Education and Communication: Prevention of Intimate Partner Violence

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We examined the relation between sex and relationship education, communication, and prevalence of intimate partner violence (IPV) among college-aged women. We hypothesized that (a) women who received more comprehensive sex and relationship education would report fewer IPV experiences, (b) women who received their sex and relationship education from certain sources would report fewer instances of IPV, and (c) women who communicated more with partners would experience fewer instances of IPV. The study consisted of a survey completed by 48 women at a liberal arts college regarding their IPV history, sex and relationship education, and communication with partners. The first hypothesis was not supported; however, the results showed that women who did not receive their education from a medical professional and women who communicated more with their partner experienced fewer instances of IPV. These results suggest the need for additional research into types of education as tools for preventing IPV and the importance of communication within relationships.

One of the many problems that American society faces today is intimate partner violence (IPV), or violence perpetrated by one intimate partner toward another including psychological, physical, and sexual violence (McDonnell, Burke, Gielen, & O'Campo, 2006). According to the Centers for Disease Control and Prevention's (CDC) estimates (2009b), 4.8 million women and 2.9 million men are raped or physically assaulted by their intimate partners every year. It is important to note that IPV includes not just rape and physical assault but also other violations such as sexual misconduct, verbal abuse, and psychological abuse; the CDC's IPV estimates do not take into account these latter violations. With these other incidents included, the National Center for Injury Prevention and Control (2003) estimated that 5.3 million IPV incidents occur among women 18 years or older a year. The U.S. Department of Justice and the CDC found in a 2000 study that 25% of women experience rape or physical assault during their life (Tjaden & Thoennes, 2000). IPV can have multiple negative effects. Beyond the apparent psychological side effects, studies show that IPV has negative health effects such as an inability to handle stress, increased number of days sick, and increased drinking of alcohol (Bell & Naugle, 2008; Tollestrup et al., 1999). In general women are victims of IPV more often than men, although both men and women experience IPV (CDC, 2009b). The numbers produced by this research show the need for additional research among women in the hopes of lowering IPV within this population. One prevention tactic supported by the CDC is comprehensive sex and relationship education (CDC, 2009a), but few researchers have investigated how certain types and sources of education might reduce the occurrence of IPV. For this reason, we sought to determine if a relation exists between women's education regarding sex and relationships and IPV. The main question we investigated was how the type and source of sex and relationship education—information about sex and intimate relationships that aims to encourage physical and emotional health—related to the number of IPV experiences (including experiences of IPV as a victim or perpetrator).

A small body of research has indicated that certain types of sex and relationship education can prevent future IPV (Foshee et al., 2004); specifically comprehensive sex education programs (Kirby, 2008). The research regarding sex education suggests that education should expand beyond abstinence-only programs into a broader study of sexuality found in comprehensive programs (Ashcraft, 2008; Kendall, 2008; Kirby, 2008; Miller & Schleifer, 2008). Comprehensive

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programs provide students with information from all perspectives (e.g., pro-sex and abstinence) and teach them about the many aspects of sex (e.g., physical, emotional, social). The goal of this type of education is to equip students with tools—such as communication techniques, questions, and activities for couples—so that they can make informed decisions about sex and their relationships (Kirby, 2008).

Some researchers and educators may want to move beyond abstinence-only programs because research has shown that these programs can be detrimental to public health and ineffective in meeting the school's goals. For example, some studies (Booonstra, 2004; Kirby, 2008; Miller & Schleifer, 2008) have shown that abstinence-only programs can cause a public health problem because they discourage condom use, which can lead to unintended pregnancy and the spread of sexually transmitted infections (STIs). Further, a recent meta-analysis of abstinence-only and comprehensive sex education programs found that only three of nine abstinence-only programs had positive benefits (Kirby, 2008). However, the same study found that, relative to abstinence-only programs, comprehensive programs delayed the initiation of sex, reduced the students' number of sexual partners, increased condom/contraceptive use, and reduced the amount of risky sexual behavior in which students engaged. Overall, these studies indicate that comprehensive programs create a healthier attitude toward sex because they encourage discussion of its positive and negative effects. In addition, research reveals that comprehensive programs that include relationship education can help people maintain healthy relationships (Kirby, 2008; Miller & Schleifer, 2008). Therefore, one unrecognized possible benefit of comprehensive sex and relationship education could be the prevention of IPV. Specifically, researchers (Foshee et al., 2004; Kirby, 2008; Miller & Schleifer, 2008) showed that, if women learn that they have power within their relationships and receive tools to deal with difficult situations that might lead to IPV, then violence might be preventable. In sum, comprehensive sex-education can result in improved health and relationships.

