during the intervention whether the participant was experiencing any abuse in their present relationship, had recently experienced abuse victimization by any partner, or was a false-positive in terms of our abuse perpetration screening criterion (e.g., had reported that they hit their partner, but during the discussion it was revealed it was horseplay or consensual sexual dominance behavior like spanking). Any time the interventionist suspected a participant was being terrorized or controlled by a dating partner, or was afraid of their partner, the intervention was halted and the participant was invited to talk with a social worker or domestic violence advocate. In practice, this occurred one time.

Importantly, at baseline 69% of the youth reported both using aggression and experiencing aggression, and those who did not appear to be afraid of their partner or in danger were accepted into the intervention. The rationale of including these youth was that victims of partner violence who use aggression against their abusers may be at increased risk of retaliatory attacks (Capaldi, Kim, & Shortt, 2007; Kimmel, 2002), and that victims who use aggression against partners when there is no imminent threat of bodily harm can be arrested and convicted of assault. In short, persuading youth not to use violence in dating relationships was considered to be of potential benefit to those who were primary aggressors or had perpetrated unidirectional ADA, and to those who were in relationships with bidirectional ADA.

Another safety concern related to the intervention participants was that their jealous and aggressive partners might later find out that they had been discussing the relationship with someone and punish them abusively. To minimize the chances of this occurring, the interventionist discouraged participants from taking any handouts out of

the room with them if they had any sense that it could be discovered and endanger them. In addition, no interventions were conducted with patients whose intimate partner accompanied them to the hospital and were waiting for them on the premises unless the patient stated with total conviction that it was safe to proceed. The research team recorded whether or not the patient was accompanied by anyone else during their hospital visit in 29% of the cases (63/216). From those cases about which we have this information (n=63), we observed that 6% (n=4) of interventions took place with an intimate partner on the premises. Importantly, no adverse or unanticipated events related to conducting the intervention with an intimate partner on the premises took place.

Intervention participants' partners: There was a concern that talking about aggression with abusive youth might rile them up and cause them to behave abusively towards their partner after leaving the hospital. To protect against this possibility, interventionists were trained to watch and listen for signals that the participant was becoming either overly-emotional or withdrawing into a dissociative state, and in this eventuality would have halted the intervention and consulted the attending physician about the potential need for a consult with a trained psychiatric care provider. However, this situation never arose.

Intervention staff: Many youth who participated in this intervention had experienced numerous adverse childhood experiences, including being abused by a parent, living in foster care, experiencing homelessness or sexual exploitation, or had been involved in the juvenile delinquency system. Although the research surveys did not ask questions about adverse experiences, and the interventionists were trained not to



ask questions about them, some youth spontaneously spoke about surviving horrific circumstances. This had the potential to cause secondary trauma in staff. In addition, even with training, not every potential interventionist can tolerate talking with perpetrators of abuse in a non-judgmental way about the harm that they have inflicted on others. A non-condemning attitude, facial expression, and body language is requisite for motivational interviewing. There was one staff person who was trained and later discovered after an intervention that she was unable to cope with the requirement to maintain a neutral expression and friendly demeanor with perpetrators of violence. That staff person was immediately provided with another assignment related to the project that did not bring her into direct contact with youth. In addition, the need for a type of clinical supervision was addressed by providing staff with 24/7 direct access to the PI or Co-Investigator (both trained to deliver trauma-informed counseling), regular team meetings, and a shared notebook that was used as a log where staff could record their thoughts, feelings and reactions to the work and respond to each other with supportive comments. A more formal secondary trauma prevention protocol would strengthen the intervention procedures in the future.

## **RESEARCH DESIGN AND METHODS**

The Real Talk intervention was evaluated using an experimental, randomized controlled trial (RCT) design. In this section, we describe the research methods in detail. Data collection took place between 2014 and 2017. Participants were asked to complete research-related surveys at baseline (before random assignment), 3-months post-baseline, and 6-months post-baseline.

