EDUCATIONAL INTERVENTIONS IN ADOLESCENT DATING VIOLENCE

EFFECTS OF PRIMARY PREVENTION EDUCATIONAL INTERVENTIONS ON DATING VIOLENCE IN ADOLESCENCE: A NARRATIVE SYSTEMATIC REVIEW

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LAY ABSTRACT

Dating violence poses a large health burden to the global population with adolescents experiencing a higher occurrence and severity in dating violence experiences. Prevention prior to dating violence exposure is crucial to prevent any recurrence of violence and manage its related consequences. There are many programs which have been developed to address dating violence in adolescents, with the most consisting of educational approaches. These programs often involve many different types of approaches, and it is unclear which aspects are important for dating violence prevention. The goal of this thesis was to conduct a review of all the types of available primary educational prevention programs for dating violence and examine them in terms of their reported characteristics to determine which ones influenced dating violence prevention. Overall, it remains unclear which characteristics of these education programs contribute to dating violence prevention in adolescents. Future research should also aim to develop a single method for dating violence evaluation. This would allow future programs to be easily compared and inform communities on the best program for their population.

ABSTRACT

Background

Dating violence poses a significant health burden to the global population with adolescents experiencing a higher occurrence and severity in dating violence experiences. There are many educational programs which have been developed to prevent dating violence in adolescents. These programs often involve different approaches, and it is unclear which characteristics are crucial for dating violence prevention. The goal of this thesis was to conduct a review of primary educational dating violence prevention programs and examine their characteristics to determine which ones influenced dating violence prevention.

Methods

This review followed the Cochrane guidelines for systematic reviews and examined the results using a feminist lens. A search was conducted on March 13, 2023, resulting in 2,594 studies, 11 of which were included in the final review. The Cochrane characteristics of included studies and template for intervention description and replication checklists were used to analyze the characteristics of the included studies. A risk of bias assessment using the original Cochrane risk of bias tool was also conducted.

Results

This review found that no intervention characteristics resulted in a clear change in either physical, psychological or sexual DV. However, interventions that were delivered within a month all resulted in an improvement in DV knowledge. Of the studies which used theory to inform intervention development, none explicated stated using feminist theory. Finally, all

studies needed to improve on their methods for allocation concealment and blinding of the outcome assessors.

Conclusion

Overall, this review presented a comprehensive delineation of complex intervention characteristics not previously demonstrated in the literature. However, the results were generally inconclusive. To allow for future reviews to gain a better understanding of the effectiveness of DV prevention programs studies need to first create and then utilize a gold standard tool to measure occurrences of DV. Until this is accomplished, reviews will continue to have varying results due to the inability to synthesize outcomes in a meaningful way.

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LIST OF ABBREVIATIONS

AADS	Attitudes About Aggression in Dating Situations
aIRR	adjusted Incidence Rate Ratio
AMSTAR	A Measurement Tool to Assess Systematic Reviews
aOR	Adjusted Odds Ratio
ATDVS	Attitudes Towards Dating Violence Scales
CADRI	Conflict in Adolescent Dating Relationships Inventory
CBPM	Community Based Participatory Methods
CI	Confidence Interval
CINAHL	Cumulative Index to Nursing and Allied Health Literature
COIS	Cochrane Characteristics of Included Studies
CTS-2	Revised Conflict Tactics Scale
DV	Dating Violence
ES	Effect Size
HIV	Human Immunodeficiency Virus
ITT	Intention To Treat
JVCT	Justification of Verbal/Coercive Tactics Scale
KBEP	Katie Brown Educational Program
OR	Odds Ratio
PP	Per-Protocol
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RCT	Randomized Control Trial

RN	Registered Nurse
ROB	Risk of Bias
RR	Risk Ratio
SLT	Social Learning Theory
SMD	Standardized Mean Difference
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TIDieR	Template for Intervention Description and Replication
WHO	World Health Organization

DECLARATION OF ACADEMIC ACHIEVEMENT

I, Mary-Beth Rush, declare this thesis to be my own work. I am the primary author of this work, dictating the research question, design and analysis of results in addition to acting as the primary reviewer. Jessica Ackerman contributed as the second reviewer for the purposes of the systematic review, including title and abstract screening, full-text screening, data extraction and risk of bias analysis. Dr. Sandra Carroll, Dr. Emily Belia and Dr. Diana Sherifali provided editing and guidance throughout the written portions of this work. Any content which is not my own is cited throughout using the 7th APA guidelines.

CHAPTER 1: Introduction

Background

Intimate partner violence, also known as dating violence (DV) in adolescence, is a pervasive problem affecting countries globally (Cotter, 2021; World Health Organization [WHO], 2021). Dating violence involves the psychological, physical, sexual, reproductive, and coercive abuse by a current or former partner (Cotter, 2021) and affects all ages, ethnicities, socioeconomic backgrounds, and genders (Guidi et al., 2012; Miller & Wiemann, 2022). Physical DV involves the threat or use of assaultive behaviours such as grabbing, hitting, and biting, among other actions (Miller & Wiemann, 2022). Whereas, sexual abuse involves unwanted touching, engagement in sexual activity, or threats of such actions (Miller & Wiemann, 2022). Psychological abuse includes behaviours with controlling features such as manipulation of social relationships, verbal belittlement, intimidation, and coercion involving threats of violence to both parties if a partner is non-compliant (Miller & Wiemann, 2022). DV can be unidirectional, involving a primary perpetrator and victim within a relationship, or it can be bidirectional, where both partners engage in violence (Miller & Wiemann, 2022; Palmetto et al., 2013).

Dating violence has also evolved with the advent of technology, where partners use digital atmospheres to perpetuate violence, stalk, harass, and retain control in relationships (Galende et al., 2020; Miller & Wiemann, 2022). The evolution of technology has enabled DV to be anonymous, constant, instant, and public (Stonard et al., 2017). While DV can be challenging to define and measure, it is broadly characterized as maladaptive methods used to maintain control in a relationship (Exner-Cortens, 2018; Miller & Wiemann, 2022). It has been shown to

have both immediate and long-term health consequences, which transcend generations, creating complexities in addressing the problem (Haag et al., 2022; Okuda et al., 2015; Toccalino et al., 2022; Wathen, 2012),

Prevalence of Dating Violence in Adolescence

Dating violence affects all ages; however, adolescents are at a higher risk for increased incidents of violence and increasingly violent episodes (Cotter, 2021). In the 2018 *Survey of Safety in Public and Private Spaces*, Canadian adolescents and young adults aged 15 to 24 were found to be at particularly high risk for DV (Cotter, 2021; Savage, 2021). Women aged 15 to 24 were twice as likely to experience DV compared to women between the ages of 25 to 44 (Cotter, 2021). Similarly, men aged 15 to 24 were 1.9 times more likely to experience DV compared to those aged 25 to 44 (Cotter, 2021).

This age cohort has been shown to not only experience disproportionately high rates of DV but more severe episodes. Women aged 15 to 24 were six times more likely to have reported being shaken, pushed, or thrown; eight times more likely to have reported being hit with a fist or object, kicked, or bitten; and five times more likely to have reported sexual assault compared to women over 25 (Savage, 2021). The elevated incidence and severity of DV among adolescents highlights the necessity for early intervention to address the disproportionate effects seen within this cohort.

Vulnerability During Adolescence

Targeting adolescence for DV intervention is critical as youth are beginning to navigate dating behaviours and attitudes (Foshee & Reyes, 2009). Adolescents' pre-existing notions about romantic relationships and their desire for social acceptance have been shown to influence their

susceptibility to DV (Weisz & Black, 2009). These notions vary for each individual and are shaped by several factors (Shorey et al., 2017). Accepting violence as a form of love, exaggerated gender roles, fantastical ideals of romance and dependency on others for social acceptance increases their risk of violence (Weisz & Black, 2009). Reframing what defines a romantic relationship and educating youth before they experience violence provides them with the knowledge and skills to avoid victimization and perpetration (Weisz & Black, 2009). This is especially important for at-risk groups such as those who experienced violence in their childhood and from cultures that value traditional gender norms, as it provides a basis for what constitutes healthy relationships (Miller et al., 2018). Interventions targeting this age have the potential to reshape the social and cognitive constructs which form the basis of behaviours and attitudes seen in DV.

Impacts of Dating Violence

Dating violence can lead to harrowing health consequences, that begin in adolescence and can subsist throughout the lifespan. DV in adolescence has direct public health implications as it is linked to an increased risk of adverse gynecological outcomes, sexually transmitted infections (STIs), depression, drug abuse and suicidality (Taquette & Monteiro, 2019). Adolescents exposed to DV are 2.42 times more likely to attempt suicide (Baiden et al., 2021), 2.6 times more likely to contract an STI or human immunodeficiency virus (HIV) (Decker et al., 2005), 3.6 times more likely to use illicit drugs, and 1.9 times more likely to experience an unwanted pregnancy (Hawks et al., 2019). Furthermore, exposure to DV in adolescence has been linked to increased victimization and perpetration of DV in adulthood (Shields et al., 2020; Taquette & Monteiro, 2019; World Health Organization [WHO], 2021). Canadian men and women who experienced DV in childhood were twice as likely to experience all forms of DV in

adulthood (Shields et al., 2020). In the United States, individuals who experienced DV in childhood and adolescence were 66 times more likely to perpetrate DV in adulthood, further solidifying and perpetuating the cycle of violence (Okuda et al., 2015).

As DV extends into adulthood, the health consequences are exacerbated. DV has been associated with cardiovascular disease (O'Neil et al., 2018), obstetric complications, traumatic brain injuries (Haag et al., 2022; Toccalino et al., 2022; Wathen, 2012), STIs, chronic pain, depression, anxiety, substance use and even death (Brown et al., 2009; Exner-Cortens et al., 2013; Taquette & Monteiro, 2019; World Health Organization [WHO], 2021). Women exposed to DV in the United Kingdom were found to have a 30% increased risk for cardiovascular events, a 50% increased risk for type 2 diabetes, and a 40% increase in overall mortality even after adjusting for confounding factors (Chandan, Thomas, Bradbury-Jones, et al., 2020). Compared to women with no DV exposure, those who experienced DV exhibited an increased rate of depression (adjusted incidence rate ratio [aIRR] 1.99; 95% Confidence Interval [CI] 1.80-2.20), anxiety (aIRR 3.05; 95% CI 2.81-3.31), and psychotic disorders (aIRR 3.08; 95% CI 2.19-4.32), even after adjusting for body mass index, deprivation, smoking status and alcohol use (Chandan, Thomas, Bradbury-Jones, et al., 2020). Women experiencing DV also face a threefold risk of STIs (Bonomi et al., 2009) and a 19% to 75% risk of traumatic brain injury (Haag et al., 2022). Pregnant women exposed to DV also have heightened risks showing a 19-fold increased risk of maternal death, a 46-fold increased risk of uterine rupture, and an eightfold increased risk of fetal death if they were hospitalized due to assault (El Kady et al., 2005). These cumulative effects underscore the importance of early intervention to prevent the intergenerational cycle of DV.

Prevention of Dating Violence

Trauma associated with DV is intergenerational, affecting not only individuals but their descendants (Cannon et al., 2009; Howell et al., 2021; Wadji et al., 2022). Adolescents are particularly amenable to changing behaviours and attitudes surrounding DV, making prevention efforts during this stage a principal interest of research (Isobel et al., 2019). First experiences of DV often occur in adolescence, indicating that intervention in early adolescence, when youth are beginning to explore relationships and intimacy, is an ideal time for prevention initiatives (Miller & Wiemann, 2022). Given this, early intervention would be beneficial, equipping youth with skills and knowledge to allow for the recognition and prevention of violent relationships (Isobel et al., 2019).

Several programs have been implemented globally to address and prevent the long-term outcomes associated with DV in adolescents. Interventions such as *Safe Dates* (Foshee et al., 1998), *Green Dot* (Coker, Bush, et al., 2017), *Coaching Boys into Men* (Miller et al., 2012) , and *IM Power* (Baiocchi et al., 2017) are all examples of education based, DV prevention interventions widely implemented across the globe. While many of these interventions report positive outcomes regarding physical, sexual, and psychological victimization and perpetration, they vary widely in structure and implementation (Reyes et al., 2021). These programs are often complex, involving multiple components and approaches. These range from interventions utilizing traditional didactic approaches, gaming, social media, or healthcare involvement to different modes of implementation, intensity, and frequency of education delivery and providers. It is thus unclear which characteristics of these interventions contribute to their success in reducing DV. Several systematic reviews have been published examining the cumulative effects of these programs on rates of victimization, perpetration, mental health-related outcomes, and

attitudes related to DV; however, many of these reviews overlooked the design, content, and implementation of these programs (De Koker et al., 2014; Fellmeth et al., 2013; Lee & Wong, 2022; Piolanti & Foran, 2022; Russell et al., 2021; Whitaker et al., 2006). Only a few of these reviews reported the intervention traits (De Koker et al., 2014; Lee & Wong, 2022; Piolanti & Foran, 2022; Whitaker et al., 2006) , and even fewer reported their effects on their reported outcomes of interest (Lee & Wong, 2022). The lack of understanding of intervention characteristics and their impact on the prevention of DV remains a large gap within the literature. Knowledge of how these programs are delivered and their effects on DV prevention are essential to developing sustainable and scalable strategies targeting DV prevention and lowering the public health burden DV poses.

CHAPTER 2: Literature Review

A targeted literature review was conducted to summarize the current evidence surrounding the crucial aspects of DV that informed the basis of this thesis. This included a summary of the main theories utilized to explain the nature of DV, the rationale for targeting adolescents for DV preventative efforts, a description of the different types of prevention efforts, and how educational interventions have been operationalized. This is then followed by a systematic search and critique of the published systematic reviews to highlight the culmination of the existing evidence and the remaining gaps within the literature.

Theory Underlying Dating Violence Perpetration

While there has been research regarding the prevalence of DV, its associated risk factors and intervention strategies, there remains limited focus on theoretical foundations that explain DV behaviours (Jackson, 1999; Shorey et al., 2008). The field has used pre-existing ideologies to

account for the phenomenon seen within adolescent DV (Shorey et al., 2008). The reason these theories became the predominant theories within adolescent DV is because they are used to explain similar concepts seen within adult intimate partner violence (Bell & Naugle, 2008). While extrapolation of these theories from an adult to an adolescent context can explain some situations, some differences remain.

Three critical reviews were examined, and it was concluded that three main theories within the literature have postulated the reasoning behind the occurrence of DV (Jackson, 1999; Shorey et al., 2008; Wolfe & Jaffe, 1999). These reviews determined that the three primary schools of thought governing adolescent DV are social learning theory, attachment theory and feminist theory (Jackson, 1999; Shorey et al., 2008; Wolfe & Jaffe, 1999). One of the earliest theories within DV literature stems from Bandura's (1973) theory of social learning. Social learning theory hypothesizes that interactions observed early in life become the primary models for the behaviours seen in later relationships (Bandura, 1973; Shorey et al., 2008). Children exposed to violence learn maladaptive coping mechanisms and relationship norms, perpetuating cycles of aggression in later relationships (Shorey et al., 2008; Bandura, 1973). Adolescents observe aggressive methods of coping and problem-solving as it relates to relationships (Bandura, 1973). These behaviours are then reinforced through punishments (or lack thereof) (Bandura, 1973). These behaviours are exacerbated when peer groups become a larger influence creating a social influence that either condones or prevents violence (Jackson, 1999). However, this theory does not account for why some individuals with violent childhoods do not perpetrate DV or those who exhibit DV in adolescence without a history of violence (Bell & Naugle, 2008).

Another theory which has been used to explain DV is attachment theory. Proposed by Bowlby (1980), attachment theory suggests that children create prototypes of relationships based

on the responsiveness of primary caregivers during childhood. Children develop what the theory describes as a secure attachment style whereby they can regulate their emotions when cared for by a nurturing and responsive parent (Bowlby, 1980). However, when a child is cared for by a frightening parent, it results in the inability for the child to anticipate if their parent would respond positively or negatively to the child's actions and leads to the development of a disorganized attachment style (Bowlby, 1980). As per the theory, a disorganized attachment style translates into an inability of the child to regulate their behaviours and emotions as they age (Bowlby, 1980). These models, as demonstrated by the parents during childhood, then serve as a template for individual actions, thoughts, and expectations in future relationships (Bowlby, 1980). Individuals will also gravitate towards relationships that match their attachment style developed in childhood (Bowlby, 1980). If these models are based on dysfunctional and aggressive relationships, these are the behaviours that will then be expected and perpetrated in future romantic relationships (Bowlby, 1980). This theory is similar to Bandura's in that it also cannot account for people who had stable attachments in childhood but now exhibit violent tendencies in adolescence or adulthood. It also cannot account for how the intersection of different social determinants of health affects the experience of DV (Gibby & Whiting, 2023).

Another theory that seeks to explain DV behaviours is feminist theory. This ideology maintains that patriarchal structures ingrained in society promote power imbalances between men and women (Shorey et al., 2008). DV is attributed to the traditional societal power structures where men dominate and females are subservient. This normative socialization process, beginning in childhood, promotes gender roles where men are in control, and women are dependent. This has been shown to result in male-to-female-directed aggression in adolescents (Malhi et al., 2020; Reyes et al., 2016). However, traditional feminist theory has

difficulty accounting for the evidence which demonstrates female-to-male-directed violence (Shorey et al., 2008), bidirectional violence (Brooks-Russell et al., 2015; Park & Kim, 2019), or violence seen within same-sex relationships (Rollè et al., 2018).

Postmodernist feminism can account for these situations in addition to the other behaviours observed in DV (Anderson, 2020). Postmodern feminism rejects the concept that there are inherent differences between males and females and that these ideas stem from masculine notions entrenched in the structure of society (Anderson, 2020). It states that these ideas devalue the significance of individual experiences (Anderson, 2020). Postmodern feminism claims that through destabilizing and restructuring societal hierarchies, male supremacy can be abolished. Furthermore, it claims that through female empowerment, equality can be obtained (McHugh et al., 2005). It postulates that the power imbalances associated with gendered differences are situational. It stipulates that the theorized patriarchal power imbalances constitute an attitude as opposed to inherent tendencies associated with sex (McHugh et al., 2005). Patriarchal societies encourage the use of violence as a means to control others. Postmodern feminism accounts for those who perpetrate DV in adulthood without a history of experiencing violence in childhood through the idea that the partner wants to maintain or gain control within the relationship, thus, they utilize violence to maintain the inequitable power imbalance (Basile et al., 2013). It accounts for those who perpetrate DV with a history of violence, as these individuals learn that violence is a method to gain control within a relationship (Basile et al., 2013). Societal norms then reinforce these ideas that violence begets control (Basile et al., 2013). These concepts are what allow for post-modern feminism to account for a wider variety of complex behaviours within DV (McHugh et al., 2005).

While theories exist to explain DV, it is important to note there is a lack of theory integration in the development of DV prevention programs. The lack of research regarding specific theoretical frameworks underlying DV has translated into a lack of theoretically supported interventions. In a review conducted by Whitaker et al. (2006), they found that the majority of programs for primary prevention of DV in adolescence did not discuss the underlying theory that guided development or implementation. Despite this, they stated it is still possible for interventions to contain ideas similar to these theories without necessarily referencing them or having a formal theoretical basis (Whitaker et al., 2009).