Instead of examining how comprehensive sex and relationship education might prevent future IPV, most current research revolves around programs for women who have already experienced abuse (McFarlane, Groff, O'Brien, & Watson, 2006; McFarlane, Soeken, & Wiist, 2000; Melendez, Hoffman, Exner, Leu, & Ehrhardt, 2003) and theory about how to define, treat, and prevent future occurrences of IPV in women who have already experienced IPV (Bell & Naugle, 2008; Ehrensaft, 2008; Tollestrup et al., 1999). For example, Ehrensaft (2008) proposed a developmental theory for IPV that looked to the intersection of IPV and violence in and outside the family. Specifically children who are exposed to violence within other intimate relationships at an early age expect to experience it in their own relationships and then teach these expectations to their peers. Therefore, the expectation of violence develops from early observations within certain children and spreads to peers throughout life. This developmental theory seeks to identify specific risk factors for IPV but research using this theory has not investigated how best to prevent IPV.

However, rather than identify risk factors, some researchers have begun to look directly into methods of wide-spread prevention. According to Whitaker et al. (2006), Foshee et al.'s (2004) is one of the few scientifically rigorous research studies that investigated the effects of a comprehensive education system on adolescents, the majority of whom had not experienced IPV. This research team created a program called Safe Dates in which adolescents learned about what a healthy relationship was, what they should get out of relationships, how to communicate with partners and avoid violence, and how to approach the issue of sex with a partner. In examining how the program affected perpetration and victimization of physical, psychological, and sexual IPV, the researchers found that the Safe Dates program reduced perpetration and victimization of physical and sexual violence. However, the program was less effective in preventing future IPV in participants who had experienced previous violence.

Research programs that examine adult populations have found that relationship education programs lose effectiveness for women who previously experienced violence, especially if it was recent or current (Foshee et al., 2004; Melendez et al., 2003). This finding emphasizes the need for women to receive relationship education early in life, in hopes of them learning techniques for keeping relationships healthy before they have experienced any IPV. However, it is important to note that Foshee et al. (2004) and Melendez et al. (2003) assessed only newly created programs rather than examining the effects of preexisting forms of education. In addition, those researchers also used samples comprised of only children and adolescents. Further, to our knowledge, no research has examined the effect of prior sex and relationship education among college-aged women or the effects of education during the college years from various resources such as family planning centers or university health centers. To fill these gaps we conducted our research among a sample of college-aged women and examined the relations between IPV and (a) current educational systems and instances of IPV and (b) communication between intimate partners.

In sum, we sought to determine how different types of previous sex and relationship education relate to the prevalence of IPV in college-aged women and how these factors might relate to fewer instances of IPV. We hypothesized that students who received more comprehensive sex and relationship education would report fewer IPV experiences. Secondly, we hypothesized that students who received their sex and relationship education from certain sources (e.g., parents, medical professionals, Internet) would report fewer instances of IPV. Our third hypothesis was that women who communicated more within their relationship would experience fewer instances of IPV.

Method

Participants

Fifty-five women from a small liberal arts college in the Midwest participated in this study. Eligibility requirements for participants included (a) at least 18 years old, (b) enrolled at Grinnell College, and (c) self-identified as a woman. After data collection we removed seven women from the sample because they had never participated in an intimate relationship (i.e., romantic partner), reducing the sample size to 48. We recruited participants from introductory psychology courses, fliers posted around campus, and tabling. Tabling consists of setting up a table near areas of high student traffic and asking people walking by whether they would like more information regarding the study and then talking with people who chose to approach the table. Following recruitment, we contacted students by e-mail with more information regarding the time, location, and nature of the study.