## Data source

Participants were recruited from the pediatric emergency department (PED) and the adolescent outpatient clinic at Boston Medical Center, which is a large teaching hospital in Boston, MA. In total, 146 (66%) participants were recruited from the pediatric emergency room and 74 (34%) participants were recruited from the adolescent outpatient clinic.

*Recruitment.* To recruit participants, research assistants (RAs) used the hospital computer system to identify patients ages 15-19 years old waiting for treatment. If the computer system indicated that the patient was not at the hospital for a traumatic injury or other debilitating/severe health problem, and a nurse or other health care provider approved that the patient was medically safe to approach, the RA would approach the patient to invite them to be screened for eligibility. As per the research protocol, patients who were at the hospital for suicidal ideation or attempt, severe anxiety attack, violent trauma victimization, or who were prisoners or juvenile detainees were not approached. Patients who had cognitive or psychiatric limitations that would render them unable to complete the eligibility form independently, or appeared intoxicated or high on drugs, were not approached. Patients were approached in treatment rooms and in waiting areas.

Patients who expressed interest in being screened by the RA for eligibility completed a paper eligibility form. These forms were completed in private; if the patient had friends or family with them at the hospital, those people were asked to leave the room or immediate vicinity of the patient and were told that they would not be permitted to read the eligibility form after it was completed. Eligibility criteria included being able to

speak English, being in a dating relationship within the last three months, reporting using at least one form of physical or sexual aggression against a dating or sexual partner within the past three months, not currently attending a batterer intervention program, and agreeing to have the research team contact them for follow-up assessments. Patients eligible on those criteria were also asked five questions to determine if they were potentially lethal or extremely dangerous, and only those whose responses indicated that they were not extremely dangerous were considered eligible. Because recruitment was initially slower than anticipated and the research team believed it might be an easy way to identify more participants, the protocol also specified that the team could approach friends or family members who accompanied hospital patients who were between 15-19 years old and met all other eligibility criteria. However, fewer than 10 research participants who were recruited into the study were not hospital patients; in other words, approaching friends and family members did not speed up recruitment. In total, 28% of individuals who were screened were determined to be eligible for the study (see Figure 1).

### **Consent and baseline data collection**

After determining eligibility, research assistants requested assent to participate in research from the youth and, if applicable, consent from their parent/guardian. The Institutional Review Board (IRB) determined that a waiver of parent or guardian informed consent was appropriate in cases where patients 15-17 years old had come to the hospital without their parent or guardian and were making their own healthcare decisions. A Spanish-language version of the parental consent form was available for parents who spoke Spanish but not English. After the assent/consent process, parents

or guardians were asked to leave the room so that the RA and research participant had privacy. In cases when an intimate partner accompanied the patient to the hospital, the RA used extra caution in determining if it was safe to proceed with the intervention, as described below in the “safety considerations” section.

After providing assent or consent, participants completed a paper baseline survey and a contact information form for longitudinal follow-up purposes, and were then randomized to the control or intervention group. The baseline survey took participants approximately 20 minutes to complete.

### **Randomization**

After baseline surveys were completed, RAs would pull a stack of envelopes from the research materials box that they carried to patient rooms. There were three stacks of four (total of 12 envelopes) in the PED materials box and one stack of four (total four envelopes) used in the outpatient setting. RAs were obligated to open the first envelope in the stack which contained an index card with either “intervention” or “control” written on it. Research participants were assigned as per the index card. The envelopes were pre-filled with index cards that had been randomized in blocks of four, meaning that every four cards contained two intervention and two control cards. RAs were not permitted to open more than one envelope for assignment purposes per patient and could not reassign patients, even when hospital staff attempted to override the random assignment. For example, on occasion a nurse or physician told RAs: “This patient would be really good for your intervention, they could really benefit from a talk about dating abuse.”

Control participants were given a palm-sized brochure about dating abuse with a hotline number. Intervention participants spent 30 minutes participating in the Real Talk brief intervention with the trained RA. Interventions were audio-recorded so that they could be checked for fidelity by a trained monitor at a later time. All participants received a \$20 gift card for participating in the baseline data collection.