Within the literature, there is still considerable debate over which theory is most applicable, and it is widely accepted that these theories only capture a portion of the phenomena observed in DV (Bell & Naugle, 2008; Jackson, 1999; Shorey et al., 2008). This is likely due to these theories being extrapolated from related fields rather than developing a theory grounded in the observed phenomena. Social learning theory and attachment theory are both limited, as they cannot account for why those with intersecting social determinants of health are at a higher risk for experiencing DV, nor can they account for those who perpetrate DV without a prior history of violence (Dutton, 1999; Gibby & Whiting, 2023). Postmodern feminism offers explanations for the behaviours accounted for in social learning and attachment theory, as well as the situations which cannot be explained by these theories (Basile et al., 2013; Becker et al., 2020; McHugh et al., 2005). Despite the limitations of these theories, postmodern feminism approaches DV with a more encompassing lens and can account for a wider variety of complex behaviours compared to both social learning and attachment theory. Given its broader applicability, postmodern feminism has been chosen as the theory to incorporate into data analysis within this review.

Targeting Adolescence

While the above theories have differing mechanisms explaining the occurrence of DV, they all have a central theme: all involve the early indoctrination of violent behaviours and attitudes in relationships. One of the parameters identified by Nation et al. (2003) in Principles of Effective Primary Prevention is the importance of appropriately timed interventions. They define suitably timed interventions as those which are implemented when the issue is relevant and before the development of any problems. According to these principles, DV primary prevention programs should be implemented when romantic relationships become of interest and before the emergence of issues related to DV (Nation et al., 2003). This becomes problematic given there is variability in the age in which adolescents have their first DV experience and the type of DV experienced (cyber, psychological, physical, or sexual) (Foshee & Reyes, 2009). A survey conducted of American middle school and high school students aged 12 to 17 showed that 28% of respondents who were in dating relationships experienced cyber DV (Hinduja & Patchin, 2021). Bonomi et al. (2012) found that females reported their first occurrence of physical and sexual DV to be 66.7% and 62.5% between the ages of 16 and 17. In males, the first occurrence of physical and sexual DV was 44.5% and 41.7%, respectively between the ages of 16 and 17 (Bonomi et al., 2012). In contrast, Johnston et al. (2015) found that 15% of males and 20% of females had perpetrated physical DV between the ages of 13 and 16. Findings of early onset of DV are consistent through other studies as well. Shorey et al. (2017) found that during study recruitment, some participants had already perpetrated DV by the age of 15. This resulted in study exclusion and possibly biased their results for the age of onset of physical and sexual (Shorey et al., 2017). This body of evidence demonstrates that most adolescents had already experienced DV in some form later in adolescence.

Early adolescence (ages 10 to 14) is marked by the onset of puberty and the beginning of romantic relationships (Forcier, 2022). While interest in dating emerges during this age, there is still variation in cognition and development, and thus the relevance of dating is likely to vary across individuals (Foshee & Reyes, 2009; Forcier, 2022). The aforementioned evidence indicates that early adolescence is a prime period for prevention interventions. This is due to the developing interest in dating, but the improbable experience of DV in this age bracket. This review will then focus on adolescents aged 10 to 18 as a means of DV prevention.

Primary, Secondary & Tertiary Prevention of Dating Violence

In the literature, there are three main areas for DV prevention, including primary, secondary, and tertiary prevention (Cohen et al., 2006). Primary prevention is aimed at preventing the initial occurrence of DV (Cohen et al., 2006; Kisling & Das, 2022). This is achieved through interventions involving education to support healthy relationships before the experience of DV (Anderson et al., 2019; Cohen et al., 2006; Daigneault et al., 2015; Taylor et al., 2013; Temple et al., 2021). Secondary prevention is the identification and treatment of DV victims shortly after the occurrence of violence (Cohen et al., 2006). These programs are targeted at those who are currently in violent relationships and are successful when the victim either leaves the situation or the violence ceases within the relationship (Foshee et al., 1996). These programs involve universal screening and safety planning to prevent violence recurrence (Cohen et al., 2006; Kisling & Das, 2022). Tertiary prevention is the treatment of the long-term effects of DV (Cohen et al., 2006; Kisling & Das, 2022). These programs involve ongoing psychological therapy and community reintegration (Cohen et al., 2006; Kisling & Das, 2022). Given the cyclical nature of violence, primary and secondary prevention approaches are utilized when targeting adolescents, as childhood exposure is one of the most consistent risk factors for DV in

adulthood (Capaldi et al., 2012; Costa et al., 2015; Jung et al., 2019; Roberts et al., 2010). The evidence suggests that by intervening early in adolescence, before the emergence of DV behaviours, it is possible to change the culture surrounding DV and its associated outcomes (Fernández-González, Calvete, & Orue, 2020; Mumford et al., 2019; Wolfe et al., 2009).

Therefore, while tertiary and secondary prevention are important avenues for managing the effects of DV, to truly prevent DV, primary interventions are needed in a younger age cohort. Primary prevention in this age group may contribute to a culture shift, which could interrupt the cycle of violence and occurrences of DV in the future, thus, this thesis will focus on primary prevention.

Educational Interventions for Dating Violence Prevention

Within the literature, educational interventions for dating violence have constituted many forms. Common approaches to educational DV prevention include didactic, bystander, gaming, social media and healthcare-based interventions. While the interventions within these approaches share similar traits in their methods for education delivery, it should be noted that these are complex interventions. Within each program, there are often numerous individual interventions that have been developed and evaluated, each containing different methods for development, implementation, scalability, and sustainability. The studies identified below exemplify characteristics seen within each type of educational intervention, however they do not encompass all possible traits given the complex nature of these programs.

Didactic Education

Traditional didactic education involves the dissemination of dating violence interventions through educational activities such as curriculum content (Foshee et al., 1996). Traditional

programs aim to change norms associated with DV and improve conflict management skills (Foshee et al., 1996). However, even similarly designed interventions can be vastly different from each other in their implementation and reporting. This is evidenced through the contrast between the two interventions Safe Dates (Foshee et al., 1998) and Fourth R (Temple et al., 2021). Safe Dates, pioneered by Foshee et al. (1998), is an example of an early didactic intervention that was designed as a randomized control trial (RCT). It universally targeted rural North Carolina adolescents in the eighth and ninth grades and was designed as a combination of both primary and secondary DV prevention (Foshee et al., 1998). The primary prevention aspect of the intervention involved students performing a theater production, a ten-session educational curriculum, delivered by teachers, and a poster contest on the prevention of DV. The curriculum was comprised of ten, 45-minute sessions addressing DV norms, gender stereotyping, conflict management skills, knowledge of DV services and help-seeking (Foshee et al., 1998). These sessions were led by 16 teachers, who taught health education at the intervention schools (Foshee et al., 1998). These teachers received 20 hours of training on DV and the Safe Dates curriculum before curriculum delivery (Foshee et al., 1998). Foshee et al. (1998) found that one month after study completion, the intervention group experienced a decrease in incidences of psychological violence of 28% ($p<0.05$) compared to the control schools.

A more recent example of a didactic educational program is Fourth R which was developed by Temple et al. (2021). This RCT tested an evidence-based intervention developed in Canada (Wolfe et al., 2009) and involved seven teacher-led sessions on personal safety, seven classes on adolescent development, and eight classes on substance use and addictions. The first unit on personal safety involved education on topics such as healthy relationships, the safe use of technology and the identification of stressors and appropriate coping strategies (Temple et al.,

2021). Activities for this unit included practicing negotiation skills and assertive communication (Temple et al., 2021). The second unit on substance use educated youth on factors associated with substance use, and its implications for family, friends, legality, health, and safety (Temple et al., 2021). Activities involved discussions on the connection between mental health and substance use, practicing help-seeking listening, and supporting skills and role-playing delaying, refusing, and negotiating in the context of substance use (Temple et al., 2021). The final unit on sexual health and adolescent growth included STI/STD education, the definition of consent and factors that influence decisions (Temple et al., 2021). Temple et al. (2021) enrolled 24 schools in urban Texas and found that at one year there was a reduction in physical DV in the intervention schools compared to the control schools (adjusted Odds Ratio (aOR), 0.66; 95% CI 0.43–1.00; p= 0.05). Odds Ratios (OR) were adjusted for possible confounders for DV including sex, race and ethnicity, school district, baseline measure of DV, parental education and intraclass correlation (Temple et al., 2021). These results suggest that Fourth R is effective at reducing physical DV.

While both these studies reported positive effects on DV outcomes, such as psychological victimization and physical DV perpetration, it is evident that they both vary widely. Both interventions contained curriculum content with DV prevention topics, however the specific content varied. Furthermore, while both were delivered by teachers, there was a difference in the number of sessions and the learning activities utilized to solidify knowledge. When adapting these programs to a new setting, it would be difficult to distill which aspects of these complex interventions are contributing to the reported effects. This would make it difficult for practitioners to adapt these interventions to their populations effectively.

Bystander

Another educational approach to DV prevention is bystander programs, where educators train a small sample of youth on ways to intervene when they observe DV and teach them to foster environments that support healthy relationships (Storer et al., 2016). The aim of this approach is both primary and secondary prevention, whereby secondary prevention occurs through bystanders intervening when DV is observed, thus curtailing the violent behaviour (Storer et al., 2016). Primary prevention occurs by shifting social norms, encouraging respect, and failing to reinforce negative behaviour through minimization (Coker et al., 2019; Ozaki & Brandon, 2020; Storer et al., 2016). Bystanders are also how to recognize a situation as problematic, develop a responsibility to intervene, acquire the knowledge to disrupt the situation and try to prevent it (Latane & Darley, 1968). An example of a bystander program trialed as a cluster RCT is the Green Dot developed by Coker, Bush, et al. (2017). The program involved the recruitment of a total of 16,509 students between the ninth and twelfth grades in 26 Kentucky high schools. Every year the student body in the intervention schools (N=13) received a motivational speech introducing the idea of active bystanders, building awareness of DV, and motivating students to get involved in prevention activities (Coker, Bush, et al., 2017; Coker et al., 2011). Then, 12 to 15% of the student body were identified as opinion leaders and given training on recognition of situations that could lead to violence and bystander behaviours which could be enacted to reduce the risk of violence (Coker et al., 2019). This involved a five-hour session training students on the topic of bystanders, barriers to bystander intervention, perpetrators of DV and patterns of DV perpetration (Coker et al., 2011). These sessions were led by educators who received four days' worth of training from the Green Dot program developer (Coker, Bush, et al., 2017; Cook-Craig et al., 2014). These educators were evaluated by the

research team after their training on their delivery of the program through analysis of audio recordings of their speeches and training sessions (Cook-Craig et al., 2014). The aim of this intervention was to change violence acceptance ideology in trained students and teach them how to reduce the risk of DV in their communities. Over five years, Coker, Bush, et al. (2017) found that intervention schools (N=12) which received Green Dot training had a prevalence rate ratio of 0.83 in year three of the program (95% CI 0.70-0.99, $p<0.05$) and 0.79 in year four (95% CI 0.67-0.94, $p<0.01$) compared to standard care schools, resulting in a 17% and 21% reduction in sexual violence perpetration respectively (Coker, Bush, et al., 2017). Compared to the previously described interventions, the educators responsible for delivering the program underwent extensive training and evaluation to determine if they were suitable to deliver the intervention. The content of the training and the activities were also very different compared to the aforementioned studies, further confounding which aspects of these interventions contributed to the observed outcomes.

Gaming

More recently educational interventions have included technology, such as gaming and the involvement of social media, to modernize their programs (Bowen et al., 2014; Lambert et al., 2014; Peskin et al., 2014). However, these interventions are not without their limitations, as technology and social media also create another avenue to perpetrate DV (Miller et al., 2018). Additionally, evaluating these programs poses further complications as previous tools for measuring DV outcomes were not validated for the measurement of cyber abuse constructs (Brown & Hegarty, 2018).

An example of this type of program is the It's Your Game… Keep it Real intervention piloted by Peskin et al. (2014). This study recruited 1445 students from ten middle schools in

Texas, predominantly examining ethnic minorities. This intervention explored how a combination of a virtual reality games and curriculum-based activities affected psychological and physical DV perpetration and victimization (Peskin et al., 2014). Computer activities included interactive skills exercises, peer role model videos, animations, quizzes and video series based on real-world style adolescents (Peskin et al., 2014). The curriculum component consisted of 24 lessons, 12 delivered in the seventh grade and 12 delivered in the eighth grade. Content included topics such as how to identify traits of healthy and unhealthy relationships, skills training regarding peer pressure, setting limits and recognizing peer norms (Peskin et al., 2014). The curriculum component also consisted of homework activities to be completed with parents focusing on improving and increasing communication about healthy relationships, refusal skills and parental rules about dating relationships (Peskin et al., 2014). Four hundred and sixty-three students from five schools in the control group were found to have higher odds of physical DV victimization (aOR = 1.52; 95% CI = 1.20-1.92, $p<0.01$), psychological DV victimization (aOR = 1.74; 95% CI =1.36-2.24, $p<0.01$) and psychological DV perpetration (aOR = 1.58; 95% CI = 1.11-2.26, $p<0.05$) compared to the 303 students who received the intervention (Peskin et al., 2014). All ORs were adjusted for age, gender, race/ethnicity, time between measures and baseline exposure to DV to account for other factors contributing to DV (Peskin et al., 2014). The reasons for students being lost to follow-up were recorded throughout the study and consisted of not completing the baseline survey, not obtaining parental consent, declining to participate, withdrawing from school, and being unable to locate (Peskin et al., 2014). This study was novel because it included a computerized environment that contained learning materials, activities, and multimedia, in addition to a didactic component. Given the previous evidence demonstrating that didactic interventions also produce efficacious results (Foshee et al., 1998;

Foshee et al., 2005; Temple et al., 2021), it remains uncertain whether the results obtained from this study were related to the curriculum component of the intervention or the computerized component.

Social Media

This is the newest avenue of DV prevention consisting of online social platforms and campaigns to target adverse DV outcomes in adolescents (Emerson et al., 2022; Michie et al., 2017). Large RCTs are currently underway examining the effects of digital health interventions on DV. One RCT designed by Koziol-McLain et al. (2021) uses a smartphone application developed in conjunction with Indigenous adolescents in New Zealand to promote healthy romantic relationships. The app allows users to create relationship profiles, utilize healthy relationship resources, and post questions and content related to their relationships with others on moderated chat boards (Koziol-McLain et al., 2021). The study aims to investigate the effects of the app on outcomes such as relationship self-efficacy and cyber safety management (Koziol-McLain et al., 2021).

Healthcare Provider Interventions

Another avenue for DV prevention is through the involvement of healthcare providers in various settings. This avenue is beneficial as it allows for the incorporation of trauma and violence-informed practices, and psychological interventions including cognitive behavioural therapy targeting at-risk populations (De La Rue et al., 2016; Miller et al., 2018; Miller et al., 2012; Rothman et al., 2020). These interventions can be delivered by any healthcare professional, however there is emerging evidence to suggest that nurses are poised to deliver effective interventions in dating violence (Raible et al., 2017). A mixed-methods study conducted by Raible et al. (2017) examined the effects of a school nurse incorporating

discussions about healthy relationships in each student-nurse interaction. This involved reviewing information using a brochure, private interviews and the provision of resources aimed at mitigating the effects of DV, such as family planning partners and a phone to contact help centers (Raible et al., 2017). The authors found that 83% of students felt safe within the school nurse's office and 25% of those who reported being in an unhealthy relationship, shared it with the school nurse (Raible et al., 2017). Registered nurses are viewed as trusted providers, and maintain the skills, knowledge, and judgment to screen and intervene in dating violence (Ames et al., 2014; Glass et al., 2003; St. Mars & Valdez, 2007). Within their scope of practice, registered nurses (RNs) can incorporate emerging educational techniques, such as cognitive behavioural therapy, as well as medical care, referrals to safe housing, academic support and mental health resources (Ames et al., 2014; Ngo et al., 2018). It is part of the public health RN competencies to be able to identify the health needs of a population and develop an appropriate intervention (Kulbok et al., 2012; Public Health Agency of Canada, 2008). However, this can only be accomplished, if registered nurses can adapt interventions to suit specific populations. This may be difficult given that these complex interventions often involve multiple traits, and it is unclear which traits are necessary to generate interventions which result in positive changes.

As evidenced above, educational interventions for DV are complex and multilayered with many methods for the delivery of education to prevent DV in adolescence. Even within each type of intervention, there are numerous ways to execute content development and implementation. Due to the vast variability between intervention design and implementation, a gap remains within the literature addressing which traits of these interventions may play a contributing role in the prevention of DV.

Systematic Reviews in Dating Violence

A literature review was conducted to identify pre-existing reviews examining the effects of primary interventions on dating violence outcomes in adolescents. The search strategy was developed in consultation with a librarian from the McMaster Health Sciences Library and executed on February 27th, 2023 (See Appendix B). There were no restrictions on publication status, dates, or language. The following databases were searched: Ovid Medline Epub Ahead of Print, In-process & Other Non-indexed Citations, Ovid MEDLINE I Daily and Ovid MEDLI(R)" (1946 to February 27th, 2023) , Embase (1974 to February 27th, 2023), Ovid Emcare (1995 to February 27th, 2023), APA PsycINFO (1806 to February 27th, 2023), Evidence-Based Medicine Reviews: Cochrane Database of Systematic Reviews (2005 to February 27th, 2023), Cumulative Index to Nursing and Allied Health Literature (CINAHL) (1981 to February 27th, 2023), Web of Science and ERIC (1966 to February 27th, 2023) and yielded 1347 publications after 492 duplicates were removed (See Appendix C). The titles and abstracts were screened for the following inclusion criteria: a systematic review examining educational interventions addressing DV and targeted an adolescent population. Fifty papers were selected for full-text review based on the aforementioned criteria. During the full-text review, articles were included if: the intervention was aimed at preventing DV, focused on the adolescent population, and was a systematic review. Articles were excluded for the following reasons, focusing on one aspect of DV (psychological, physical, cyber or sexual, including studies that addressed other forms of violence (non-partner sexual violence, bullying, child abuse etc.), compiled only qualitative research studies, limited the population to one sex (male vs female), limited to specific populations (at-risk vs universal) and other article types other than a systematic review.

Five systematic reviews met the inclusion criteria and 45 were excluded from the review (See Appendix C). These reviews were summarized and then appraised using the AMSTAR 2 tool , highlighting their strengths and weaknesses (Shea et al., 2017). This appraisal aimed to establish current knowledge gaps within the literature.