The women included in the final sample were relatively evenly represented across class years (first year, $n = 12$; second year, $n = 17$; third year, $n = 8$; fourth year, $n = 11$). The majority of the women identified their ethnicity as White ($n = 37$), but other ethnicities were represented as well (Asian/Pacific Islander, $n = 4$; African American, $n = 1$; Latin American/Hispanic, $n = 3$; Native American, $n = 1$; other, $n = 2$). The participants also identified under a variety of sexual orientations (bisexual, $n = 5$; heterosexual, $n = 39$; lesbian, $n = 1$; not sure, $n = 3$). In terms of intimate relationships, participants reported participating in various numbers of relationships during their lifetimes (1 relationship, $n = 22$; 2–4 relationships, $n = 15$; 5–9 relationships, $n = 10$; more than 10, $n = 1$).The number of sexual partners each participant had varied from zero to greater than 10 (0 sexual partners, $n = 11$; 1 sexual partner, $n = 11$; 2-4 sexual partners, $n = 19$; 5–9 sexual partners, $n = 6$; greater than 10, $n = 1$).

Design

The independent variables were sex and relationship information received, source of sex and relationship education, and use of communication within relationships. The dependent variables were types of IPV (i.e., physical, sexual, psychological) and lifetime numbers of IPV experiences.

Measures

Demographics. This 20-item section of the survey asked for basic information such as age, ethnicity, sexual history, and relationship history.

IPV history. This section consisted of 28 questions asking if the participant ever experienced or perpetrated various types of IPV. The questions were phrased as "I have [insert description of IPV; e.g., assaulted my intimate partner]...times in my life" or "An intimate partner [insert description of IPV; e.g., has assaulted me]...times in my life." Participants then circled the range of numbers that represented the number of times (from 0 to more than 7) they had experienced or perpetrated that type of IPV. Questions addressed physical violence (e.g., hurt an intimate partner in a way that left a bruise, cut, or sprain), psychological violence (e.g., my intimate partner made me feel unsafe), and sexual violence (e.g., began to have either anal, oral, or vaginal sex with me even though I recently told him/her I did not want to have sex). We adapted these questions from existing questions from various published studies (Melendez et al., 2003; Straus, Hamby, Boney-McCoy, & Sugarman, 1996).

Sex and relationship education. This section examined the source of 14 elements of sex and relationship education. Each question was framed as "I received information regarding [insert topic; e.g., sex, how to communicate with an intimate partner] from..." followed by a list of popular sources of sex and relationship education. The list included parents, adult family members (not parent), siblings, friends, school (all levels), religious organizations, community organizations, medical professionals (doctor, nurse, etc.), TV, Internet, magazines, was not taught, and other. We instructed participants to select the top two sources of information for the topic proposed. The questions ranged from basic topics such as sex, STIs, and intimate relationships to how to communicate with an intimate partner and the possible emotional reactions to sex/intimate relationships. We developed these questions partially from the research of Powell (2008), who examined the sources of sex education of adolescents in the United Kingdom.

Relationship beliefs. These four questions listed different relationship beliefs based on the frame "How important is it for you to..." followed by different

relationship philosophies. Some of the philosophies included the importance of communicating directly with an intimate partner about topics such as relationships, sex, and STIs. The participant circled one of the following answers: not important, somewhat important, very important, or essential.