### **Follow-up contact and data collection**

RAs contacted intervention participants up to three times within the first six weeks after enrollment to boost the effect of the intervention. During booster calls, interventionists discussed any barriers the participants might have experienced while putting their personalized behavior change plans into action and gave any additional resource information that was needed. For research purposes, all participants were also contacted once a month by a member of the research team to confirm that the team still had their correct contact information. Participants received a \$5 gift card for completing each contact check.

RAs also contacted participants at three and six months post-baseline to complete a follow-up survey. Participants could take the surveys online, over the phone, or in-person with a RA. They received a \$25 and \$30 gift card for completing the three and six month surveys, respectively.

### **Measures**

In addition to demographic questions about ethnicity and race, gender, marital/dating relationship status, sexual orientation, number of dating/sexual partners, and highest level of education, data collection instruments assessed ADA-related knowledge, behavioral intentions, behavior, readiness to change, alcohol and marijuana

consumption, use of anger management techniques, depression and anxiety, physical and emotional health, school bonding, health care service utilization, resources use, and acceptability of intervention. We used psychometrically-sound instruments whenever possible, but there were several concepts for which we had to create original measures because no previously-tested one existed.

*ADA-related knowledge.* Knowledge about ADA was measured using a 24-item scale that was adapted from the 42-item MPAB, which has a Cronbach's alpha of 0.98 and good discriminant validity (Follingstad, 2011). The MPAB was designed to assess adults' opinions about whether abusive acts were more severe or less severe violations. Some items from the MPAB were determined to be not relevant for this study population, and the wording was changed to be more interpretable by youth and more relevant in many instances. For example, the word "keepsakes" was changed to "cell phone." Consistent with the MPAB, the response options were a Likert-type scale ranging from 1 to 10. The MPAB instructs respondents that 1 represents "not a violation at all" and 10 represents "worst possible violation." On our measure 1 represents "no big deal," 6-9 represents "kind of an unhealthy thing," and 10 represents "a VERY unhealthy thing." A sample item from our measure is: "Throwing a fit (e.g., breaking objects, acting in a rage) as a way to frighten the person. The Cronbach's alpha in our sample was 0.96.

*ADA behavioral intentions.* ADA behavioral intentions were assessed via an original 15-item scale. Many of the items were adapted from the revised Conflict Tactics Scale (Straus, Hamby, BoneyMcCoy, & Sugarman, 1996). Participants were instructed to indicate "how likely it is that you will do each of these things the next time you are in a

very big conflict with your partner” and response options were “I would definitely do this,” “I would probably do this,” “I am not sure if I would do this,” “I would probably not do this,” and “I would definitely not do this.” One item was reverse coded. The Cronbach’s alpha was 0.86.

*ADA perpetration.* ADA perpetration in the past three months was measured using 23 items of the 24-item Dating Aggression Perpetration Acts Scale (the DAPAS) (Goncy & Rothman, 2016), a modified version of the Safe Dates Perpetration Acts Scale (Foshee et al., 1998). A full description of how the DAPAS differs from the Safe Dates Perpetration Acts Scale, and its reliability and validity, is described in detail elsewhere (Goncy & Rothman, 2016). In this study, one item of the DAPAS was left out of the scale: “gave my partner alcohol or drugs in order to take advantage of them.” Participants were asked how many times in the past three months they had done each of the acts to a dating or sexual partner. The instructions specified “only include it when you did it first. In other words, don’t count it if you did it in self-defense or as joking around.” Response options were “10 or more times,” “4 to 9 times,” “1 to 3 times,” and “never.” Cronbach’s alpha in this sample was 0.81.

*ADA victimization* in the past month was measured using all 23 items of the DAPAS used to assess perpetration, but re-worded for victimization and with two additional questions: “pushed or shoved your face,” and “hit you in the face.” The response options were the same as for ADA perpetration. Cronbach’s alpha was 0.91.