A critical review of interventions for the primary prevention of perpetration of partner violence

The earliest systematic review of DV prevention interventions was conducted by Whitaker et al. (2006). This review included 15 studies, which evaluated 11 interventions, and narratively synthesized program traits and the effects of the intervention on DV perpetration, knowledge and attitudes (Whitaker et al., 2006). Whitaker et al. (2006) carried out a search across eight databases for any experimental studies (randomized, pre/post design, quasi-experimental), that investigated interventions that targeted the prevention of the perpetration of DV between 1990 and March 2003. Studies were excluded if they were aimed at preventing initial or re-victimization of DV, if they were not in the English language and if they were not published in a peer-reviewed article, book, or government publication (Whitaker et al., 2006). Whitaker et al. (2006) found that all, but one study, were within school settings and took a universal approach as opposed to targeting at-risk populations when addressing DV. They found that most methods were didactic with only two studies containing non-curriculum-based activities. Whitaker et al. (2006) also found that the reporting on intervention traits was limited within each study. The authors also found that the majority of interventions were brief, with only five of the 11 interventions totaling more than five hours in duration (Whitaker et al., 2006). The authors found limited reporting of intervention fidelity with only two programs reporting actively monitoring intervention fidelity, both of which had approximately 90% program adherence

(Whitaker et al., 2006). Seven of the programs did not report on participants exposure to the intervention and four of the interventions monitored attendance (Whitaker et al., 2006). Two of the five studies that reported changes in DV perpetration reported positive intervention effects resulting in a decrease in DV perpetration (Whitaker et al., 2006). Nine studies reported changes in attitudes related to DV, five of which reported improved attitudes, three reported no effects and one reported worsened attitudes related to DV (Whitaker et al., 2006).

One of the strengths of this review is that it was one of the few to report intervention traits and examine how existing theory was integrated into intervention design (Whitaker et al., 2006). However, while the authors did describe the intervention traits, they also noted that many of these early studies lacked information regarding intervention description and evaluation of intervention fidelity among the population (Whitaker et al., 2006). Whitaker et al. (2006) did not examine how these intervention traits impacted the outcomes of interest. A limitation of the review by Whitaker et al. (2006) was the methodology, as their search strategies for each database were not identified, nor did they identify how many articles were found through the initial search (Shea et al., 2017). They did not articulate their criteria for title and abstract screening, nor did they state the reasons for study exclusion in the full-text review (Shea et al., 2017). Furthermore, they also included non-RCT study designs, which are at a higher risk of bias (ROB) (Higgins et al., 2022; Shea et al., 2017). Whitaker et al. (2006) detailed that they followed specific guidelines for ROB evaluation however, they neglected to articulate if the ROB assessments were completed independently by two authors and the specific criteria for how each study was rated (Shea et al., 2017). An important limitation relates to the currency of the review; since it was published almost two decades ago, there have been several emerging publications within the field, meaning that their findings may be dated.

Educational and skills-based interventions for preventing relationship and dating violence in adolescents and young adults

Despite an increasing amount of literature on DV, only one Cochrane systematic review by Fellmeth et al. (2013) has been published which examined the effects of educational interventions on the prevention of DV in adolescents and young adults. This Cochrane review aimed to examine the effects of primary and secondary educational interventions on episodes of relationship violence, physical and psychosocial health, attitudes, knowledge, and behaviours related to relationship violence in adolescents and young adults (aged 12 to 25 years) (Fellmeth et al, 2013). The authors searched 12 databases for any RCT (individual, quasi or cluster) that examined interventions that explicitly stated were for the prevention of DV and involved the provision of education or skills (Fellmeth et al., 2013). Their initial search yielded 18,352 records after duplicates were removed, which they narrowed to 98 records for full-text review (Fellmeth et al., 2013). Fellmeth et al. (2013) included 38 studies in the review and 33 in the meta-analysis after full-text review. This review identified 38 relevant RCTs that found no statistically significant effect of educational programs on episodes of relationship violence, changes in behaviour and protective skills (Fellmeth et al, 2013). Studies (n=8) evaluating episodes of relationship violence had a reported risk ratio (RR) of 0.77 (95% C, 0.53-1.13; p=0.02). Twenty-two studies were included which assessed attitudes toward DV and reported a standardized mean difference (SMD) of 0.06 (95% CI, -0.01-0.15). Four of the included studies assessed behaviour related to DV and reported an SMD of -0.07 (95% CI -0.31 to 0.16). The results indicate that while educational interventions resulted in fewer incidences of relationship violence, less acceptance of DV, and improved positive behaviours in relationships, the true effect may be null or even negative. Fellmeth et al. (2013) did report a statistically significant

difference between intervention and control groups in knowledge of relationship violence (SMD 0.44, 95% CI 0.28 to 0.60, p=0.03), demonstrating a slightly beneficial effect. Unfortunately, knowledge of relationship violence also had substantial statistical heterogeneity in the summary statistic (I^2= 57%) limiting its utility. While the study was able to draw quantitative statistics and generate a forest plot from the data collected there were a few limitations. The first limitation, outlined by the authors included a lack of studies that examined health outcomes, both physical and mental, as a result of the educational intervention. This is despite DV being linked to significant physical and mental health effects. Second, many of the outcomes measured were proxies for DV. For example, concepts such as knowledge, attitudes and skills related to DV, while important precursors and risk factors for DV, are not a direct measure of DV perpetration and victimization. It is important to measure these, in addition to direct measures of DV, such as DV perpetration and victimization. Fellmeth et al. (2013) also concluded that positive changes in attitudes and beliefs surrounding DV may not necessarily translate into a direct reduction in DV. It was hypothesized by Fellmeth et al. (2013) that youth may understand the concepts behind prevention of DV, but they may not be able to effectively employ them, meaning they still become either victims or perpetrators of violence despite adequate knowledge. Therefore, Fellmeth et al. (2013) stated that data collection of more direct measures is required, such as reported DV perpetration and victimization, as opposed to solely predictive measures such as knowledge, attitudes, and beliefs. This is to ensure that while there is a change in knowledge, there is also a change in the behaviours associated with DV.

Another limitation identified by Fellmeth et al. (2013) is that all the included studies were from high-income countries. The authors concluded that this was potentially due to classifying dating violence as intimate partner violence, given the younger age for marriage in some

countries. Additionally, there was speculation that there was potentially limited research in these countries as well as fewer reports of DV due to differences in gender norms, perpetrated by cultural variation. Since its publication, several studies have been conducted in low-middle-income countries, mitigating this limitation in future reviews (Kieselbach et al., 2022; Reyes et al., 2021; Rumble et al., 2020). While not mentioned by the primary authors, there were several other limitations regarding this review as outlined through the AMSTAR 2 tool (Shea et al., 2017). The first of which is that Fellmeth et al. (2013) did not justify the broad range for their population of interest. As previously discussed, there are significant differences between the targeting of interventions of different age cohorts. Fellmeth et al. (2013) did not make justifications as to why older age groups were included or why the age limit of 12 years was selected (Shea et al., 2017). Another limitation of this study is their oversimplification of complex interventions. In their reporting, they did not address the multilayered traits of each intervention but rather oversimplified how each was developed and delivered (Shea et al., 2017). Finally, despite exceeding their predetermined limit for heterogeneity outlined in their review protocol, the authors conducted a meta-analysis instead of pursuing a different avenue of data synthesis (Shea et al., 2017). This was rationalized as the heterogeneity was only marginally over their 50% limit, however it could be argued that the data would have been better reported using alternative methods such as a narrative synthesis. The observed heterogeneity could be due to the inherit difference interventions, such as population, content and program delivery, as opposed to a true effect seen due to the intervention. The combination of instrument measures also affected their reported results as authors could only report findings as SMDs (Shea et al., 2017). SMDs are difficult to interpret in the context of quantifiable clinical effects and make translation of the research difficult (Schünemann et al., 2022).

Randomized controlled trials evaluating adolescent dating violence prevention programs with an outcome of reduced perpetration and/or victimization: A meta-analysis

Russell et al. (2021) conducted a systematic review and meta-analysis examining the effects of DV prevention programs on DV perpetration and victimization in adolescence. Their inclusion criteria were any RCT on DV prevention interventions that measured their outcomes of interest (Russell et al., 2021). They also limited their inclusion criteria to studies with populations under the age of 18 and had no restrictions on geographic location or publication date (Russell et al., 2021). They excluded any programs that evaluated other forms of violence and studies that were not peer-reviewed (Russell et al., 2021). Their search of ten databases yielded 9919 records which was narrowed to nine studies for synthesis (Russell et al., 2021). They found that there was no significant effect on overall DV perpetration (n=2) (SMD = −0.04, 95% CI [-0.11, 0.04]) (Russell et al., 2021). Six studies examined emotional DV, with three reporting continuous outcomes and three reporting dichotomous outcomes, resulting in separate summary statistics for each outcome method (Russell et al., 2021). Interventions were found to reduce emotional DV perpetration in both the categorical (RR = 0.75, 95% CI [0.70, 0.80], p=<0.001) and the continuous (n=3) (SMD = −1.13, 95% CI [-2.09, −0.17], p=<0.05, I^2 = 97%) outcome measures (Russell et al., 2021). Seven studies were found that reported intervention effects on physical DV perpetration, three of which measured the outcome categorically, one measured it continuously, one measured it in combination with sexual DV and two measured it by level of severity (Russell et al., 2021). Authors only reported one summary statistic for the categorical measurement of physical DV perpetration (n=3) and found that interventions reduced the risk of physical DV perpetration (RR = 0.77, 95% CI [0.63, 0.94], p=<0.05) (Russell et al., 2021). The authors found two studies which reported intervention effects on sexual DV

perpetration, one which measured the outcome continuously and one which measured it categorically with physical DV perpetration (Russell et al., 2021). Authors only reported one summary statistic for the categorical measurement of sexual DV perpetration (n=1) and found that interventions reduce sexual DV perpetration (SMD = −0.14, 95% CI [-0.26, −0.03], p=<0.05) (Russell et al., 2021).

Russell et al. (2021) then looked at how interventions affected victimization-related outcomes. They reported that overall DV victimization was measured continuously by only one study and resulted in no statistically significant change in DV victimization (SMD = −0.03, 95% CI [-0.17, 0.11]) (Russell et al., 2021). The authors found six studies that measured emotional DV victimization, three of which measured it using categorical variables and three measured it using continue variables (Russell et al., 2021). They found that emotional DV victimization measured categorically (n=3) was reduced significantly by these interventions (RR = 0.77, 95% CI [0.73, 0.81], p=<0.001) with an I^2 = 81%, whereas the continuous measurement of emotional DV victimization had no significant change (SMD= −0.07, 95% CI [−0.17, 0.04]) (Russell et al., 2021). Similar to physical DV perpetration, the authors found six studies that evaluated physical DV victimization in response to educational interventions (Russell et al., 2021). Of these six studies, one measured physical DV victimization continuously, two measured it categorically, one measured it categorically in combination with sexual DV victimization, and two measured it by level of severity (Russell et al., 2021). Physical DV victimization measured categorically (n=2) was found to be significantly reduced by the interventions (RR = 0.79, 95% CI [0.71, 0.87], p=<0.001) (Russell et al., 2021). Sexual DV victimization was measured by two studies, one continuously and one in combination with physical DV victimization (Russell et al., 2021).

The authors found that there was no change in sexual DV victimization measured continuously (n=1) (SMD= 0.08, 95% CI[−0.23, 0.40]) (Russell et al., 2021).

The strengths of this study included an explicit rationale for RCT restriction, explaining the inclusion and exclusion criteria for study selection and their comprehensive search of the literature (Shea et al., 2017). However, the reviewers did not state if the screening, both title and abstract and full-text, was done independently, nor did they provide search strategies for each database (Shea et al., 2017). Furthermore, while the authors conducted a ROB assessment utilizing the Cochrane guidelines, they failed to articulate if the assessment was done independently by at least two reviewers, and they did not provide detailed justifications for their ratings of each study (Shea et al., 2017). They also did not include how their ROB assessment affected their results given that some had a high risk of bias ratings (Russell et al., 2021; Shea et al., 2017). Furthermore, of the 24 summary statistics they calculated, only seven contained two or more studies in their calculations (Higgins et al., 2022). This means that the majority of their statistics are not a meta-analysis given that meta-analyses require two or more studies (Higgins et al., 2022). Additionally, the authors selectively reported some of the I^2 statistics, those that are reported as being very high, limiting the applicability of their results and creating bias within their review (Higgins et al., 2022; Shea et al., 2017). The authors also provided a minimal amount of information regarding the details of each study's population, intervention, comparators and outcomes (Shea et al., 2017). Therefore, while the authors generated numerous summary statistics, the conduct of their study has methodological limitations and lacks reporting.

Efficacy of Interventions to Prevent Physical and Sexual Dating Violence Among Adolescents: A Systematic Review and Meta-Analysis

Piolanti & Foran (2022) conducted a systematic review and meta-analysis examining the effects of prevention programs on adolescent physical and sexual DV. Their inclusion criteria included any randomized study that examined the efficacy of an intervention in reducing DV in adolescence (Piolanti & Foran, 2022). Their analysis included 18 trials and showed a statistically significant reduction in physical DV perpetration (n=13) (OR, 0.74; 95% CI, 0.59-0.92; p = 0.01) and survivorship (n=10) (OR, 0.78; 95% CI, 0.64-0.95; p= 0.01). However, for sexual violence they reported not statistically significant pooled effects for both perpetration (n= 6) (OR, 0.88; 95% CI, 0.76-1.02; p=0.09) and survivorship (n=4) (OR, 0.88; 95% CI, 0.71-1.08; p=0.22) (Piolanti & Foran, 2022). This study did extract data about interventional components, such as targeted (high-risk) versus universal application, age of delivery (above or below 15 years of age) as well as if there was parental involvement (Piolanti & Foran, 2022). They concluded that primary interventions that targeted high-risk adolescents (n=5) with a history of violence and universal (n=13) interventions both resulted in a statistically significant reduction in combined physical and sexual DV (Piolanti & Foran, 2022). However, targeting high-risk youths, resulted in a larger effect size (OR 0.61; 95% CI, 0.49-0.76; p<0.001) compared with universal interventions (OR 0.84; 95% CI, 0.74-0.96; p= 0.01). Furthermore, studies that had interventions that targeted adolescents both under (n=9) and over (n=9) the age of 15 produced statistically significant results, but the latter group had larger effect sizes (OR 0.85; 95% CI, 0.73-0.99; p= 0.04 vs OR 0.65; 95% CI, 0.55-0.78; p<0.001) (Piolanti & Foran, 2022). These authors conducted this review guided by Cochrane guidelines however, it is not without limitations (Piolanti & Foran, 2022). First, the review limited the search to English language studies. This

introduced bias into the results as they cannot include data from other countries that may not have the resources to translate their journal, overall contributing to publication bias (Shea et al., 2017). Furthermore, the study lacked clarity regarding the description of what they had defined as a preventative intervention (Shea et al., 2017). The only criteria outlining their inclusion criteria for the intervention was that it had to reduce DV concerning a control group (Piolanti & Foran, 2022). The review also lacks clarity in the reporting of interventions of included studies. The authors reported collecting data on the intervention characteristics however did not report them, despite using them in their meta-analysis and data synthesis (Shea et al., 2017, Hoffmann et al., 2014, Piolanti & Foran, 2022). Authors also reported several composite values with moderate heterogeneity including physical perpetration (I^2= 66%), physical violence survivorship (I^2= 64%), sexual violence survivorship (I^2= 45%), physical/sexual violence perpetration (I^2= 45%), and physical/sexual violence survivorship (I^2= 48%) (Piolanti & Foran, 2022). While the authors later conducted a subgroup analysis on the overall effect size to investigate heterogeneity, it was not addressed, nor was its potential impact on the results (Shea et al., 2017). Additionally, the authors acknowledged that they only evaluated studies that involved the prevention of physical and sexual dating violence (Piolanti & Foran, 2022). While both these aspects of DV are important as they carry notable health consequences, they are also not as common as other forms of DV such as psychological or coercive abuse (Cotter, 2021; Savage, 2021). The authors justified not including this measure, because the scales and dimensions of psychological violence needed critical review within the literature.

Examining the Effects of Teen Dating Violence Prevention Programs: A Systematic Review and Meta-Analysis

The final systematic review examined prevention interventions addressing DV targeted at adolescents under the age of 18 (Lee & Wong, 2022). This review aimed to examine the effects of preventative programs targeting dating violence in adolescents under the age of 18 and their effects on knowledge and attitudes towards dating violence, bystander behaviours, or DV victimization/perpetration. Lee & Wong (2022) identified 38 studies for inclusion in the meta-analysis which examined the effects of prevention interventions on DV knowledge, attitudes, bystander intentions, bystander behaviours, DV victimization and DV perpetration. The authors concluded that violence prevention programs improved knowledge with a reported effect size (ES) of 0.57 ($n = 16$; 95% CI 0.26-0.88; $p < 0.001$), attitudes with a reported an ES of 0.19 ($n = 20$; 95% CI 0.09-0.29; $p < 0.001$) and DV perpetration reporting an ES of 0.16 ($n = 16$; 95% CI 0.06- 0.26; $p < 0.01$) (Lee & Wong, 2022). However, these interventions did not improve DV victimization reported as ES of 0.10 ($n = 12$; 95% CI -0.02-0.23; $p=0.11$) or bystander behaviours and intentions reported as an ES of 0.12 ($n=6$; 95% CI -0.00-0.24; $p=0.10$) (Lee & Wong, 2022). Another unique facet of this review was that they synthesized data on the different intervention traits including, program facilitators, components, and approaches which they used to conduct a subgroup analysis in their reported results (Lee & Wong, 2022). One of the first limitations of this review is that they limited their inclusion criteria to only include North America, Western Europe, Australia, and New Zealand (Lee & Wong, 2022). This is problematic given that data is already biased in the literature to favour developed countries over developing ones (Yousefi-Nooraie et al., 2006). This could further bias the literature to represent only Westernized perspectives on the topic of DV. Furthermore, they excluded very specific

populations such as those with a history of maltreatment or abuse, teen mothers and youths living in residential facilities (Lee & Wong, 2022). These populations would arguably be the most important to include as each has risk factors for DV such as childhood experience of abuse, pregnancy, homelessness, and poverty (Glass et al., 2003; Taquette & Monteiro, 2019). By limiting the population there is a risk that these groups may not have interventions designed with them in mind. Another major limitation of the review was the reporting of statistics. The authors reported their results as "effect size", however they did not describe how they calculated this. This greatly limits the ability for interpretation of the results and extrapolation in any clinical context as they do not report their results in a way which allows for interpretation by the reader (Higgins et al., 2022; Shea et al., 2017). One limitation of this paper is that they pooled both pre and post-test experimental designs with two-group trial designs data for summative effects. There is considerable debate regarding the methodological robustness of this method of pooling data (Cooper et al., 2019; Cuijpers et al., 2017). Pooling both study designs introduces the possibility of inaccurate intervention effect sizes, which would affect the summary statistics provided by the review. This is compounded by the fact that they included non-RCT experimental trials which, while this can be done, is not desirable due to the inherent risk of bias that is ingrained into those study designs (Higgins et al, 2022). Furthermore, the results had significant heterogeneity, with the lowest reported I^2 statistic being 46.4%, indicating that there are many differences between the pooled studies, limiting the interpretation of the results (Higgins et al., 2022). This suggests that the results obtained by may have been due to the differences between the studies as opposed to the effects of the intervention. This could be explained as many of these interventions are complex, often containing different content, methods of delivery, duration, and intensity. Therefore, while the review reported that prevention

programs improved DV-related outcomes, there is a possibility that the observed differences were due to inherent differences within the designs of the pooled studies. Authors also failed to conduct a risk of bias assessment and subsequent effects on their presented results (Higgins et al., 2022; Shea et al., 2017). While this review had significant issues in its methodology, it is one of the few reviews that collected specific intervention traits of these complex interventions and then examined their effects on DV outcomes.