Procedure

When a participant arrived at the location, she checked in with the researchers. While checking in, the participant was asked if she was participating in order to receive introductory psychology credit or $5. If she wanted to receive introductory psychology credit, she provided the appropriate information (i.e., name, student I.D., and section number). If she wanted to be compensated with cash, she did nothing further at that time. We kept compensation receipts separate from the survey information and destroyed the receipts after an appropriate amount of time. Next, we handed the participant the informed consent and asked her to read it and sign and date the bottom. The informed consent included a description of the research, discussed how the study was voluntary and confidential, and described the possible benefits and risks. After completing and returning the informed consent, the participant received the survey and the instructions. After completing the survey, the participant received a debriefing form, which discussed the aims of the study in more detail and provided contact information for the researcher and various counseling resources around campus. If the woman participated for cash, she received her $5 at this point and then printed and signed her name as proof that she received compensation.

Results

Statistics of IPV Prevalence. We conducted chi-squared tests on created IPV scores (general, physical, sexual, psychological) to test the hypothesis. The tests were conducted with a prevalence level of 25%, the estimated level of IPV in the USA (Tjaden & Thoennes, 2000), and the alpha level for all analyses was .05.

First, a significant number of women reported experiencing any number of instances of general IPV relative to women who reported no instances of IPV ($n = 33$, 71.7% of the total sample), $\chi^2(1, N = 46) = 53.58$, $p < 0.001$. Among women who reported experiencing IPV, psychological IPV ($n = 26$, 55.7%), $\chi^2(1, N = 46) = 23.62$, $p < 0.001$, a significant number of women; and sexual IPV ($n = 23$, 44.9%), $\chi^2(1, N = 46) = 15.33$, $p < 0.001$, a significant number of women, were the most common. However, experiencing physical IPV did not appear at a statistically significant level when comparing any level of reported instances to reporting no instances ($n = 8$, 16.7%), $\chi^2(1, N = 46) = 1.41$, $p > 0.05$. Women were also found not to perpetrate general IPV or any subtype of IPV at a significant level ($n = 15$, 31.2%), $\chi^2(1, N = 46) = 1.41$, $p > 0.05$.

Testing the Hypotheses

Education and IPV. Our first hypothesis stated that students who received more comprehensive sex and relationship education would report fewer IPV experiences. First we examined the frequency at which each educational source was reported (parents, 7%; adult family member, 8%; siblings, 8%; friends, 6%; school, 6%; religious organization, 8%; community organization, 8%; medical professional, 7%; TV, 7%; Internet, 8%; magazines, 7%; not taught, 8%; other, 8%); it appeared that no one source predominated.

With respect to the sex and relationship education section of the survey, we found that instead of entering the top two sources of information for each question, some participants noted every source of information for every subsection of sex and relationship education. To remedy this error, we analyzed every source of information for every subsection of sex and relationship education separately (i.e., each of the educational questions had 13 lines, and we noted "yes" or "no" on each line depending on whether the participant put a check mark next to it). Next, we conducted a one-way ANOVA (with the alpha level for all analyses set at .05) to determine if certain sources of sex and relationship education related to elevated or lowered levels of specific types of IPV (i.e., general, physical, psychological, sexual). In our analyses, we entered educational source for a specific topic (i.e., sex education, how to say no to an intimate partner) as the independent variable and a specific type of IPV (i.e., psychological, sexual) as the dependent variable. From these analyses, one significant difference was found. Specifically, the data indicated that women who were not taught how to say no to an intimate partner by a medical professional experienced more sexual IPV, $F(1, 46) = 9.06$, $p = .004$. No other sources of information (parents, adult family members [not parent], siblings, friends, school [all levels], religious organizations, community organizations, TV, Internet, magazines, was not taught, other) were found to change types or amounts of IPV. Through these analyses we determined that there was no support for the first hypothesis. Our second hypothesis was that students who received their sex and relationship education from certain sources (e.g., parents, medical professionals, Internet) would report fewer instances of IPV. The previous analyses partially supported our second hypothesis because college-aged women who received their sex and relationship education from a medical professional experienced fewer instances of sexual IPV.