*Readiness to change ADA behavior.* The 32-item URICA-Domestic Violence instrument (Levesque, Gelles, & Velicer, 2000) was reduced to 10 items. The same 5-point Likert-type scale was used for response options as the original instrument, with response

options that included “Strongly disagree,” “Disagree,” “Undecided,” “Agree,” and “Strongly agree.” An example item is: “I’ve been thinking that I might want to change something about myself.” The Cronbach’s alpha was 0.73.

*Alcohol and marijuana use.* A slightly modified version of the three-item Alcohol Use Disorders Identification Test (AUDIT-C) was used to assess alcohol use. The AUDIT-C asks participants to report their alcohol use in the past year and our version did not refer to the past year, but instead asked: “How often do you have a drink of alcohol” with response options “Never,” “Monthly or less,” “2-4 times a month,” “2-3 times a week,” and “4 or more times per week.” Marijuana use was assessed through two original items: “How often do you have marijuana, even one hit (blunt, reefer, bowl)?” with the same response options as the listed above, and “How many times a day do you smoke or use marijuana on days when you are using it?” with response options “Not applicable,” “1 or 2,” “3 or 4,” “5 for 6,” “7 to 9,” or “10 or more.” Cronbach’s alpha was 0.81 for the three AUDIT-C-based items.

*Anger management technique use.* Actions that the participant took to manage anger in the past three months was assessed via 13 original items. These items were designed to reflect some of the healthy relationship behaviors discussed during the intervention. Sample items are: “Take a time out,” “Count to 10,” and “Take a walk or a break when I feel myself getting angry or heated up.” Response options were “no times,” “1-3 times,” “4-6 times,” and “7 or more times.” Cronbach’s alpha was 0.79.

*Depression and anxiety.* 11-items of the 18-item Brief Symptom Inventory (BSI-18) were used to assess past month depression and anxiety. The BSI-18 has been found to have good internal consistency, fair to poor test–retest reliability, and good convergent



validity with other measures of emotional functioning in a sample of high school and college athletes (Lancaster, McCrea, & Nelson, 2016). However, the BSI-18 refers to the past 7 days and our measure referred to the past month. In addition, the response options provided to participants differed from those of the BS1-18. Our response options were “no times,” “1-3 times,” “4-10 times,” and “don’t know.” Cronbach’s alpha was 0.86.

*Physical and emotional health.* Health was assessed via 7 questions adapted from the Rand 36-Item Short Form Health Survey (SF-36). These included questions about self-reported general health, health limitations to physical activity and work, emotional well-being, and the impact of physical or emotional health problems on social activities.

*Academic engagement.* Academic engagement was assessed using 12 questions from the Toolkit for Evaluating Service-Learning Programs (Abt Associates Inc., 2011). A sample item is: “I like being at school.” Response options were “strongly disagree,” “disagree,” “agree,” and “strongly agree.”

*Other questions.* Respondents were also asked 13 original questions about their use of health care services, 7 questions about whether they had used resources to which they could have been referred by the Real Talk interventionist (*i.e.*, talking to a counselor about their relationship, talking to a doctor about getting help for drug, alcohol, sexual, relationship or mental health problems), and five questions about their satisfaction with the intervention.

## **DATA ANALYSIS**

Data collection concluded in July 2017, so as of September 2017 we are still in the process of analyzing data and preparing manuscripts. Basic descriptive statistics

about the sample are available from baseline surveys, and these were tabulated in STATA/SE version 13.1 and SAS version 9.4 (see Table 1). In addition, preliminary exploratory analyses related to changes in ADA perpetration have been conducted and one presentation was made in August 2017 (American Psychological Association annual conference, Washington, DC). The analytic approach used for these preliminary analyses was that change scores representing the difference in scale scores from pre- to three-month post-test were calculated. Differences in those change scores by randomization group were assessed using t-tests. In addition, we conducted analyses of covariance which allows us to compare randomizations groups on change scores and other outcomes while controlling for baseline characteristics.