Summary of Systematic Reviews on Dating Violence

While each review has its limitations, the Cochrane review is the most methodologically sound and the results contain the broadest examination of the effects of educational interventions on adolescents (Fellmeth et al, 2013). It is important to note, however, that this review is also a decade old, there have been several RCTs published in this area, as well as published longitudinal data, since the publication prompting the need for an updated review (Coker et al., 2019; Daigneault et al., 2015; K. M. Edwards et al., 2019; Mathews et al., 2016; Pulerwitz et al., 2015). While the Piolanti & Foran (2022) and the Lee & Wong (2022) studies provide updated data on the topic, they fail to address the psychological component of DV. The Lee & Wong (2022) study also presented problems with how the data was reported making interpretation of their results in a clinical context difficult (Okuda et al., 2015). While these studies produced summary statistics on the data, they all contained high heterogeneity, indicating that there was a substantial number of intrinsic differences between the synthesized interventions. This suggests that results should be interpreted in the context of the study differences as opposed to distilling all the studies into summary statistics.

Finally, while three of the studies collected data on intervention characteristics, the primary focus was not on the characteristics of these interventions, but rather on how the pooled

data produced either positive or negative results on their outcomes of interest (Lee & Wong, 2022; Piolanti & Foran, 2022; Whitaker et al., 2006). Given that the intervention traits were not the focus of these studies, the data that was synthesized was minimal and inconsistent between the reviews. To address the heterogeneity seen within the meta-analyses of the aforementioned reviews, study results should be interpreted in the context of the different intervention characteristics, which were also poorly reported within the preceding studies. Doing so will aid in revealing which intervention traits are contributing to the results seen within these programs.

The Aim of the Systematic Review

The proposed systematic review addresses the gaps in the previous reviews in several ways. First, this review proposes to include a broader definition of educational intervention, which encompasses social and public health campaigns and technology-based interventions as opposed to the traditional methods, such as didactic and bystander, included in other reviews (Fellmeth et al., 2013; Lee & Wong, 2022; Piolanti & Foran, 2022). Second, this review proposes to extract, and report detailed intervention characteristics of complex programs using a standardized tool (Hoffmann et al., 2014). To this author's knowledge, this has not been done to the proposed level of detail in previous reviews and this review will be the first to synthesize results of intervention characteristics using a standardized tool. This will be done in the context of synthesized study results where possible. Ideally, this review will aid in identifying essential components of complex interventions that are required for successful program implementation. This would inform the development of future programs on the aspects of educational interventions that contribute to DV prevention.

In summary, the review of the literature revealed that DV is an extensive public health problem resulting in deleterious effects throughout the lifespan including effects on mental

health, diabetes and cardiovascular disease. Adolescence has been identified as an integral period where youth are at the highest risk for the experience of DV, but also at the most pliable for preventive interventions. While there have been publications demonstrating the positive effects of educational interventions on DV they also vary widely in their development and implementation. This variance between studies has led to uncertainty regarding which aspects of educational interventions are contributing to the positive outcomes being reported. This systematic review aims to examine which characteristics of these complex interventions, or combination of traits, contribute to effective changes in DV outcomes, to aid in the development, adoption, and maintenance of future educational interventions. With the significant burden that DV poses on public health, effective programs for DV prevention are imperative to avoid the long-term complications associated with exposure to DV.

Research Question

What characteristics of primary educational interventions, or a combination thereof, contribute to the prevention of dating violence in adolescents aged 10 to 18?

CHAPTER 3: Research Methods

This review follows the Cochrane Handbook of Systematic Reviews of Interventions as closely as possible (Higgins et al., 2022). Any deviation from the recommendations in this manual are justified throughout the text to maintain transparency and to minimize bias.

Theoretical Lens: Feminism

Given that female adolescents are disproportionately affected by DV (Savage, 2021), and that DV has been categorized as a form of gender-based violence (Stark & Ager., 2011), the results of this study were interpreted through a feminist lens. Interventions were critiqued based on how their development aligns with postmodern feminist theory. Additionally, results were interpreted concerning how postmodern feminist theory may (or may not) influence the outcomes of interest. This may include an analysis of the congruency of post-modern feminism constructs with study design, implementation, and interpretation and how it could have contributed to the reported outcomes. Limitations of this theory will also be discussed concerning its impact on the results and how it may impact the direction of future educational interventions (Fellmeth et al., 2013; Lee & Wong, 2022; Piolanti & Foran, 2022).

Search Strategy

A search strategy was developed in consultation with a health sciences librarian (See Appendix D). The following databases and registries were searched for articles about the thesis topic: OVID, Medline, CINAHL, Embase, Cochrane CENTRAL, Emcare, APA PsycINFO, ERIC, WHO International Clinical Trials Registry and ClinicalTrials.gov. Databases were searched from database inception to the date of the search. These databases were searched on the same day. The search results were then extracted to Covidence for further screening (Covidence, 2022). Search terms were adapted based on each database being searched. Reference lists of relevant syntheses identified during the search (clinical guidelines, systematic reviews, meta-analyses, scoping reviews, rapid reviews) were hand-searched to ensure that all articles were

captured through the electronic search. There were no restrictions on language or publication status. Duplicate citations were removed from Endnote before screening.

Title & Abstract Screening

The initial phase of screening titles and abstracts from the electronic search was done independently by two reviewers using Covidence (Appendix E). Reviewers (MR and JA) initially screened the citations based on inclusion and exclusion criteria established a priori (See Methods: Criteria for Considering Studies in this Review). This was condensed into a screening form, within Covidence, utilized by both reviewers to determine if the study should be included for full-text review (Appendix E). The form for title and abstract screening was independently piloted on five records and received a consensus between both reviewers, thus requiring no modifications (See Appendix E). If either reviewer decided that a citation should be included or deemed one of the criteria as "unclear", the article progressed to a full-text review. If the relevance of an article could not be decided based on title and abstract screening, it was included for full-text review. Non-English abstracts and full texts were excluded if English copies could not be obtained from the author or the publication. This was done as the reviewer could not accurately assess, extract, and synthesize data that was not in English.

Full-Text Screening

After all articles underwent title and abstract screening, full-text screening proceeded. Articles included for full-text review were obtained and screened by two independent reviewers (MR & JA). A priori criteria were created and utilized to create a screening form within Covidence to assist with full-text review (Appendix F). The full-text screening form was piloted

by two reviewers on five studies, and determined two categories should be modified (See Appendix F). The exclusion criteria "not primary prevention" was changed to "Education Provided Does Not Address DV" as there were no exclusion criteria for this, and it was redundant with the criteria of "includes secondary/tertiary approaches". The exclusion criteria "Cannot determine type of violence that intervention is targeting" was changed to "Not Dating Violence and/or multiple types of violence" given that studies often were able to articulate the type of violence they were addressing but included multiple forms or other forms of violence than DV. Another category "Secondary Study" was added to the tool, as several studies had numerous publications from the same RCT (Coker, Bush, et al., 2017; Taylor et al., 2013). All changes were agreed on by both reviewers (MR & JA). Both reviewers must have agreed with the final article inclusion or exclusion. If there was disagreement, reviewers would attempt to resolve it through discussion. If, in the case that it could not be resolved through discussion, a third party would function as an arbitrator. At this stage, any article excluded was listed in an appendix in addition to the reason for exclusion (Appendices I). The process of selecting studies for inclusion in the review was reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Page et al., 2021).

Criteria for Inclusion and Exclusion of Studies

Study Design

Studies were restricted to randomized controlled trials and cluster randomized controlled trials, given their propensity for rigorous methodology. This will increase the robustness of the review. Excluded studies included qualitative studies, non-randomized experimental studies, cohort studies, case-control studies, theses, poster and conference abstracts.

Population

Studies included adolescents aged 10 to 18 years of age in any setting and any country. Examples include educational interventions within a school, community, or healthcare setting. Adolescents may identify as any gender, with no previous history or current situation involving dating violence as either a perpetrator/victim or both. This review excluded studies that include additional age groups where the data from the population of interest could not be isolated. This included any studies in which other populations are also receiving the intervention in conjunction with the population of interest. An example of this is adolescents receiving an educational intervention as well as their parents receiving a component of the same educational intervention.

Interventions

Any primary educational intervention that involves providing the population of interest with education addressing dating violence (or any variation thereof, as long as the authors defined it to involve the perpetration of violence by a current, former, or future partner) was included. Primary interventions were defined as interventions that are designed to prevent DV from ever occurring (Kisling & Das, 2022). This can be universally applied or specifically target subpopulations, in any setting and can be of any duration. Additionally, these interventions can constitute any form. Examples include educational interventions in the form of social media campaigns or didactic approaches.

Studies were excluded if the provided education on types of violence other than DV, where the details of the paper do not adequately specify the type of violence-based intervention, or if the effects on DV could not be isolated from other types of violence. Studies were also excluded if interventions targeted multiple forms of violence, such as if an intervention targets

DV as well as non-intimate partner sexual assault. Studies were also excluded if they constituted secondary or tertiary prevention approaches which were defined as interventions that either aim to identify DV early within a population and then intervene to prevent further recurrence or which are aimed at preventing further complications after DV victimization/perpetration (Kisling & Das, 2022). Finally, studies that only provided the educational component to healthcare providers, social workers, educators, or other service providers were excluded.

Comparators

Studies could include either usual care, no intervention, or a separate type of intervention. Studies were excluded if only two educational programs were compared with no control, or if usual care and the effects of the educational component could not be isolated. Usual care is defined as care that is not changed to suit the needs of a particular population or context and is the usual care that is given to the population.

Outcomes

Outcomes were not limited within this review. This decision was made given that the focus of this review was to examine intervention traits in depth and how they contributed to the outcomes as opposed to the outcomes themselves. Decision makers in public health will require more information than solely intervention effectiveness, rather information such as how are these effects mediated in different settings, and how certain traits such as provider, length of intervention or frequency can moderate the effects of the outcomes (Skivington et al., 2021). By not limiting the review to having predefined outcomes, it ensured that all studies could be included in the analysis. In effect, this allowed for the interventions of all eligible studies to be examined in detail and allowed for a more comprehensive portrayal of their characteristics and how they are designed, implemented, and evaluated, thereby examining the most important traits

or combination of traits that are essential for the functioning of these interventions (Petticrew et al., 2013). By not limiting the outcomes, the aim is to allow for a better examination of all the educational interventions and their respective components rather than examining how the interventions contributed to an outcome of interest. This review aims to synthesize the process of complex interventions related to DV and how they achieved outcomes. Outcomes could include but were not limited to DV perpetration and victimization, possibly subcategorized into types of violence, such as physical, psychological, and sexual, attitudes towards DV and knowledge of DV.

Since there were a variety of scales and outcomes that were measured across the studies, a decision was made to narratively synthesize the data as opposed to conducting a meta-analysis. The focus of this review was on the intervention characteristics as opposed to the outcomes, utilizing a narrative synthesis ensures that this review could maximize the number of included studies. No study was excluded based on the scale that was chosen for outcome measurement. Data was included regardless of the method for outcome measurement.

Data Extraction & Management

Data extraction methods were guided by the Cochrane Handbook (Higgins et al., 2022). Data was extracted from the final included studies using an established form based on the Template for Intervention Description and Replication (TIDieR) and Cochrane Characteristics of Included Studies (COIS) to ensure adequate reporting of trials and their interventions (Appendix G & H) (Higgins et al., 2022; Hoffmann et al., 2014). The data extraction form was piloted by two reviewers, using a sample of two included studies. Both reviewers evaluated the forms to ensure they understood what was required under each domain. During the pilot extraction, the

primary author (MR) extracted the data and the secondary reviewer (JA), confirmed the data extracted. Any modifications to the form were made after the pilot if deemed necessary. The data extracted was based on the COIS and included the study title, authors, funding source, setting, randomization methods, blinding and allocation concealment, population characteristics, duration, compliance, outcomes measurements/tools, and the results obtained from each study (Table 1) (Higgins et al., 2022). Data was also extracted based on the TIDieR criteria including study theory, materials, procedures, providers, tailoring, modifications, fidelity and intervention intensity and duration (Hoffmann et al., 2014). Reviewers could add additional notes to each study they deemed relevant to the review, such as the clinical trial number. Any discrepancies were resolved through discussion.

Missing Data

For missing or incomplete data, the study authors were contacted for the original data. If the original data could not be obtained, study results were included within the review and the missing data was highlighted in the ROB analysis.

Risk of Bias Assessment

To assess the methodological quality of the studies included in the review, a risk of bias assessment was conducted, using the first version of the Cochrane Risk of Bias Tool (Higgins, Altman, Gotzsche, et al., 2011). This tool was chosen as the studies analyzed were not limited to the outcomes of interest. Given that the outcomes were not limited, the studies had to be evaluated on a study level as opposed to an outcome level, which is how the latest version of the Cochrane ROB tool is utilized. The domains assessed for ROB included the randomization process, allocation concealment, incomplete outcome data, blinding of participants and

personnel, blinding of outcome assessors, and selection of the reported results (Higgins, Altman, Gotzsche, et al., 2011). Domains were given ratings of "low risk," "unclear risk" or "high risk" by each reviewer. Any discrepancies were resolved through discussion or involvement of a third party for arbitration if an agreement could not be reached.

After the ROB assessments were completed and agreed upon, a summary figure was created using Review Manager 5.4 (The Cochrane Collaboration, 2020).

Synthesis of Results

Given the anticipated likelihood of significant clinical and statistical heterogeneity, data synthesis was done narratively according to the criteria set out by the TIDieR tool and COIS tool (Higgins et al., 2022). Studies were synthesized based on each individual criteria set forth in these tools and then examined in the context of the results of those studies, if they could be synthesized. This was done as the major aim of this review is to delineate the traits of the interventions and how they compare to each other. If the study is examined based on synthesized outcomes, then aspects of this may be lost for studies that do not examine similar outcomes.

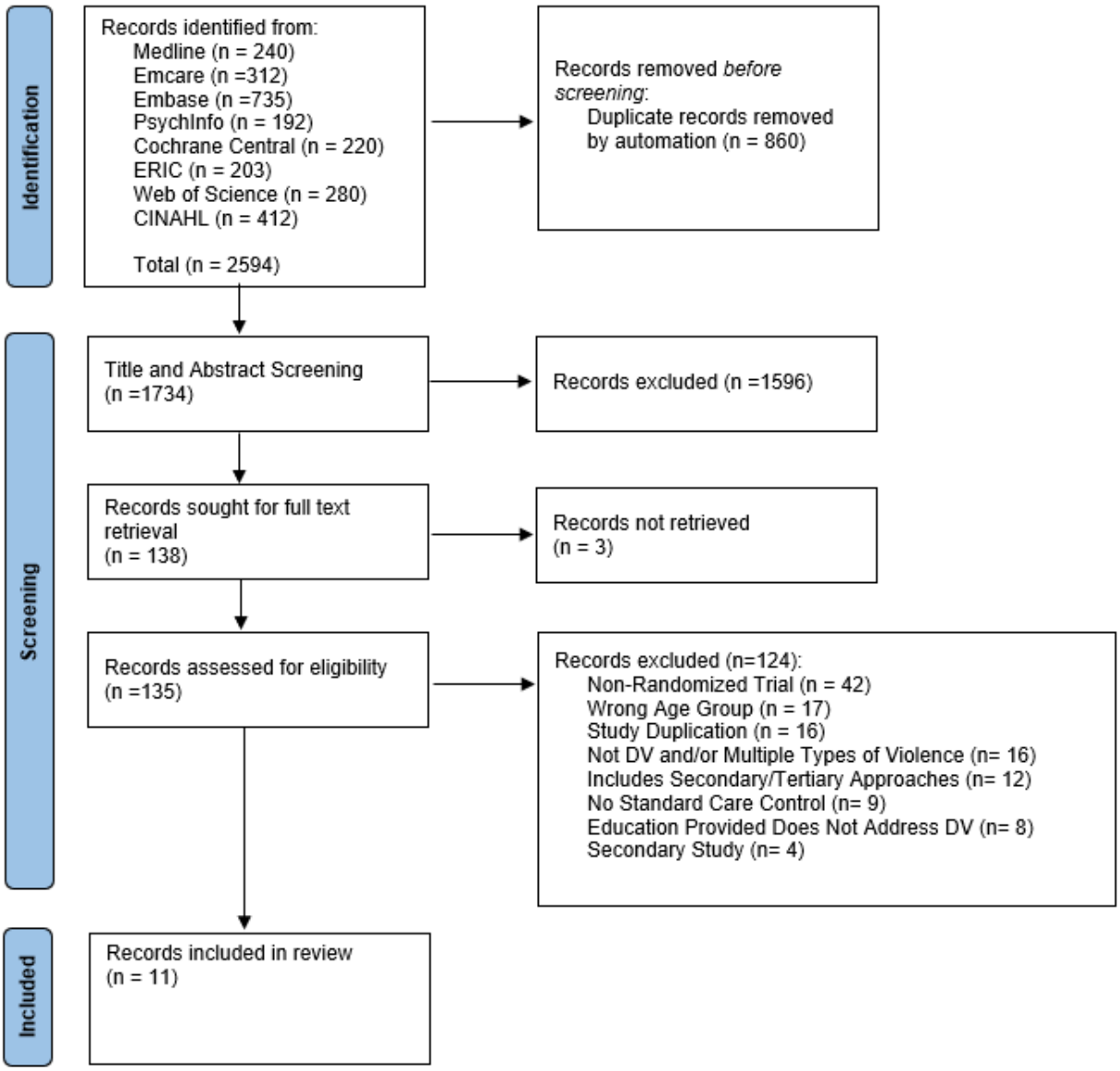
CHAPTER 4: Results

Description of the Search Results & Included Studies

On March 14th, 2023, the search yielded a total of 2594 records of which, 860 duplicates were removed leaving 1734 records for title and abstract screening. Following this, 138 studies were then identified for full-text review, of these studies three could not be obtained for full-text review (Baumann, 2006; Munoz Maya et al., 2013; Munoz-Rivas et al., 2019). Two of the studies had full-text available in Spanish, however when emailed to request an English version, neither responded (Munoz Maya et al., 2013; Munoz-Rivas et al., 2019). The third study offered no contact details, and the manuscript available from the university thesis repository was incomplete, containing only the first 26 pages (Baumann, 2006). At full-text review, 124 studies were excluded for various reasons (See Appendix I; See Figure 1). This resulted in a total of 11 studies included in the review for narrative synthesis, reported as per the PRISMA guidelines (See Figure 1) (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Navarro-Pérez et al., 2019; Page et al., 2021; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021; Wolfe et al., 2009).