Relationship beliefs and IPV. Most people stated that the relationship beliefs (e.g., equality between partners, communicating relationship expectations) were very important or essential to them (not important, $n = 13$, 4%; somewhat important, $n = 40$, 14%; very important, $n = 101$, 35%; essential, $n = 134$, 47%). This finding is important because it shows that women generally believe in communicating with their partners and creating egalitarian relationships. We conducted one-way ANOVAs to determine if certain relationship beliefs elevated or lowered levels of certain types of IPV or certain behaviors. We entered the relationship belief as the independent variable and the type of IPV as the dependent variable. We found that women who had conversations with their partners regarding relationship expectations experienced less sexual IPV, $F(1, 46) = 2.92$, $p = .045$. This finding supports our third hypothesis that college-aged women who communicated more within their relationships would experience fewer instances of IPV.

Discussion

The purpose of this study was to determine the relations between experiences of certain types of IPV, sex and relationship education, and specific beliefs within a relationship. We did not find evidence that comprehensive sex and relationship education was related to fewer instances of IPV. The findings did suggest that women whose medical professional did not teach them about how to talk to and say no to an intimate partner experienced more sexual IPV. These results imply that medical professionals might play an integral role in educating women about sex and relationships. Further, women who talked to their partners about relationship expectations in general experienced less IPV.

Our study has significant implications for the development of sex and relationship education. Previous research has shown that sex and relationship education is most effective in preventing violence when the information is taught before the person experiences violence (Foshee, et al., 2004, Melendez et al., 2003). Our research, in conjunction with these previous studies, suggests that adolescents (an age where fewer people have experienced some form of violence) should be taught about relationships and IPV because we found that college-aged women who communicated relationship expectations with their partners—something most likely taught in relationship education—experienced less sexual IPV. However, adolescents also need to learn this information from a reliable source. The current study suggests the importance of sex and relationship education through medical professionals, such as doctors or nurses. Implementing more sex and relationship education might take more time and money but these costs would be offset because preventing IPV in future generations could improve quality of life for many people and diminish costs to the public health system (McDonnell et al., 2006). This study, in combination with previous research (Foshee et al., 2004; Melendez et al., 2003), indicates that teaching adolescents about many elements of relationships, especially how and what to talk to an intimate partner about, could help diminish IPV.

One question this study raises is why medical professionals were the only source of information significantly related to fewer instances of IPV. Perhaps this finding is the result of the training medical professionals receive. Other studies have analyzed how nurse interventions could help detect IPV early and have found relative success (McFarlane et al., 2006; McFarlane et al. 2000). However, most of these studies focus on relatively small populations. A few factors that might make medical professionals better educators than the other sources listed (e.g., parents, friends, community organizations, Internet) include their awareness of the body and relative ease of discussing it, their patient-centered training, and the consistency of their training across the country. However, more research needs to be conducted to examine why medical professionals should conduct sex and relationship education.

This study also has important implications for the specific population studied: college-aged women. We found that intimate partner violence does happen among college-aged women. Ideally the discovery of this fact will encourage college communities to take actions to diminish IPV in their settings.

It is important to note that this study had some limitations. First, we were able to investigate the relation between IPV and sex and relationship education only via a survey because of restrictions on time and resources. We propose conducting additional studies consisting of one-on-one interviews with women, possibly across time. Only through discussing women's changes in education, relationships, and relationship beliefs across time will researchers be able to gain a clearer picture of how sex and relationship education affects IPV. In addition, this population was not diverse in terms of ethnicity and sexual orientation. Further, during the course of the study, about half the participants did not read the directions correctly for the sex and relationship education section, causing them to check more than two choices for sources of sex and relationship education. We had difficulty analyzing the data because some participants checked all the sources they used and others picked the two most prominent sources. This difference in completion of the survey made it harder to distinguish possible relations between education sources and IPV. Our small sample size also

limited this study.

This study suggests that a relation exists between IPV and sex and relationship education and begins to unpack the relation between IPV and sex and relationship education and relationship communication. In addition, our results could influence the development of future sex and relationship education and IPV prevention programs for college-aged populations. This work could be done by analyzing the current sex and relationship education system and its connection to future healthy relationships and by creating new programs and evaluating their effectiveness. The current study is a stepping stone for investigating the relation between current sex and relationship education and prevention of IPV.

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