## **SAMPLE RETENTION**

A total of 140 participants (69% of those enrolled) completed the three-month survey, and 154 participants (77% of enrolled) completed the six-month survey (see Figure 1). These are good to excellent rates of retention for high risk adolescent populations and comparable to what others have achieved with demographically similar research samples (E. Bernstein et al., 2009; J. Bernstein et al., 2010). Importantly, we did not observe any noteworthy differences in demographic or baseline variables for those who were retained vs. loss to follow-up; the comparison of those retained vs. lost to follow up is discussed in detail elsewhere (Velasquez, 2016).

## **FINDINGS**

Based on preliminary analyses, we have three main observations. First, youth in both the intervention and control group appeared to experience improvements in ADA-related knowledge and ADA perpetration behavior from baseline to six months. Second,

it appears that a subset of those in the intervention group experienced statistically significantly better gains in ADA perpetration reduction than those in the control group. Specifically, the subset of youth who were less frequent perpetrators of ADA at baseline appeared to make gains in ADA perpetration reduction that may be attributable to the intervention; for those youth who were less frequent perpetrators at baseline, gains were larger than gains achieved by their control group counterparts. The third observation is that despite the potentially modest impacts on effects, the low cost of the intervention relative to the control suggests that this intervention may be very cost-effective in reducing ADA perpetration relative to control. Our cost analysis is in progress, but preliminary estimates suggest that for hospital systems with social workers or child life specialists already in place—the added cost of this intervention would be small and there would be savings for government and institutional systems of care.

We presently have three papers in preparation which will be under review before December 31, 2017. These include a paper on the main effects of the intervention on ADA perpetration, a cost analysis paper, and a paper that uses qualitative methods to analyze the narratives of abusive incidents provided by the youth who participated in the intervention.

**Table 1. Descriptive statistics for intervention and control group samples at baseline**

	Intervention	Control	$\chi^2$ or t-test, p-value
Total	100% (106)	100% (109)	
<u>Sex</u>			0.012, p=0.91
Male	14% (15)	14% (15)	
Female	86% (91)	86% (95)	
Other	0% (0)	0% (0)	
<u>Race/ethnicity</u>			6.26, p=0.40
Black/African-American	70% (74)	61% (66)	
Hispanic	14% (15)	18% (20)	
Multiracial	9% (10)	12% (13)	
White	4%(4)	6% (6)	
Other	4% (4)	3% (3)	
<u>Relationship status</u>			3.47, p=0.32
Married	4% (4)	1% (1)	
Unmarried but in a dating relationship	50% (54)	56% (59)	
Single	39% (43)	32% (34)	
Other	7% (8)	10% (11)	
<u>Country of birth</u>			0.30, p=0.58
Born in U.S.	81% (88)	78% (80)	
Not born in U.S.	19% (21)	22% (23)	
<u>Sexual orientation</u>			0.23, p=0.63
Heterosexual	78% (83)	81% (89)	
Gay, lesbian or bisexual	21% (23)	19% (21)	
Age (mean average, SD)	17.81 (1.16)	17.68 (1.19)	-0.81, 0.79



## **IMPLICATIONS FOR CRIMINAL JUSTICE POLICY AND PRACTICE IN THE U.S.**

The development and testing of the Real Talk brief intervention addressed a clear and specific gap in criminologic research. As delineated by NIJ experts in 2013, a substantial problem in the field of dating abuse has been that “the majority of established prevention programs [are] universal, school-based programming. While such programs are critically important, given the limitations of school-based programming, alternatives are needed. Specifically, more research is needed to develop effective programs for youth who may not be in traditional school settings—such as youth in the juvenile justice system” (Mulford & Blachman-Demner, 2013). The Real Talk brief intervention was designed to be used outside of school settings and delivered by people who are not professional psychologists and might include probation officers, nurses, youth development program staff, and potentially even peers. The research conducted via this grant has established that it is feasible, practical, relatively low cost, and efficacious for non-clinician young adults to deliver the intervention in a health care setting. An important next step will be to assess whether juvenile probation officers, staff of residential, locked facilities for delinquent youth, or youth outreach specialists that are part of law enforcement or public health violence intervention teams may be able to deliver the intervention and achieve similar outcomes in non-health care settings.