Figure 1

PRISMA Flow Diagram



Note. Diagram demonstrates the screening and selection of studies for inclusion in the review from the literature search (Page et al., 2021).

Characteristics of Included Studies

Table 1

Characteristics of Included Studies

Study Author and Date	**Study Design**	**Setting**	**Participants & Mean Age (years)**	**Participants**	**Intervention**	**Outcomes Measured**	**Measurement Instrument**
Avery-Leaf et al., 1997	Cluster RCT Classroom Clusters	USA Grades 9 to 12	193 individuals 1 school Age: 16.5	Universal Audience	Didactic	Physical DV	Modified Conflict Tactics Scale Justification of Interpersonal Violence Questionnaire Justification of Dating Jealousy and Violence Scale (Investigator Developed)
Coker, Bush, et al., 2017	Cluster RCT Institution Clusters	USA Grades 9 to 12	16,242 individuals 26 schools Age Not Reported	Universal Audience	Bystander	Physical DV Sexual DV Psychological DV	Investigator Developed National Intimate Partner and Sexual Violence Survey

							Sexual Experiences Questionnaire National Violence Against Women Survey
Dos Santos et al., 2019	Cluster RCT Classroom Clusters	Spain Government Work Program	90 4 Classes Age:17	Universal Audience	Bystander	Bystander Behaviours/Attitudes	Bystander Attitudes in DV Scale Davis Multidimensional Interpersonal Reactivity Scale Intention to Help in DV (Investigator Developed)
Jaycox, McCaffrey, Eiseman, et al., 2006	Cluster RCT Classroom Clusters	USA Grade 9	2617 individuals 10 schools Age:14.42	Universal Audience Latino Population	Didactic	DV Knowledge Physical DV Sexual DV	Investigator Developed Scale for DV knowledge CTS-2 Modified Women's Experience of Battering Scale
Joppa et al., 2016	Cluster RCT Classroom Clusters	USA Grade 10	433 Individuals 24 Classes Age:15.85	Universal Audience	Didactic	DV Knowledge Physical DV Psychological DV	CADRI Normative Beliefs about Aggression Scale Attitudes Towards DV Scale

Muñoz-Fernández et al., 2019	Cluster RCT Institution Clusters	Brazil Grades 7 to 10	1423 7 schools Age:14.98	Universal Audience	Didactic(Dos Santos et al., 2019)	Physical DV Sexual DV Bullying	CTS-2 Sexual Violence Scale European Bullying Intervention Project Questionnaire
Navarro-Perez et al., 2020	Cluster RCT Institution Clusters	Spain Children's Residential Home	71 individuals Age:15	Universal Audience Institutionalized Minors	Gaming	DV Knowledge Sexism	Ambivalence Toward Men Inventory Myths, Fallacies and Erroneous Beliefs about the Ideal of Romantic Love Scale Ambivalent Sexism Inventory
Taylor et al., 2010a	Cluster RCT Classroom Clusters	USA Grades 6 & 7	1639 individuals 123 classes 7 schools Age:12	Universal Audience	Didactic	DV Knowledge Physical DV Sexual DV Bystander Behaviours/Attitudes	Investigator Developed
Taylor et al., 2013	Cluster RCT Institution Clusters	USA Grades 6 & 7	2665 individuals 117 classes Age:12	Universal Audience	Didactic	DV Knowledge Physical DV Sexual DV Bystander Behaviours/Attitudes	Investigator Developed
Temple et al., 2021	Cluster RCT	USA Grades 6 & 7	2768 individuals 24 schools	Universal Audience	Didactic	Physical DV Substance Use Bullying	CADRI Olweus Bullying Questionnaire

	Institution Clusters		Age:14.5				
Wolfe et al., 2009	Cluster RCT Institution Clusters	Canada Grade 9	1713 individuals 20 schools Age:14.5	Universal Audience	Didactic	Physical DV Substance Use Bullying	CADRI Investigator Developed National Longitudinal Survey of Children and Youth

Note. DV is an abbreviation for dating violence

Study Type

All of the 11 included studies were cluster RCTs. Four studies were clustered by classroom (Avery-Leaf et al., 1997; Dos Santos et al., 2019; Joppa et al., 2016; Taylor et al., 2010a), and one clustered based on school "tracks" which are cohorts of students starting school at different timepoints during the year (Jaycox, McCaffrey, Eiseman, et al., 2006). The remaining seven studies were clustered at the institutional level (schools and community center) (Coker, Bush, et al., 2017; Muñoz-Fernández et al., 2019; Navarro-Perez et al., 2020; Taylor et al., 2013; Temple et al., 2021; Wolfe et al., 2009).

Settings

Of the 11 included studies, seven were conducted in the United States (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021). Two were conducted in Spain (Dos Santos et al., 2019; Navarro-Perez et al., 2020), one in Brazil (Muñoz-Fernández et al., 2019) and one in Canada (Wolfe et al., 2009). All studies were conducted in educational settings except one, which was in a children's residential home (Navarro-Perez et al., 2020). One study was not in a traditional school, but rather in a program designed to promote the civic education of vulnerable adolescents run by the socio-professional education sector of Brazil (Dos Santos et al., 2019). Of the studies conducted in a school setting, three were in middle schools, inclusive of grades six and seven (Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021), and the remining conducted in high schools (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Wolfe et al., 2009). Two studies included grade nine through twelve in their sample (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017), two studies only included grade nine students (Jaycox, McCaffrey,

Eiseman, et al., 2006; Wolfe et al., 2009) and one sampled grade ten students (Joppa et al., 2016). The final study reported that they conducted the study in a high school setting, however in Spain, this is inclusive of grades seven through ten by Canadian educational standards (Muñoz-Fernández et al., 2019).

Participants

All studies, apart from one, targeted a universal audience as opposed to those with a high risk of committing or experiencing violence. Navarro-Perez et al., (2020), targeted institutionalized minors given their increased risk of experiencing and perpetrating DV. Two studies had a sample size of 90 and 35 (Dos Santos et al., 2019; Navarro-Perez et al., 2020), two studies had sample sizes with a few hundred participants (Table 1) (Avery-Leaf et al., 1997; Joppa et al., 2016), three studies had sample sizes between 1400 and 1750 participants (Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Wolfe et al., 2009), three studies had samples between 2500-2800 participants (Jaycox, McCaffrey, Eiseman, et al., 2006; Taylor et al., 2013; Temple et al., 2021) and one had a sample size of 16,242 participants (Coker, Bush, et al., 2017).

Of the included studies seven described their participant demographics based on the invention and control arms of the studies (Coker, Bush, et al., 2017; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Temple et al., 2021; Wolfe et al., 2009) and the remaining four (Avery-Leaf et al., 1997; Navarro-Perez et al., 2020; Taylor et al., 2010a; Taylor et al., 2013) examined participant demographics as a whole, only noting statistically significant differences if there were any. Of the seven studies which reported intervention and control arm demographics, each arm in each study reported between 45 to 55% of the study arm comprising of female participants (Coker, Bush, et al., 2017; Jaycox, McCaffrey, Eiseman, et al., 2006; Muñoz-Fernández et al., 2019;

Temple et al., 2021; Wolfe et al., 2009). The other two studies included 57% females in the control group (Joppa et al., 2016) and 64% in the intervention group (Dos Santos et al., 2019). The remaining four studies reported 45 to 55% of their populations as female (Avery-Leaf et al., 1997; Taylor et al., 2010a; Taylor et al., 2013) with one other reporting 43% (Navarro-Perez et al., 2020). Only two studies reported statistically significant differences related to sex between control and intervention arms (Avery-Leaf et al., 1997; Taylor et al., 2010a). The groups were mixed-sex groups with the exception of the study conducted by Wolfe et al., (2009) which was segregated based on sex (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Navarro-Perez et al., 2020; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021).

Of the included studies only two examined the lower age range of the inclusion criteria with the majority of participants being between 11 to 13 years of age (Taylor et al., 2010a; Taylor et al., 2013). Most studies reported a mean age of 14 to15 (Jaycox et al., 2007; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Navarro-Perez et al., 2020; Temple et al., 2021; Wolfe et al., 2009). Two reported the average ages of participants to be between 16 to 18 years (Avery-Leaf et al., 1997; Dos Santos et al., 2019). One study did not collect data on the ages of the students, only the grades to which they attended (Coker, Bush, et al., 2017).

Eight studies collected data on participant ethnicity and race, however there was inconsistency between studies of what was collected, and how they defined these terms. Of these, only Jaycox McCaffrey, Eiseman, et al., (2006), specified targeting a Latino population, with at least 90% of participants with Latino backgrounds in both the control and intervention group. This was done as evidence shows that there is a higher incidence and more deleterious outcomes of DV within this population in comparison to others (Jaycox, McCaffrey, Eiseman, et

al., 2006). Seven studies collected participant data as it relates to their race including whether students identified as Caucasian, Asian, Hispanic and Black for example (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Dos Santos et al., 2019; Joppa et al., 2016; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021). The remaining three studies did not report any ethnicity or race demographics (Muñoz-Fernández et al., 2019; Navarro-Perez et al., 2020; Wolfe et al., 2009).

Outcomes

There were a variety of outcomes measured in the included studies related not only to DV, but substance use and bullying. Of the 11 studies, eight evaluated physical DV (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021; Wolfe et al., 2009). Four showed no effects on physical DV (Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Taylor et al., 2013), three showed a decrease in physical DV within the intervention group (Coker, Bush, et al., 2017; Temple et al., 2021; Wolfe et al., 2009) and one reported an increase in physical DV in the intervention group (Taylor et al., 2010a).

Five studies evaluated sexual DV (Coker, Bush, et al., 2017; Jaycox, McCaffrey, Eiseman, et al., 2006; Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013). Two reported a decrease in sexual DV (Coker, Bush, et al., 2017; Muñoz-Fernández et al., 2019), two reported no differences between the control and intervention groups (Jaycox, McCaffrey, Eiseman, et al., 2006; Taylor et al., 2013) and one which reported an increase in sexual DV (Taylor et al., 2010a).

Two evaluated psychological DV both of which reported a decrease in psychological DV (Coker, Bush, et al., 2017; Joppa et al., 2016). Other relevant outcomes which were measured included bystander behaviours, where two studies showed no effect on bystander behaviours and one showed an increase in intervening behaviours (Dos Santos et al., 2019; Taylor et al., 2010a; Taylor et al., 2013). DV knowledge and attitudes were also measured in six studies, all of which reported an improvement within the intervention groups (Avery-Leaf et al., 1997; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Navarro-Perez et al., 2020; Taylor et al., 2010a; Taylor et al., 2013). Other outcomes measured included substance use (Temple et al., 2021; Wolfe et al., 2009), bullying (Muñoz-Fernández et al., 2019; Temple et al., 2021; Wolfe et al., 2009) and sexism (Navarro-Perez et al., 2020).

Similar to the variability seen within which outcomes were measured, there was also variability in the instruments utilized to measure them, even within the same outcome. When measuring physical DV, the two most common instruments used were a modified version of the Conflict in Adolescent Dating Relationships Inventory (CADRI) and the Revised Conflict Tactics Scale (CTS-2) (Avery-Leaf et al., 1997; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Temple et al., 2021; Wolfe et al., 2009). The remaining three studies developed their own instruments to measure physical DV, and only used the Cronbach alpha score as a method of psychometric evaluation (Coker, Bush, et al., 2017; Taylor et al., 2010a; Taylor et al., 2008; Taylor et al., 2013).

Sexual DV was also commonly reported to have been measured through researcher-developed instruments which also utilized solely the Cronbach alpha score for psychometric testing (Coker, Bush, et al., 2017; Taylor et al., 2010a; Taylor et al., 2008; Taylor et al., 2013). Muñoz-Fernández et al. (2019) utilized a modified version of an instrument that had no previous

psychometric testing (Vangie Ann Foshee et al., 2004; Muñoz-Fernández et al., 2019). The other scale utilized was the CTS-2 (Jaycox, McCaffrey, Eiseman, et al., 2006). There were only two studies that examined psychological DV, one utilized the CADRI (Joppa et al., 2016), while the other utilized a self-developed instrument (Coker, Bush, et al., 2017).

There were three studies where bystander behaviours and/or attitudes were measured (Dos Santos et al., 2019; Taylor et al., 2010a; Taylor et al., 2013). Two studies developed their measures for bystander behaviours, and only reported psychometrical testing them using Cronbach's alpha (Taylor et al., 2010a; Taylor et al., 2008; Taylor et al., 2013). The remaining study used the Bystander Attitude in Dating Violence Scale (Dos Santos et al., 2019).

All studies measured outcomes at different timepoints. Three studies only measured outcomes once, up to six months after intervention deliver (Avery-Leaf et al., 1997; Dos Santos et al., 2019; Navarro-Perez et al., 2020). Five studies examined outcomes twice, once immediately after the interventions and again between one to six months afterward (Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013). Only three studies examined long-term effects which ranged from one to four years post-intervention (Coker, Bush, et al., 2017; Temple et al., 2021; Wolfe et al., 2009).

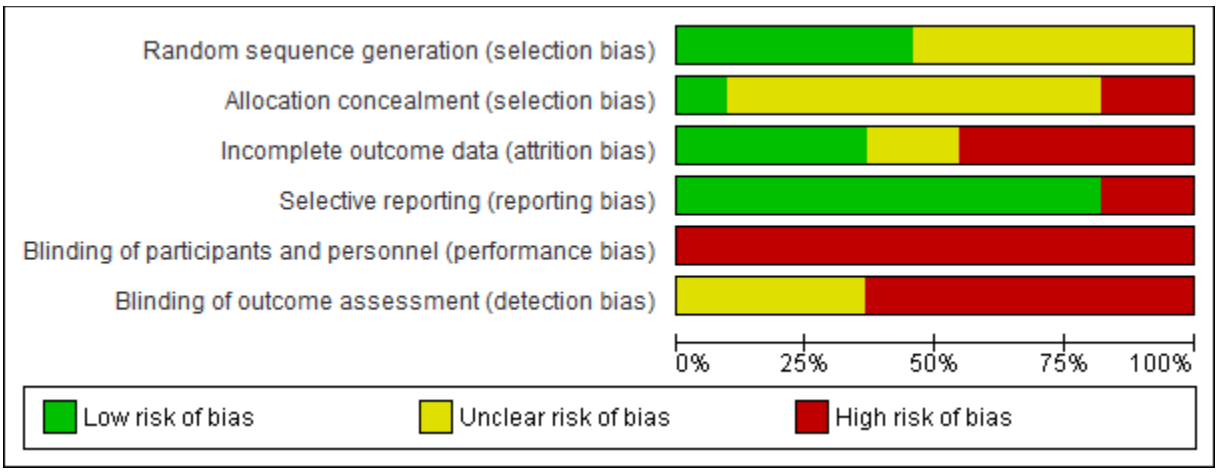
Risk of Bias Assessment of Included Studies

The risk of bias in each of the six domains examined is summarized for all included studies in the tables below (See Figures 2 & 3). These figures demonstrate that, between 55% to 90% of studies had an unclear risk of bias for random sequence generation and allocation concealment. Between five to 11 studies were high risk of bias for incomplete outcome data and

blinding of both study participants, personnel, and outcome assessors. Whereas selective reporting was the only category where there was a low risk of bias in the majority of studies with nine of the studies being assessed as low risk of bias.

Figure 2

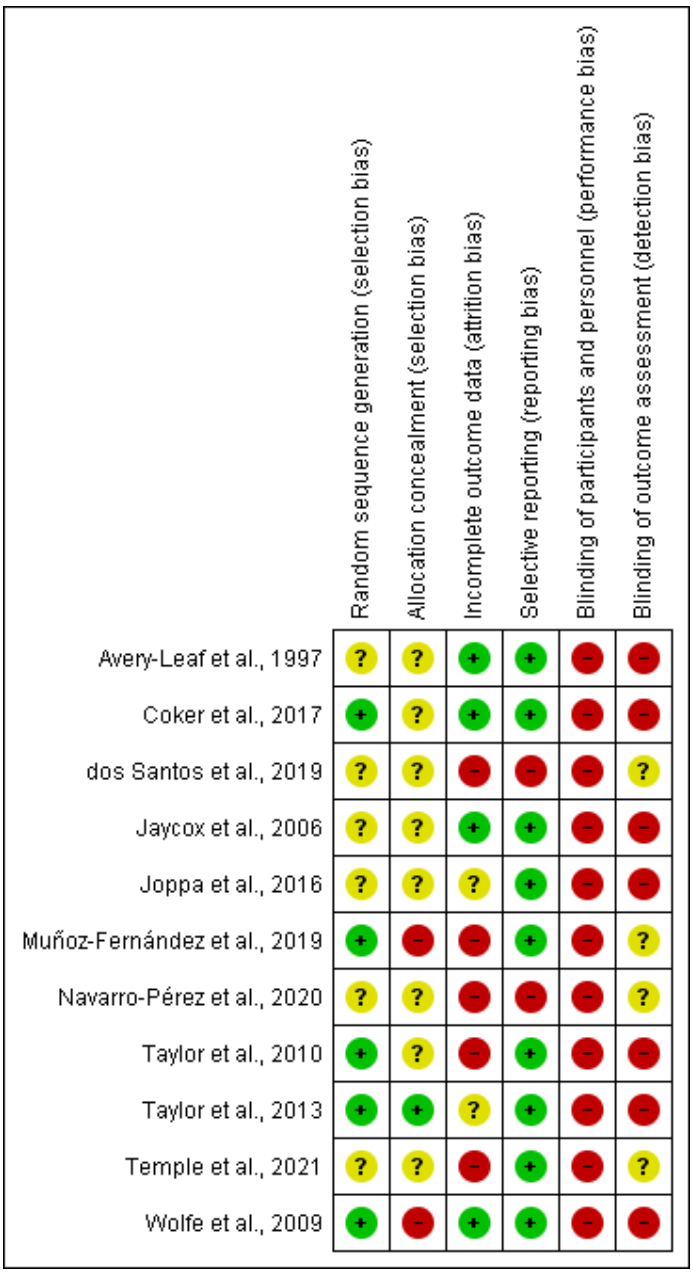
Risk of Bias Assessment



Note. The figure depicts the authors' judgements of the risk of bias items presented as percentages across all included studies. Created using Review Manager 5.4 (The Cochrane Collaboration, 2020).

Figure 3

Risk of Bias Individual Study Summary



Note. The figure depicts the authors' risk of bias judgements about each risk of bias item for each included study. Created using Review Manager 5.4 (The Cochrane Collaboration, 2020).

Random Sequence Generation

Studies deemed low ROB for this domain had sufficient detail within the text of the study, or their associated protocols, indicating the methods utilized for randomization (Higgins, Altman, & Sterne, 2011). Five studies were able to indicate how they generated the random sequence, and of these, two utilized stratified random allocation (Taylor et al., 2010a; Taylor et al., 2013), two used a simple randomization method (Coker, Bush, et al., 2017; Muñoz-Fernández et al., 2019), and another used a coin toss (Wolfe et al., 2009). The remaining studies only mentioned that participants/centers were randomly assigned, however did not mention how this was accomplished (Avery-Leaf et al., 1997; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Navarro-Perez et al., 2020; Temple et al., 2021).

Allocation Concealment

The majority of studies did not report their methods for allocation concealment, resulting in an unclear risk of bias judgement (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Navarro-Perez et al., 2020; Taylor et al., 2010a; Temple et al., 2021). Of the remaining studies, both randomly allocated study arms through a coin toss conducted by the researchers, allowing researchers to foresee allocation (Muñoz-Fernández et al., 2019; Wolfe et al., 2009). There was only one study that was deemed low ROB in this domain as the authors utilized a computer-generated process for allocation (Taylor et al., 2013).

Incomplete Outcome Data

Studies that were deemed low ROB in this domain had attrition rates below 10%, equal attrition between study arms and utilized intention to treat (ITT) analysis in their statistical

analyses plans (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Higgins et al., 2022; Jaycox, McCaffrey, Eiseman, et al., 2006; Wolfe et al., 2009). Two studies that were deemed unclear ROB were close to the 10% attrition standard (Joppa et al., 2016; Taylor et al., 2013). Taylor et al. (2013) attempted to mitigate their slightly higher attrition rate of 11% through statistical methods, such as multiple imputations. The other study by Joppa et al. (2016) noted that there was a slight difference in results between those retained within the study and those who withdrew but utilized an ITT analysis to try and account for their attrition rate of 12.7%. This form of analysis means that researchers analyzed all participants by the study arm in which they were assigned through the randomization process, regardless of the extent of their adherence to the study protocol (Higgins et al., 2022). By utilizing this form of statistical analysis, the researchers ensured that the comparability between study arms due to the randomization process was maintained, thus minimizing selection bias and attrition bias. The studies that were deemed high ROB had high rates of attrition ranging from 17% to 63% (Dos Santos et al., 2019; Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Temple et al., 2021). Furthermore, two of these studies utilized a per-protocol (PP) analysis (Dos Santos et al., 2019; Temple et al., 2021). Using PP means that these authors only included the participants who adhered to the intervention protocol, eliminating those who deviated from the trial protocol (Higgins et al., 2022). This means that these studies are at risk for selection and attrition bias (Higgins et al., 2022).

Selective Reporting

Studies were deemed low ROB if they reported all outcomes described within their methods or within the published study protocol (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Higgins et al., 2022; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021; Wolfe et al., 2009). The Navarro-Perez et

al. (2020) study was missing the multivariate analysis of their outcome, ambivalence towards men, despite stating they would report this within their methods. Dos Santos et al. (2019) did not do an intragroup analysis within the control arm, however, did one within the experimental arm.

Blinding of Participants and Personnel

All studies were deemed to have a high ROB as blinding could not be done for the participants nor the personnel implementing the study. All personnel administering the interventions and controls were aware of the educational program they were implementing, making blinding of this group impossible. While participants may not have known whether they were receiving traditional education (usual care) or the intervention, studies that were randomized at the classroom strata had a high potential for study arm contamination given that students could interact outside the classrooms in which they were randomized to (Avery-Leaf et al., 1997; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Taylor et al., 2010a).

Blinding of Outcome Assessment

There was overall a lack of reported information concerning the blinding of outcome assessors. Studies were deemed an unclear ROB if they contained no information regarding the assessor of outcomes and distributed surveys for intervention assessment (Dos Santos et al., 2019; Muñoz-Fernández et al., 2019; Navarro-Perez et al., 2020; Temple et al., 2021). The remaining studies were deemed a high ROB given that either the researchers conducting the study or the personnel who delivered the study were responsible for the administration, collection and analysis of study measures (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017;

Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Taylor et al., 2010a; Taylor et al., 2013; Wolfe et al., 2009).

Intervention Characteristics as per the TIDieR Criteria

This next section of the results synthesizes the included studies based on each aspect of the TIDieR criteria. These criteria are used to improve the completeness of reporting of interventions within the literature and will be used to assess the structure of the interventions used for the primary educational prevention of DV (Hoffmann et al., 2014**).** The summary of intervention traits as per the TIDieR criteria for each study can be found in Appendix J.

Intervention Theory Incorporation

Of the 11 studies included in this review, eight utilized a theory to aid in the development of their DV prevention programming (Coker, Bush, et al., 2017; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021). Of these, four based their intervention design on Social Learning Theory (SLT) or Social Cognitive Learning Theory, an expanded version of Bandura's SLT (Dos Santos et al., 2019; Ewen & Ewen, 2009; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Temple et al., 2021). Three of the studies detail that this theory provides the knowledge to change cognition associated with DV and then practices skills that promote healthy relationship behaviours (Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Temple et al., 2021) Two reported a decrease in DV (Joppa et al., 2016; Temple et al., 2021) whereas one reported no difference between study arms (Jaycox, McCaffrey, Eiseman, et al., 2006). Only two studies measured DV knowledge, and both reported improvements in DV knowledge and decrease in the acceptance of gendered violence (Jaycox, McCaffrey, Eiseman, et

al., 2006; Joppa et al., 2016). The remaining study which utilized SLT did not detail how it informed program development (Dos Santos et al., 2019). This study examined bystander attitudes and behaviours and reported no differences between the study groups (Dos Santos et al., 2019).

Two studies by Taylor et al. (2010a) and Taylor et al. (2013) had similar program structure and based the development of their interventions on the Theory of Reasoned Action. This theory states that an intention to behave is the best indicator of a person engaging in that behaviour (LaCaille, 2013). Intentions are predicted by attitudes and perceived societal norms towards a behaviour (LaCaille, 2013). The results of these studies are conflicting, with the initial study leading to an overall increase in the reports of non-sexual DV in both groups at the end of the study (Taylor et al., 2010a). Whereas the latter reported no differences between intervention arms (Taylor et al., 2013).

Muñoz-Fernández et al. (2019) utilized the Dynamic Systems Model theory to ground their intervention development. This theory states that behaviours are a result of multiple interacting forces, both external and internal to an individual (Newman & Newman, 2020). The study measured trends and changes in trend trajectory based on multiple group latent growth models (Muñoz-Fernández et al., 2019). Overall, the study reported a decrease in the growth trajectory of severe physical DV, sexual DV and bullying, but not in moderate physical DV (Muñoz-Fernández et al., 2019).

Coker, Bush, et al. (2017) based their intervention on the Diffusion of Innovation theory (Dearing, 2009). This theory states that an innovation will be adopted by a society when opinion leaders begin supporting an intervention by gradual communication through societal channels (Dearing, 2009). This is evidenced in the study design as opinion leaders were agreed upon by

school personnel and the research team (Coker, Bush, et al., 2017). These opinion leaders were then given the Green Dot training with the expectation that the training would diffuse to other students in the school (Coker, Bush, et al., 2017). The study found a decrease in physical, psychological, and sexual victimization and perpetration (Coker, Bush, et al., 2017).

The remaining three studies did not explicitly describe using a theory during the development of the interventions (Avery-Leaf et al., 1997; Navarro-Perez et al., 2020; Wolfe et al., 2009). Two reported an improvement in the intervention groups related to attitudes towards gendered violence (Avery-Leaf et al., 1997; Navarro-Perez et al., 2020), while the third did not report on this (Wolfe et al., 2009).

Materials

Five of the 11 studies (45%) provided extensive curriculum materials for the intervention arms of their studies including, but not limited to, intervention manuals, lesson plans, activity sheets, rubrics, standardized information for teaching and handouts (Joppa et al., 2016; Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013; Wolfe et al., 2009). Three studies only provided high-level details of the curriculum materials (Joppa et al., 2016; Muñoz-Fernández et al., 2019; Wolfe et al., 2009). All three detailed the worksheets and handouts for students but provided no details as to the contents. All three described instructor manuals given to intervention providers, with two detailing that manuals described the session aims, contained lesson plans, lesson activities and materials for each., however the specifics were not included in the study (Muñoz-Fernández et al., 2019; Wolfe et al., 2009). The final two studies, conducted by the same authors, detailed lesson plans for the instructors including opening statements, safety statements, instructions for how to answer certain questions when it pertained to other study arms, the exact copies of the activity plans and the handouts provided to students (Taylor et al.,

2008; Taylor et al., 2011). The lesson plans detailed how much time was to be spent on each activity and also gave scripts to teachers in certain circumstances (Taylor et al., 2008; Taylor et al., 2011). If videos were shown, these items were also provided (Taylor et al., 2008; Taylor et al., 2011).

Two studies provided materials, although these were limited (Coker, Bush, et al., 2017; Dos Santos et al., 2019). One study provided workbooks for students but did not provide content details (Coker, Bush, et al., 2017) and the other an intervention support manual to the participants with information on DV and skills to recognize DV and enable seeking aid in those who were in violent situations or who had peers in violent situations (Dos Santos et al., 2019).

The only material provided by one study was the app itself (Navarro-Perez et al., 2020). The app consisted of a roulette wheel that was divided into coloured sections, each responding to a different type of game related to DV knowledge (Navarro-Pérez et al., 2019). This app includes other gamification aspects such as a points system where players can gain points based on correct answers, lose them based on landing on certain tiles in the wheel and further increase their scores through multiplication tiles (Navarro-Pérez et al., 2019). The remaining studies did not report the materials provided (Avery-Leaf et al., 1997; Jaycox, McCaffrey, Eiseman, et al., 2006; Temple et al., 2021).

Procedures

Of the included studies eight (73%) delivered educational materials over multiple sessions, resembling a traditional school curriculum, taken during class time at school (Avery-Leaf et al., 1997; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021; Wolfe et al.,

2009). Within these studies, there were slight variations in the content and how it was delivered. All eight studies included information on DV prevalence, signs, romantic myths, communication skills and traits of healthy relationships (Avery-Leaf et al., 1997; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021; Wolfe et al., 2009). In addition, three studies also included the legal repercussions of DV and information on the intersection of DV and the justice system (Jaycox, McCaffrey, Eiseman, et al., 2006; Taylor et al., 2010a; Taylor et al., 2013). Two studies also provided education on substance use and sexual health in addition to the aforementioned topics (Temple et al., 2021; Wolfe et al., 2009).

All eight studies include a multimodal approach to education by providing a combination of lectures, handouts, individual and group activities to aid with learning (Avery-Leaf et al., 1997; Dos Santos et al., 2019; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021; Wolfe et al., 2009).

The first study provided very few details regarding the intervention procedures (Avery-Leaf et al., 1997). The authors described a five-session curriculum that discussed how gender inequality may foster violence, promote equity in relationships, identifying positive communication skills such as negation and conflict resolution, resources for victims of violence (Avery-Leaf et al., 1997). The authors did not provide any further breakdown of the process regarding the content covered in each class nor the activity details (Avery-Leaf et al., 1997).

Muñoz-Fernández et al. (2019) had sparse details concerning the reporting of their curriculum. The authors reported that the first five sessions were led by the researchers to develop knowledge as it relates to romantic myths and healthy relationships, encouraging better emotional regulation and expression and improving communication skills (Muñoz-Fernández et

al., 2019). These sessions also discussed different forms of violence and worked to promote self-esteem (Muñoz-Fernández et al., 2019). These sessions consisted of web-based activities, videos, debates, role-playing and discussions, but no further breakdowns were provided as to how they were implemented (Muñoz-Fernández et al., 2019). The last two sessions were peer-led, with one being delivered by a female student and one delivered by a male student. These involved presenting a conflict or abusive situation to raise bystander awareness and influences on DV and promoting coping skills in response to aggression (Muñoz-Fernández et al., 2019). Activities for these sessions include group exercises and decision-making games, but no additional details were provided (Muñoz-Fernández et al., 2019). The last aspect of this intervention was a final school-wide activity to cover all the key lessons from the intervention, the authors did not specify what the activity was, how it was delivered or by whom it was delivered (Muñoz-Fernández et al., 2019).

Taylor et al. (2010a) described foundation for the curriculum seen in the Taylor et al. (2013) study. In the 2010 study, there were two intervention arms, one consisted of an interaction-based curriculum, whereas the other consisted of a law and justice-based curriculum (Taylor et al., 2010a). Both intervention arms had five lessons, each once a week with the first lesson being the same on measuring personal space. In lessons two to five in the interaction-based curriculum classes discussed friendships, differences between consent, flirting, and sexual harassment, bystander responsibilities and courage in relationships (Taylor et al., 2008). The law and justice curriculum, however talked about boundaries, dominance and violence, classifying behaviours and sexual harassment in these lessons (Taylor et al., 2008). All lessons in both curriculums consisted of active learning activities including group discussions, games, videos, and individual work (Taylor et al., 2008). It should be noted that the focus between the

curriculums differs with the interaction based on focusing on communication between the parties and the law curriculum focusing on the consequences of doing something when someone says stop (Taylor et al., 2008). This study found that both treatment groups had an increase in DV knowledge, and improvement in attitudes towards personal space (Taylor et al., 2010a). However, they also both showed an increase in the reporting of DV perpetration, but not victimization in both treatment arms compared to the control (Taylor et al., 2010a).

Taylor et al. (2013) condensed the law and justice curriculum with the interaction-based curriculum into a six-session curriculum named *Shifting Boundaries*. This study also had three intervention arms consisting of classroom-based interventions only, school-based interventions only and a group consisting of both classroom and school-based interventions (Taylor et al., 2013). The classroom-based interventions had six lessons in total (Taylor et al., 2013). The first five lessons were a combination of concepts and activities from the law and justice curriculum and the interaction curriculum of the preceding study (Taylor et al., 2008; Taylor et al., 2011). The last lesson however involves students individually mapping out areas of their school in which they feel comfortable, somewhat comfortable and uncomfortable followed by a group discussion on the topic (Taylor et al., 2011).

In the school-based intervention, schools implemented respecting boundaries agreements, in which students whose boundaries were violated could proceed with a process of rectifying that violation with the offending student (Taylor et al., 2011). It consisted of defining a boundary, a description of the incident, and a reflection and how it could be prevented in the future, completed by both the student whose boundaries were violated and the offending student (Taylor et al., 2011). A follow-up was then done with both students two weeks later to determine how well the agreement was maintained (Taylor et al., 2011). Posters increasing DV awareness and

encouraging reporting to school faculty were also placed for the same duration that the classroom interventions took place, approximately six to ten weeks (Taylor et al., 2011). Finally, students completed the school maps, but these were then analyzed by the instructor and taken to school leadership to develop a plan to address students' concerns (Taylor et al., 2011).

In the study arm which employed both the classroom and school-based interventions, all the aforementioned activities took place (Taylor et al., 2011).

Two other studies also closely mimicked each other regarding their delivery and content. Wolfe et al. (2009) developed a three-unit curriculum with 21 lessons delivered during a grade nine Canadian health class called *Fourth R.* The first unit discussed how to form healthy relationships, active listening skills, factors that contribute to violence, media representation of violence and conflict resolution skills (Wolfe et al., 2009). Unit two focused on healthy sexuality, sexual decision-making, pregnancy, STDs and skills in handling pressure in relationships (Wolfe et al., 2009). Unit three then discussed topics regarding substance use such as drug use, skills to avoid being pressured into substance use and the connection between substance use and violence (Wolfe et al., 2009).

Temple et al. (2021) based their intervention on the Wolfe et al. (2009) study with some modifications. Temple et al. (2021) stated that they amended the content to make the references more applicable to the American population and the content more age appropriate. They described how they changed hockey references to football, however, did not provide further details, nor did they discuss how they made it developmentally appropriate for the seventh grade (Temple et al., 2021). Unit one had the same focus as the Wolfe et al. (2009) study but, provided more details including the benefits and dangers of technology, coping strategies, and decision-making tools (Temple et al., 2021). The second unit consisted of the substance use topics seen in

unit three of the Wolfe et al. (2009) study in addition to connecting substance use with mental health and help-seeking practices (Temple et al., 2021). Unit three consisted of the sexual health topics seen in unit two of the Wolfe et al. (2009) study in addition to discussions on consent (Temple et al., 2021). Any further breakdown for activities or individual lessons was not provided by either study (Temple et al., 2021; Wolfe et al., 2009).

The *Katie Brown Educational Program* (KBEP) was developed to closely resemble the *Fourth R* program (Joppa et al., 2016; Temple et al., 2021; Wolfe et al., 2009). It consisted of five units which could be incorporated into any high school health curriculum (Joppa et al., 2016). The focus of these units was to describe DV, discuss relationship expectations, and improve communication skills (Joppa et al., 2016). The authors discussed how each session included a lecture, discussion, and individual and group work however, did not detail these activities any further (Joppa et al., 2016). This program was developed to facilitate ease of incorporation into other health curriculums to allow for wide dissemination (Joppa et al., 2016).

The last study, while delivered in a school, focused primarily on the legal aspects of DV (Jaycox, McCaffrey, Eiseman, et al., 2006). Consisting of three sessions, the content of the first session focuses on the prevalence and consequences of DV and attorney-client privileges (Jaycox, McCaffrey, Eiseman, et al., 2006). The researchers provided a video on the introduction of the project with a background on DV, in addition to discussion and active learning-based activities (Jaycox, McCaffrey, Eiseman, et al., 2006). The second session focused on domestic violence law with a discussion on legal options, both criminal and civil (Jaycox, McCaffrey, Eiseman, et al., 2006). The third session focussed on the legal process of safety planning and healthy relationships (Jaycox, McCaffrey, Eiseman, et al., 2006). The program facilitators explained how to obtain a restraining order under civil law and used role play to demonstrate a

mock hearing for a restraining order (Jaycox, McCaffrey, Eiseman, et al., 2006). All sessions used active learning strategies including, discussion, games and videos (Jaycox, McCaffrey, Eiseman, et al., 2006). Beyond what is described here, the authors provided no further details as to how the programs conducted each activity, nor how the lessons were organized or delivered (Jaycox, McCaffrey, Eiseman, et al., 2006).

The remaining three studies delivered their programs differently than the aforementioned studies (Coker, Bush, et al., 2017; Dos Santos et al., 2019; Navarro-Perez et al., 2020) The Dos Santos et al. (2019) study was formatted similarly to the other educational programs in that it was delivered didactically, however it was conducted within classrooms of a government-run educational work program (Dos Santos et al., 2019). Classes were delivered over three sessions, which included information on DV, relationships, the role of friends in DV, and romantic myths (Dos Santos et al., 2019). Researchers aimed to foster emotional support and guidance from the peer networks and promote attitudes that foster the intervention of bystanders when they witness DV (Dos Santos et al., 2019). It aimed to teach empathetic communication concerning DV and mobilize helping behaviours (Dos Santos et al., 2019). Activities included a video and debate on the bystander approach in DV and an exercise in empathy (Dos Santos et al., 2019). The authors did not divulge any further details about the curriculum concerning the specifics of the activities (Dos Santos et al., 2019).