The Real Talk brief intervention project has helped advance the field by providing the first-ever RCT of a brief motivational interview-style intervention that was exclusively focused on ADA perpetration. There has been one prior RCT of a hospital-based intervention that addressed ADA perpetration called SafERteens (Cunningham et al., 2013). The evaluation of SafERteens found effects of the intervention after one year on

peer aggression perpetration and victimization, and on dating abuse victimization, but not on ADA perpetration or alcohol use (Cunningham et al., 2012; Cunningham et al., 2013). The SafERteens intervention was different from Real Talk in a few ways (*NB*: The PI consulted the SafERteens team in the development of Real Talk). The Real Talk intervention was focused on ADA perpetration exclusively, not on victimization or other forms of aggression. The SafERteens intervention was for youth who were alcohol users, and Real Talk did not take into account alcohol use for eligibility purposes. Finally, SafERteens was developed to be delivered by an interventionist or a computer, and Real Talk was only developed for human interventionists to deliver. As a result, Real Talk is a unique intervention and its evaluation makes a significant contribution to the field.

The NIJ-funded STRiV project documented that 69% of U.S. youth report lifetime ADA victimization and 63% report lifetime perpetration, and that 84% of those reporting victimization also reported perpetration (Taylor & Mumford, 2016). Multiple prior studies of ADA have found, as we did, that ADA perpetration is perpetrated by both males and females (Capaldi et al., 2007; Cunningham et al., 2012; Giordano, Copp, Longmore, & Manning, 2016; Taylor & Mumford, 2016). This study builds upon these prior investigations into the prevalence, nature and dynamics of ADA and provides one option for potentially preventing perpetration. This is a novel and urgently-needed approach, as virtually all other ADA prevention strategies are the primary prevention (or population-based) level.

Real Talk results highlight the importance of developing new counseling strategies and intervention modalities through which to communicate with youth about

their aggression perpetration. Not all youth perpetrate ADA for the same reasons (Giordano et al., 2016), and some desist spontaneously while others continue the aggressive behavior with successive partners. Identifying why some desist and what motivates and supports others to make changes in their use of aggression is critically important. To date, nearly all research and programming attention has been devoted to finding pathways to safety for victims and determining which resources they need, or why it is that they are victimized. The topic of ADA perpetration has been critically overlooked. The Real Talk intervention demonstrates that it is not impossible to communicate with youth about their perpetration of ADA; it is possible to further their readiness to change their aggressive behavior--and for some--to alter their use of violence in ADA relationships. Even if the final data analyses reveal that Real Talk had a small affect that was for a short duration for a subset of youth who perpetrated ADA, it is still an achievement because of the number of incidents of ADA that could be reduced annually nevertheless, and because for the first time we have evidence that some strategy can be used to motivate the youth to change. Failing to engineer new methods for engaging with youth who perpetrate ADA, communicating with them, and supporting them in maintaining behavior change would be a serious lost opportunity.

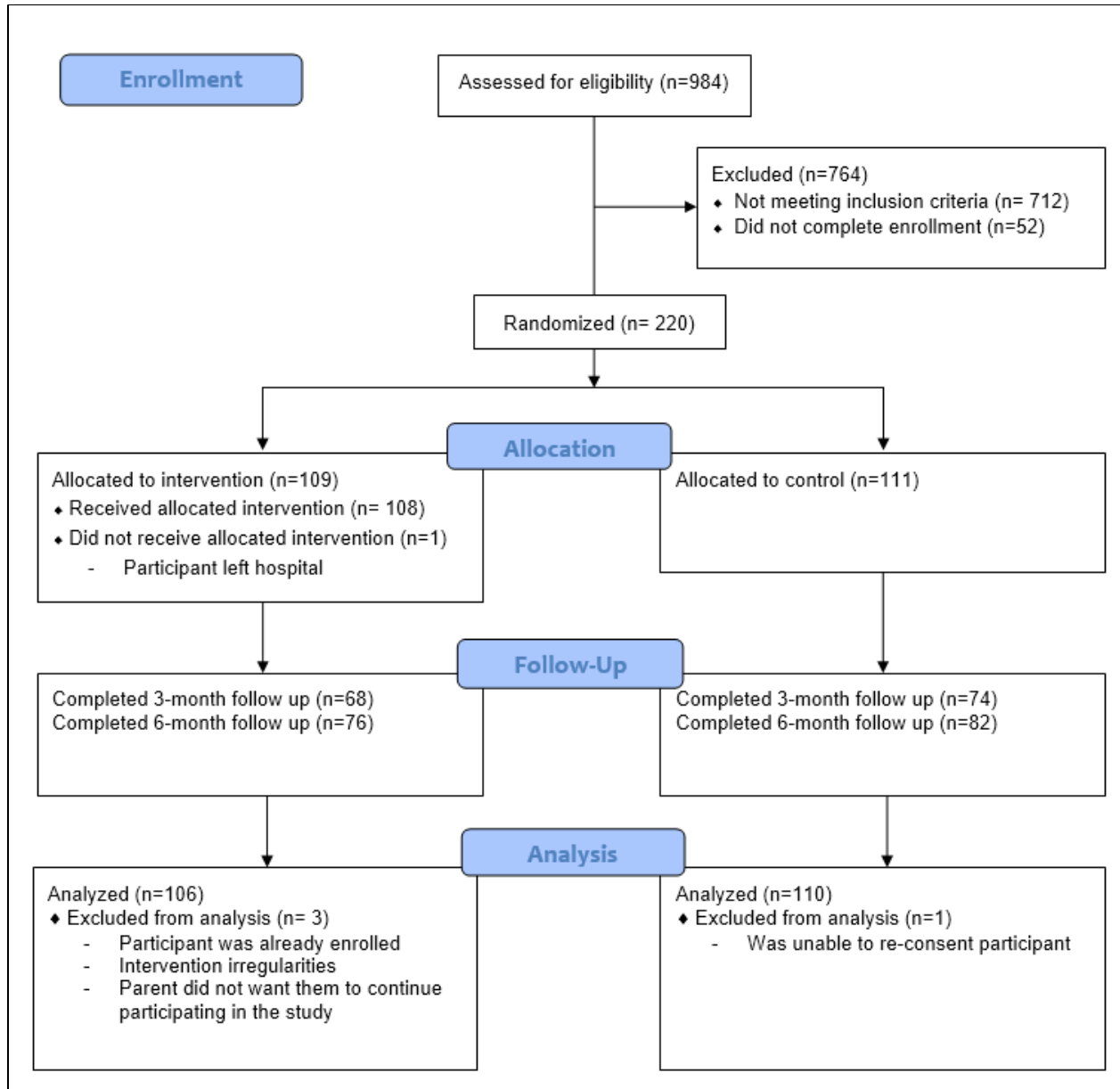
There are numerous future directions that are important for furthering the impact of this research. First, it is important to test if the Real Talk intervention can be adapted for new settings and new types of interventionists (*e.g.*, probation officers, school guidance counselors, school nurses, youth development workers, etc.). Second, it may strengthen the impact of the intervention to include parents, siblings, or friends. Third, it may strengthen the impact of the intervention if it were multi-session. Fourth, we should



develop engaging online assessment and intervention materials for adolescent and young adult dyads to use together, when they recognize and are concerned about the levels of conflict and use of unhealthy behaviors in their dating relationships.

There are 23 million youth ages 12-18 years old in the U.S. who have perpetrated ADA (Taylor & Mumford, 2016). A substantial percentage of them likely feel guilty, frustrated with the quality of their relationships, and want to look forward to an adulthood in which their intimate partnerships are fulfilling, nurturing, satisfying, peaceful, and do not involve assaults, threats, or stalking perpetration. It is the responsibility of adults to craft effective methods for these youth to reach their healthy relationship goals—not only because of the insidious nature of intimate partner homicide and violent crime and its intergenerational adverse effects, but because healthy intimate partnerships, healthy families, and healthy communities will likely exert a net positive effect on other forms of criminal and health-related behavior.

**Figure 1. CONSORT diagram of enrollment, allocation, follow-up and analysis**



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