Coker, Bush, et al. (2017), were similar in that they delivered their intervention over four years at intervention schools. It involved a yearly 50-minute presentation by rape crisis educators on DV and how bystanders could help in conjunction with how to recognize green dots and red dots (Coker, Bush, et al., 2017). Green Dots are actions that help reduce acts and tolerance of violence whereas Red Dots are words or actions that condone or lead to violence (Coker, Bush,

et al., 2017). In the second year of the intervention, researchers worked with school staff to identify popular opinion leaders (Coker, Bush, et al., 2017). These opinion leaders were students that school staff identified as those who were respected and emulated by other students (Coker, Bush, et al., 2017). The researcher theorized, using maximum diffusion theory, that training 12 to 15% of the student body and those who are opinion leaders, will maximize the diffusion of the intervention across each school. This intensive training of opinion leaders was five hours and consisted of building skills to prevent aggression, addressing barriers to intervening in DV and patterns of DV perpetration. It also consisted of how these leaders could intervene in red dot behaviours and communicate their training to their peers (Coker, Bush, et al., 2017). While the training was prioritized for these opinion leaders, it was open to those who were interested as well, space permitting (Coker, Bush, et al., 2017).

The Navarro-Perez et al., (2020) study involved researchers giving a presentation to the intervention arm of the study on DV and the app they developed to help address it (Navarro-Perez et al., 2020). The app was a roulette game that had different mini-games within each tile on the wheel (Navarro-Pérez et al., 2019). The games were developed to help provide education on DV with each mini-game accumulating points based on correct answers (Navarro-Pérez et al., 2019). Participants within the intervention arm interacted with the app on their terms with the only requirement that they accumulated 2,500 points by the end of the trial to ensure sufficient app exposure (Navarro-Perez et al., 2020). Content aimed to reduce sexist behaviours and increase knowledge related to gender-based violence (Navarro-Pérez et al., 2019). Games consisted of question-answer formats, choosing the correct answer from a group of options, rearranging words representative of key content, bursting balloons with harmful words displayed

on them, identifying true and false statements and judging conversations (Navarro-Pérez et al., 2019). No further breakdown of the question content is provided (Navarro-Pérez et al., 2019).

Intervention Provider

Five of the studies had teachers employed at the intervention sites deliver the intervention (Avery-Leaf et al., 1997; Joppa et al., 2016; Taylor et al., 2010a; Temple et al., 2021; Wolfe et al., 2009). Of these studies, Joppa et al. (2016) did not provide any additional training, nor did they detail the level of expertise of the providers beyond that they were bachelor level paraprofessionals employed by the KBEP. Temple et al. (2021) provided a similar level of detail describing that seventh-grade teachers were trained by the research team to deliver the intervention, however provided no additional details regarding this training, nor the level of experience of the teachers delivering the study. Avery-Leaf et al. (1997) stated that health teachers received eight hours of training involving knowledge on DV and curriculum implementation one week prior to intervention delivery. They did not describe the level of expertise of the teachers involved or any additional details regarding training (Avery-Leaf et al., 1997). Wolfe et al. (2009) also described how health teachers received a six-hour training session on DV and healthy relationships from an educator and psychologist. They also had training videos of curriculum implementation, role-play demonstrations and feedback from an experienced educator on their curriculum implementation (Wolfe et al., 2009) They also implemented the curriculum one semester prior to the start of the trial to increase familiarity (Wolfe et al., 2009). The final study utilized a combination of teachers for implementation and a rape crisis educator depending on the location of the school (Taylor et al., 2010a). The level of experience of the teachers involved was not described and the orientation varied depending on the site the study was implemented (Taylor et al., 2010a). At one school, all staff received the

same orientation, whereas not all academic staff were able to receive the orientation session in others (Taylor et al., 2010a). The schools that had teachers implementing the intervention had additional training for teaching the session, but the authors provide no additional details regarding either the general or additional training provided (Taylor et al., 2010a). Of these five studies, four showed a reduction in physical DV occurrences within intervention schools (Avery-Leaf et al., 1997; Joppa et al., 2016; Temple et al., 2021; Wolfe et al., 2009). The remaining study however, showed an increase in physical violence (Taylor et al., 2010a).

Four studies utilized educators who specialized in violence prevention to deliver the intervention (Coker, Bush, et al., 2017; Dos Santos et al., 2019; Taylor et al., 2010a; Taylor et al., 2013). The training for the Taylor et al. (2010a) study was mentioned above, however the later study utilized substance abuse prevention and intervention specialists to deliver the revised program (Taylor et al., 2013). The study mentions how the training of these staff members was extensive but, then provides no further details regarding what it consisted of, nor the education of the specialists being trained (Taylor et al., 2011; Taylor et al., 2013). Coker, Bush, et al. (2017) also utilized rape crisis educators to deliver their intervention, again with no details regarding their level of training or expertise. These educators received four days of training from the Green Dot developer, but there were no additional details about what this involved (Coker, Bush, et al., 2017). The last study had clinical psychology doctorate students with experience in group interventions, DV prevention, bystander intervention and spectator approach (Dos Santos et al., 2019). There was no additional training provided for these providers in this study (Dos Santos et al., 2019). The results from these studies were varied ranging from increasing incidents of DV, no effect on DV, to having reductions in psychological, sexual and physical forms of DV (Coker, Bush, et al., 2017; Taylor et al., 2010a; Taylor et al., 2013). The remaining study did not evaluate

incidents of DV, only bystander attitudes and showed no changes after the implementation of the intervention (Dos Santos et al., 2019).

Two studies had members of the research team deliver the intervention (Muñoz-Fernández et al., 2019; Navarro-Perez et al., 2020). There was no additional training given to those administering the intervention in these studies nor was the level of expertise of the researchers discussed (Muñoz-Fernández et al., 2019; Navarro-Perez et al., 2020). Both studies examined different outcomes and therefore their results cannot be aggregated. The Navarro-Perez et al. (2020) study examined sexist attitudes and found that there was an overall decrease in sexist attitudes and distortion of romantic ideas. The Muñoz-Fernández et al. (2019) study found that there was no change in moderate physical violence, but did observe a decrease in severe physical violence, sexual DV and bullying.

Finally, one study had attorneys with backgrounds in intimate partner violence deliver the intervention however did not detail if they were trained for the purposes of the study (Jaycox, McCaffrey, Eiseman, et al., 2006). This study showed an increase in DV knowledge and less acceptance of gender based violence, however there was no change in the experience of abusive dating experience post-intervention (Jaycox, McCaffrey, Eiseman, et al., 2006).

Mode of Delivery

As previously mentioned, the majority of studies delivered the intervention within a school setting except for one (Navarro-Perez et al., 2020). All these studies delivered their intervention in person to groups of study participants (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Navarro-Perez et al., 2020; Taylor et al., 2010a; Taylor et al.,

2013; Temple et al., 2021; Wolfe et al., 2009). Two studies had an online portion of their intervention (Muñoz-Fernández et al., 2019; Navarro-Perez et al., 2020). The Navarro-Perez et al. (2020) study utilized an app that the intervention arm could use at their leisure accompanied by an in-person presentation introducing the app. The Muñoz-Fernández et al. (2019) study reported using a web-based platform for participants to use to complete activities related to the intervention, but there was no elaboration beyond this statement.

Schedule of Intervention Delivery

Five of the studies delivered the entirety of their intervention within a month (Avery-Leaf et al., 1997; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Navarro-Perez et al., 2020). Of these studies, there were four that measured DV knowledge and attitudes (Avery-Leaf et al., 1997; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Navarro-Perez et al., 2020). These studies all demonstrated an improvement in DV knowledge and a decrease in attitudes justifying gender-based violence (Avery-Leaf et al., 1997; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Navarro-Perez et al., 2020). Five studies delivered their intervention within a period of one to six months (Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021; Wolfe et al., 2009). These studies reported mixed results on physical DV ranging from increasing to decreasing instances of DV in the intervention group (Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021; Wolfe et al., 2009). Only one study delivered the intervention over four years which resulted in a reduction in psychological, physical and sexual DV in years three and four of the intervention (Coker, Bush, et al., 2017).

Within each intervention, sessions lasted between 40 to 90 minutes however, in the Navarro-Perez et al. (2020) study, the duration of sessions were individualized given that it was

determined by participant interactions with an app. Coker, Bush, et al. (2017) provided five hours of bystander training within a single session. Two studies did not mention the length of their intervention sessions (Avery-Leaf et al., 1997; Jaycox, McCaffrey, Eiseman, et al., 2006).

Most studies delivered their intervention in three to eight sessions (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013). Two studies delivered their intervention over approximately 20 sessions (Temple et al., 2021; Wolfe et al., 2009), with one being an adaptation of the former intervention for the US population (Temple et al., 2021). The latter two studies both showed a reduction in physical DV (Temple et al., 2021; Wolfe et al., 2009).

Intervention Adaptations

The majority of the studies did not report any tailoring of the intervention to participants (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021). Two studies had some level of tailoring (Navarro-Perez et al., 2020; Wolfe et al., 2009). Wolfe et al. (2009) stated that they had different activities for males and females within their intervention but provided no further details. The Navarro-Perez et al. (2020) study was completely individualized as participants chose how they interacted with the app, including what content they consumed, when it was consumed, and how long each session lasted. Unfortunately, they were unable to report how each participant tended to utilize the app beyond the requirement that each participant had to log a minimum of 2,500 points within the app (Navarro-Perez et al., 2020).

Intervention Fidelity

Fidelity was largely monitored through self-reporting on tools created by the research teams in each study (Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021; Wolfe et al., 2009). Three of the studies solely reported that there was "high fidelity", however did not disclose the related statistics (Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021). The remaining study by Wolfe et al. (2009) reported an 88% to 90% adherence to the delivery of the lessons based on the teacher completed fidelity checklists. These studies reported mixed results on physical DV ranging from increasing to decreasing instances of DV in the intervention group (Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021; Wolfe et al., 2009).

There were four studies that utilized direct observation of the intervention by the researchers to assess adherence to the intervention (Coker, Bush, et al., 2017; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Temple et al., 2021). Of these studies, only two reported on program fidelity adherence outcomes (Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016). Joppa et al. (2016) monitored 23 of the active classroom sessions and determined that there was 97% adherence to the program. Whereas the Jaycox, McCaffrey, Eiseman et al. (2006) study had researchers observing 10% of the classrooms and rating the content coverage as well as the quality of the presentations. They found that 69% of the curriculum was completely covered, 26% was partially covered and 5% was not covered with all but six sessions rated as moderately to extremely engaging (Jaycox, McCaffrey, Eiseman, et al., 2006). Of these four studies, three reported a decrease in instances of physical DV (Coker, Bush, et al., 2017; Joppa et al., 2016; Temple et al., 2021). The Navarro-Perez et al. (2020) study utilized app usage as a metric for adherence to the intervention. The remaining three studies did

not report any methods for assessing intervention fidelity, nor did they report on adherence to the curriculum (Avery-Leaf et al., 1997; Dos Santos et al., 2019; Muñoz-Fernández et al., 2019).

CHAPTER 5: Discussion

Summary of the Evidence

This review intended to examine the characteristics of primary prevention educational interventions, or a combination thereof, that contributed to the prevention of dating violence in adolescents aged 10 to 18. The systematic search identified 11 studies to be included in the review, that examined primary prevention educational programs for DV as it relates to a variety of outcomes such as instances of physical, sexual, psychological DV, DV knowledge and attitudes as well as bystander behaviours. This review then examined the directionality of the reported outcomes based on the TIDieR characteristics where applicable. The studies primarily took place in high-income countries within academic settings and reported a generally equal split of male and female participants with a mean reported age between 12 to 17 years old.

Methodologically, all studies needed to improve on their methods for allocation concealment and blinding of the outcome assessors. Given the nature of the interventions, it is recognized that blinding of the participants and personnel may be near impossible, as such, there needs to be further actions taken to mitigate these effects in the form of allocation concealment and blinding of outcome assessors.

One of the main findings from this review is that there were no intervention characteristics which resulted in clear change in either physical, psychological or sexual DV. It is difficult to be confident in the results obtained, as studies looked at different outcomes and used varying outcome measures. Additionally, many of the instruments lacked the appropriate

psychometric validation as they were developed by the researchers for the purposes of their study. A narrative synthesis of the results was undertaken due to the variability in the nature of the outcomes to allow for a more comprehensive summary of the characteristics of the available interventions.

One observation that could be made, was that interventions which examined change in DV knowledge and delivered their interventions within a month all resulted in an improvement in DV knowledge (Avery-Leaf et al., 1997; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Navarro-Perez et al., 2020). When examining the synthesized data of all the studies which measured DV knowledge within this review, all reported an improvement within the intervention arm in DV knowledge (Avery-Leaf et al., 1997; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Navarro-Perez et al., 2020; Taylor et al., 2010a; Taylor et al., 2013).

Finally, while eight studies were found to have based the development of their intervention on theory, none of those studies explicated stated using feminist theory to inform program development (Coker, Bush, et al., 2017; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021).

Feminist Analysis

Despite this issue disproportionately affecting females, none of the eight studies that incorporated theory in the development of their programs included a feminist theory (Coker, Bush, et al., 2017; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021). When studies were examined with a broader lens, looking at feminist components within

the interventions, only four of the studies had content that addressed the gender inequalities and societal norms that contribute to the perpetuation of DV (Avery-Leaf et al., 1997; Navarro-Perez et al., 2020; Taylor et al., 2010a; Taylor et al., 2013). Furthermore, in these studies, the feminist content was a limited portion of the education delivered within the intervention (Avery-Leaf et al., 1997; Navarro-Perez et al., 2020; Taylor et al., 2010a; Taylor et al., 2013).

While content addressing societal norms and gender inequalities aligns with post-modernist feminism, these curriculums also have content that segregate groups and answers based on if participants identify as a boy or a girl (Taylor et al., 2010a; Taylor et al., 2013; Wolfe et al., 2009). This segregation of genders further reinforces patriarchal ideas and norms, which is the opposite of the assumptions of this theory (Anderson, 2020). Some programs instead teach that DV is a result of a power imbalance within a relationship, due to either societal structures or the attitudes of the people within the relationship (Avery-Leaf et al., 1997; Dos Santos et al., 2019; Joppa et al., 2016; Muñoz-Fernández et al., 2019). This aligns with postmodern feminism which states that DV occurs due to power as opposed to inheriting differences between males and females (Anderson, 2020).

These programs further embody the assumptions of this theory by providing tools and resources that allow participants to garner control in situations (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Dos Santos et al., 2019; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Navarro-Perez et al., 2020; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021; Wolfe et al., 2009). In these studies, which provide education on effective forms of communication, bystander interference strategies and negotiation skills, power is given to participants to regain control of situations. DV can be perpetrated by any gender, and through universally providing this education it also allows for any gender to use it as a means of gaining power within a

situation. This could help balance the power dynamic between individuals in DV relationships and conform with postmodern feminist ideals (McHugh et al., 2005).

While intentional or not, many of these programs have components that coincide with postmodern feminist notions. However, when examining the structure of intervention delivery, all except one study is delivered within a school setting (Avery-Leaf et al., 1997; Coker, Bush, et al., 2017; Dos Santos et al., 2019; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Navarro-Perez et al., 2020; Taylor et al., 2010a; Taylor et al., 2013; Temple et al., 2021; Wolfe et al., 2009). Schools have been shown to reinforce patriarchal structures within society and exacerbate societal gender norms (Cimpian et al., 2016; Hamel, 2021; Robinson-Cimpian et al., 2014; Turetsky et al., 2021). Solely by implementing these programs within an educational setting, these interventions are also subject to the same patriarchal biases that are entrenched within these institutions.

When looking at the previous reviews, none of them specifically addressed feminist components or how the results of their reviews aligned with this ideology (Fellmeth et al., 2013; Lee & Wong, 2022; Piolanti & Foran, 2022; Russell et al., 2021; Whitaker et al., 2006). A review conducted by Reyes et al. (2021) that examined a similar question, however in a broader context, did discuss how there was a difference in low-income and high-income countries in how they operationalized their interventions as they related to gender inequalities. Reyes et al. (2021) critiqued high-income countries for not addressing how gender inequalities drive adolescent DV within their programs compared to low-income countries. They concluded that a potential reason for the variability seen in the results of their review was due to high-income countries' lack of acknowledging and accounting for DV being a gendered issue within their interventions (Reyes et al., 2021). They stated that programs need to go beyond solely addressing modifying

behaviours and addressing societal structures that reinforce gender inequalities (Reyes et al., 2021).

Implications for Practice

One of the main findings of this review was that there was an improvement in DV knowledge in interventions that delivered their program within a month (Avery-Leaf et al., 1997; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Navarro-Perez et al., 2020). This is further supported when examining the synthesized data of all the studies that measured DV knowledge within this review that all reported an improvement within the intervention arm in DV knowledge (Avery-Leaf et al., 1997; Jaycox, McCaffrey, Eiseman, et al., 2006; Joppa et al., 2016; Navarro-Perez et al., 2020; Taylor et al., 2010a; Taylor et al., 2013).

When analyzing the structure of these programs, they were very similar in terms of structure and delivery. As mentioned within the literature review, there are many facets for addressing DV education and prevention such as didactic, social media, gaming, and bystander methods to name a few. All these studies, except one (Navarro-Perez et al., 2020) utilized a traditional didactic approach to program delivery (Avery-Leaf et al., 1997; Coker et al., 2017; Dos Santos et al., 2019; Jaycox et al., 2006; Joppa et al., 2016; Muñoz-Fernández et al., 2019; Taylor et al., 2010; Taylor et al., 2013; Temple et al., 2021; Wolfe et al., 2009). While this approach works for some learners, there is evidence that suggests more modern teaching methods are more effective at facilitating the development of skills, such as a flipped classroom (Burkhalter, 2016; Hewitt & Tarrant, 2015). These programs, while didactic, did include active learning strategies in their interventions, that have been shown to cultivate learning more successfully than traditional didactic methods (De Witte & Rogge, 2016; Strelan et al., 2020;

Wilder, 2015). This could be one of the reasons why all studies that reported on this measure resulted in an improvement in DV knowledge compared to the control arms. This does have to be interpreted in the context of the other major finding of this review, that there were no clear intervention characteristics that contributed to a change in DV related behaviours. This means that while these DV prevention programs may result in a change in knowledge, this does not translate into a change in behaviours. This finding aligns with the Fellmeth et al. (2013) and Lee & Wong (2022) review findings that also show that there were changes to DV knowledge, however it did not translate into a change in DV behaviour. This review is different in that it demonstrates that interventions implemented over the course of a month result in this change in DV knowledge. Fellmeth et al. (2013) hypothesized that the reason why there was not a subsequent change in behaviours was that adolescents were able to comprehend the concepts, however they were unable to successfully employ them. Furthermore, Fellmeth et al. (2013) also concluded that while there was no evidence of effect within their review, it did not necessarily mean there was no effect, so at a practical level, programs should continue when feasible.

This review has also highlighted that, despite only having a few studies to support their development, several of the programs have been adopted across the nation. Both Green Dot and Fourth R have been implemented in several states and provinces across the United States and Canada (Coker, Bush, et al., 2017; Crooks et al., 2015). If nursing leaders are considering implementing a program within their communities, the fact that there have not been very many studies reproducing these effects and considerations should be made towards how the components align with their feasibility, goals, and population they are targeting. As previously mentioned, not having these within a systematic review, makes adhering to evidence-based practices difficult (Guyatt et al., 2015). Choosing a program on the basis of a few individual

studies, largely conducted by the same group of researchers, could lead to the implementation of an ineffective program for the targeted population (Guyatt et al., 2015). Nursing leaders need to be cognizant of the processes and factors that they are using when determining the most appropriate program for implementation within their communities.

This review has also highlighted that while there are components of these prevention interventions that align with feminist theory, there is no active thought and considerations made to include feminist ideals. To combat the effects of societal structures that would work against these interventions there needs to be a more considerate approach to incorporating these ideas and values into intervention development. Institutions and programs that have taken this proactive approach are more successful in combating the effects of patriarchy (Grissom-Broughton, 2020; Kulkarni, 2019; Rogers, 2006). One way that organizations can begin to account for these disparities is through community-based participatory methods (Kulkarni, 2019; Leavy, 2020). Community-based participatory methods (CBPM) leverage the community in which an intervention is planned and involves them in the design and implementation of programs (Leavy, 2020). CBPM is used to empower disadvantaged individuals and promote social justice for marginalized people (Leavy, 2020). It is context-specific and often targeted to meet the needs of a specific group and works to challenge the inequalities that systems place on marginalized populations (Leavy, 2020). Employing these methods often leads to more successful programs and helps to address complex societal issues that cannot be easily understood through conventional research methods (Hay et al., 2019; Kulkarni, 2019; Leavy, 2020). Institutions would benefit from involving the adolescents they are targeting when deciding what program to implement, how to implement it and how they decide if it is

contributing to meaningful change. While these methods often take time and resources to enact, they will result in a more impactful program with more salient effects (Leavy, 2020).

Implications for Research

This review highlighted that no intervention characteristic resulted in a clear change in the instances of physical, psychological or sexual DV. One of the reasons for this is that studies not only varied on which of these to measure, but when they were measured, they used different instruments. An avenue for potential research is by creating and psychometrically evaluating scales to measure DV perpetration, victimization, and attitudes within an adolescent population. As evidenced by the review, there were seven different instruments utilized to measure these outcomes between studies, many of which were developed by the study authors for the purpose of their studies. It should be noted that there are a multitude of scales that can be used to assess DV victimization and perpetration, and few were developed with the consideration of the adolescent population (Smith et al., 2015; Thompson et al., 2006). Scales that were developed for adult populations experiencing DV and then employed in adolescent populations, examined different behaviours than those seen within the adolescent population and resulted in poor adaptation (Tarriño-Concejero et al., 2022). Several scales, such as the CTS-2 and the CADRI, were validated in the context of an adolescent population (Smith et al., 2015). The aforementioned scales also measure both victimization and perpetration whereas other scales measure only one or the other and may fail to account for the directionality of violence (Smith et al., 2015). Despite capturing instances of psychological, physical, and sexual violence, the way each operationalizes these concepts varies. This results in some of the scales potentially missing more nuanced concepts of violence, which may be more frequently experienced in adolescence, such as unwanted kissing (Smith et al., 2015). Furthermore, many of these scales were developed

during a period when cyber violence was not as pervasive and many of the scales are not validated for use in this metric (Martínez Soto & Ibabe, 2022; Thompson et al., 2006).

Attitudes regarding DV attempt to measure the beliefs of a population surrounding the acceptance of DV (Exner-Cortens, 2018). This measure is often included when evaluating interventions as attitudes surrounding DV have been demonstrated to be predictive of DV behaviours (Bookwala et al., 1992; Exner-Cortens, 2018; Vagi et al., 2013). A review examining the literature on scales employed to measure DV attitudes in adolescents found that the most commonly used scales were Attitudes About Aggression in Dating Situations (AADS) and Justification of Verbal/Coercive Tactics Scale (JVCT) and the Attitudes Towards Dating Violence Scales (ATDVS) (Exner-Cortens et al., 2016). The former scale measures both physical and psychological attitudes while the latter measures all three constructs including sexual violence (Exner-Cortens et al., 2016). Similarly, to the previous outcomes, measures involving cyberaggression have not been validated for these tools and thus would require the incorporation of another tool if measurement of this parameter was desired (Brown & Hegarty, 2018). This review also highlighted how many researchers will truncate scales without conducting any additional validation or reliability testing. Formally testing abbreviated versions of these scales should be done so that authors may deploy them and rely on their results in future studies. Conversely, if this research demonstrates that the instruments cannot be shortened without sacrificing the validity or reliability, then researchers then know to employ the full instrument to ensure that their outcomes are accurately captured. Due to the way the scales were psychometrically tested for DV, there is no agreed-upon gold standard for the measurement of perpetration, victimization or attitudes and thus results in variability across studies (Exner-Cortens et al., 2016).

Future research could benefit from creating and improving on existing scales so that they are both reliable and valid in the current context of DV research. This includes incorporating measures for cyberviolence and creating shorter instruments for researchers. This would encourage future researchers to use the same scales to generate a body of evidence that could be easily compared and compiled to create systematic reviews reflecting the reality of DV prevention programs. This same critique aligns with other reviews that also found that measures had to more synonymous with how they were evaluated to generated a better body of evidence (Fellmeth et al., 2013; Lee & Wong, 2022; Piolanti & Foran, 2022; Reyes et al., 2021). Amalgamation of quantitative data into a forest plot was not feasible in this study due to the number of conflicting measures, hence the decision to utilize a narrative analysis. Other reviews also cited similar issues with their data (Fellmeth et al., 2013; Lee & Wong, 2022; Piolanti & Foran, 2022; Reyes et al., 2021). The review by Piolanti & Foran. (2022) cited that they did not include psychological DV as a measure given that the scales were not validated within the literature. Thus they excluded it from their review, despite citing how it was an important outcome to measure (Piolanti & Foran, 2022). Fellmeth et al. (2013) stated that they had to convert all their data into SMDs, which comes with the assumption that all scales can be standardized and have the same standard deviation. They stated that this affects the applicability of their results as, practically, it is difficult to translate SMD results into clinical significance and determine the effect sizes within a clinical context (Fellmeth et al., 2013). Furthermore, they attempted to collect data on health outcomes including, episodes of physical injury, mental well-being and adverse events, however none of their included studies reported data on these outcomes (Fellmeth et al., 2013). They stated that it was not due to a lack of poor indicators on the reviewers part, rather a significant gap in the literature as it relates to what is measured

between studies to assess DV (Fellmeth et al., 2013). Reyes et at. (2021) also did not conduct a meta-analysis based on the data they collected. They categorized study results based on significance of effects and then pooled based on the directionality of the studies for each of their outcomes of interest (Reyes et al., 2021). In their study limitations they stated that the variance of outcomes and how they are measured precluded them from conducting a meta-analysis which they stated would have led to more meaningful results (Reyes et al., 2021). They cited a need for future studies to identify common means of measuring outcomes as it relates to adolescent DV (Reyes et al., 2021). While this review was able to examine the different aspects of the programs included, and completeness of reporting across the literature, it encountered the same issues as previous reviews. Determining the level of effect that each program characteristic had on DV outcomes cannot be done without a quantitative analysis. Therefore, the recommendation of this review is that before additional studies are conducted to evaluate DV program effectiveness, there should be development and validation of scales to measure common DV outcomes. By having single scales measuring specific outcomes, this will make the results from the body of literature more amenable to consolidation. Having this body of evidence would then support the development best practice guidelines and facilitate better clinical decisions when it comes to implementing a DV prevention program.

Another implication for research that this review underscores is that decisions should be made with the consideration that the quality of evidence is weak. The majority of the studies have inadequate randomization processes, minimal to no procedures for allocation concealment and had no mitigating measures for blinding of outcome assessors. This is relevant as decisions for implementation will have to be based on the needs of the target population balanced with the weaknesses of the studies and their programs. To make more sound decisions regarding DV

prevention for adolescents, further high-quality studies need to be conducted to add to the body of evidence. These studies should include methods of true randomization such as use of a computer based algorithm (Higgins et al., 2022). Furthermore, these studies need to have methods of allocation concealment which cannot be perceived by those implementing the randomization sequence, such as through a third party or computer-generated assignment (Higgins et al., 2022). Since these studies are often cluster RCTs, additional precautions need to be taken so that there is no contamination between trial arms, such as clustering at the level of the institution as opposed to structures within that organization, such as classrooms (Higgins et al., 2022). This minimizes the contact of experimental and control participants and adds to the rigor of the study (Higgins et al., 2022). Given the complexity of these studies and the need for program providers to understand the content being delivered, blinding of participants cannot be achieved. However, the effects of not blinding these groups can be mitigated through blinding those responsible for the data collection and assessment of the outcomes (Higgins et al., 2022). This is a more feasible option given that this group is not required to deliver the intervention.

In addition to including these steps within their study designs, it is important for future authors to thoroughly report on their methods, so that policymakers and other researchers can accurately assess the quality of their study. The CONSORT guidelines are a widely used benchmark for the reporting of cluster RCTs and should be adhered to in future publications (Campbell et al., 2012; Moher et al., 2010). Until these studies are conducted, policymakers will have to consider the weaknesses of the intervention, its feasibility for implementation at the local level and its applicability to their intended population.

Review Strengths and Limitations

One of the strengths of this review is that it is the first to examine the components of these interventions using the TIDieR criteria (Hoffmann et al., 2014). This has allowed for a detailed comparison of the interventions which has not been established in previous reviews (Fellmeth et al., 2013; Lee & Wong, 2022; Piolanti & Foran, 2022; Russell et al., 2021; Whitaker et al., 2006). This is further strengthened by having these TIDieR components interpreted in the context of the trial outcomes wherever possible, allowing for a more comprehensive interpretation of the results. It further allows for the identification of patterns in the effects of different intervention components on the reported outcomes, allowing clinicians to determine if certain traits are more important than others.

Another strength of this review is the interpretation of the results using a feminist lens. Previous reviews have focused on creating summary statistics to contribute to the DV body of literature without the consideration for how this is a feminist issue (Fellmeth et al., 2013; Lee & Wong, 2022; Piolanti & Foran, 2022; Russell et al., 2021; Whitaker et al., 2006). Incorporation of the feminist lens has highlighted that there are additional issues within DV prevention programs that were not highlighted or addressed by other reviews (Fellmeth et al., 2013; Lee & Wong, 2022; Piolanti & Foran, 2022; Russell et al., 2021; Whitaker et al., 2006).

Finally, reviewers adhered to Cochrane standards of systematic reviews whenever possible (Higgins et al., 2022). Title and abstract screening, as well as full-text screening was done independently by two separate reviewers (Higgins et al., 2022). ROB was done independently and then verified by the second reviewer (Higgins et al., 2022). All steps of the review process were documented, in addition to the reasoning behind each decision and then reported according to the PRISMA guidelines (Higgins et al., 2022; Page et al., 2021).

One of the limitations of this review is with regard to the nature of the studies and the content topic. Newer studies had a multifaceted approach, providing education to not only adolescents, but to their families and communities as well (Foshee et al., 1998; Foshee et al., 2000; Miller, Jones, Ripper, et al., 2020; Miller et al., 2012). This education also encompassed multiple topics such as bullying, sexual education and life skills (Degue et al., 2021b; Kilburn et al., 2018; Mathews et al., 2016). Given the criteria set out in this review, these studies were excluded from analysis, however their results could be of interest and could potentially reflect a more modern approach to DV prevention or further research.

Another limitation of this review was that the older version of the Cochrane Risk of Bias tool was used as opposed to the current, recommended version (Eldridge et al., 2021; Higgins, Altman, & Sterne, 2011). Using this older version could potentially alter the ROB analysis given that the guidance is not up to date (Eldridge et al., 2021; Higgins, Altman, & Sterne, 2011). Since the new tool requires each study to be evaluated on each outcome that it examines, it was determined that a study level ROB would be more relevant to this review as opposed to an outcomes level ROB. Furthermore, reviewers required explicit reporting of proper methods to ascertain a low ROB in a study domain. If methods were not reported, inadequately reported, or poorly executed within the study, then studies received either a moderate or high ROB depending on the extent of the methodological fault. Additionally, it is near impossible to blind participants and those delivering the intervention in public health studies such as these. Using the guidance from the Cochrane ROB tool results in a high ROB in the blinding in this domain. The tool does address this fault in the blinding of outcome assessors however, which is possible within the context of these studies. It should be noted, that while caution was taken determining

the ROB, there remains a possibility the results are not as accurate had the newer tool be utilized impacting the appraisal of the quality of the included studies.

Finally, synthesizing the outcomes was narratively challenging given that studies examined different outcomes, often using different instruments, many of which were not psychometrically validated and created by the authors in the context of the study. Even though the results were presented narratively, due to the heterogeneity seen between the studies, the outcomes presented in conjunction with TIDieR criteria were often unclear or conflicting. This is in alignment with the other systematic reviews which reported unclear effects when examining educational programs effectiveness at preventing DV (Fellmeth et al., 2013; Lee & Wong, 2022; Piolanti & Foran, 2022; Russell et al., 2021; Whitaker et al., 2006). However, unlike other reviews, there was a more comprehensive comparison of the characteristics which comprise each program in this review, allowing for clinicians to ascertain which components would potentially be more feasible for them within their clinical contexts.

Conclusion

This systematic review examined the characteristics of primary educational interventions on the prevention of dating violence in adolescents aged 10 to 18. This was the first systematic review to synthesize the results based on the TIDieR criteria in the context of the results obtained (Hoffmann et al., 2014). Of the 11 studies included in the final review, the majority largely resembled each other, all favoring didactic methods of instruction within educational settings and mirroring each other in the content presented to participants. This review demonstrated that a program delivered within a month resulted in a change in DV knowledge, however, this did not necessarily translate into a change in DV behaviours. This aligns with two previous systematic

reviews which had the same conclusions. It was hypothesized that this was due to adolescents not being able to practically employ the knowledge (Fellmeth et al., 2013). This was further supported by the other major finding of this review in that none of the intervention characteristics resulted in a clear change in DV behaviours. This is possibly due to the difficulty in synthesizing the outcomes given that there is no gold standard or instrument for construct measurement. For future reviews to have more impactful results, the DV field needs to create and validate a tool that can be universally utilized to measure and subsequently compare results.

Methodologically, studies needed improvement in adhering to the PRISMA reporting guidelines to ensure that they had low ROB. Overall, it is well known that blinding of personnel and participants in curriculum interventions is near impossible and thus the possible bias arising from this needs to be mitigated through other measures. Unfortunately, many studies either lacked reporting on allocation concealment and blinding of outcome assessors or failed to consider it. This resulted in the possible introduction of bias into many of the studies included within the review.

Overall, this review presented a comprehensive delineation of complex intervention characteristics not previously demonstrated in the literature. However, the results were generally inconclusive. To allow for future reviews to gain a better understanding of the effectiveness of DV prevention programs studies need to first create and then utilize a gold standard tool to measure occurrences of DV. This same recommendation has been discussed in other reviews on this subject and continues to have no clear solution (Fellmeth et al., 2013; Lee & Wong, 2022; Piolanti & Foran, 2022; Russell et al., 2021; Whitaker et al., 2006). Until this is accomplished, reviews will continue to have varying results due to the inability to synthesize outcomes in a meaningful way. This then translates into an inability to generate best practice guidelines and

treatment standards in a clinical context. Once a body of evidence is generated with this data, then a review should be undertaken, however until then any further review will likely have similar results to what is currently presented within the literature.

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Appendices

Appendix A: Tables Comparing Dating Violence Theories

Table A1: Barnum's Criteria for Theory Evaluation

Clarity	• Does the theory clearly state the main concepts? • Is it easily understood?
Consistency	• Does the theory maintain the definitions of the concepts throughout its explanation? • Does it congruently use terms, principles, interpretations and methods?
Adequacy	• How completely does the theory speak to the topics it claims to address? • Are there gaps that need to be filled by other work or does the theory need further refinement? • Does it account for the subject matter under consideration?
Logical Development	• Does the theory follow a line of thought of previous work that has been shown to be true or does it launch into unproven territory? • Do the conclusions proceed in a logical fashion? • Are the arguments well supported?
Level of Theory Development	• Is the theory in the early stages of development or has it been around for a long time? • How often have different researchers conducted independent studies applying the theory to different situations and reported their findings?
Reality Convergence	• How well does the theory build on the premise from which it was derived? • How well does it relate to reality?
Utility	• How useful is the theory to the nursing researcher? • Can the theory be used to generate hypotheses which can be researched by nurses?

Significance	• To what extent does the theory address the phenomena of nursing and lends itself to further research? • Will the results generated from hypotheses related to this theory lead to changes in nursing practice?
Discrimination	• Ability of the theory to differentiate nursing from other health-related fields?
Scope of Theory	• Is the scope of the theory narrow or wide?
Complexity	• How many variables are contained within the theory?

Note. Adapted from Barnum's Criteria for Theory Evaluation (Bredow, 2013)

Table A2: Social Learning Theory Analysis

Clarity	• Main concepts regarding observational learning, external, internal, positive, negative and vicarious reinforcement, identification well described in many sources
	• Children observe those they perceive to be similar to them and are referenced as models within the theory
	• The behaviour of the model is encoded and may be later imitated
	  o This is known as observational learning
	• The behaviour initiated can then be reinforced
	  o External reinforcement is reinforcement external from the person performing the behaviour
	  o Internal reinforcement are the feelings experienced by the individual performing the behaviour
	  o Positive reinforcement is the introduction of a desirable stimulus after a behaviour
	  o Negative reinforcement is the introduction of a non-desirable stimulus after a behaviour
	  o Vicarious reinforcement is the observation of behaviour reinforcement in others and consequently the likelihood of an individual to repeat that behaviour themselves
	• Identification involves adopting a set of behaviours in order to emulate a model
	• Imitation is the copying of a single behaviour
	• Bandura also articulates how a person processes observing a behaviour (stimulus) to imitating it (response) through mediational processes
	• Mediational processes are comprised of attention, retention, reproduction and motivation
	  o Attention: involves the individual paying attention to the behaviour to form a mental representation
	  o Retention: involves the accuracy to which the behaviour is recalled
	  o Reproduction: is the ability to perform/imitate the behaviour
	  o Motivation: involves the will to perform the behaviour. Involves balancing the consequences and rewards of the behaviour.

Consistency	• The definitions, and concepts are maintained throughout the explanation of Bandura's theory and in his subsequent works (Bandura, 1973, 1977; Bandura et al., 1961, 1963) • These definitions are also maintained in the research conducted by others (Anderson & Kras, 2005; Bahn, 2001; Chen et al., 2015; Horsburgh & Ippolito, 2018)

Adequacy	• Able to address how youth may perpetrate violence if they have witnessed forms of violence in childhood (Bandura, 1978) • Addresses how youth perpetrate violence witnessed/influenced by peers • Fails to address how violence is perpetrated by those who do not witness violence/have violent role models (Dutton, 1999) • Fails to address those who do not perpetrate violence after having witnessed violence in their childhood (Dutton, 1999) • Fails to address how youth exhibit violent actions they have never witnessed (EX. DV perpetrator cyber stalks, however, has never witnessed this action) • Fails to account for choosing to exhibit certain behaviours over others (Ex. witnessing both violent and non-violent coping, but exhibiting one behaviour over the other)
Logical Development	• Developed on previously established behavioural and cognitive theories • Conclusions proceed in a logical fashion • Arguments supported by the Bobo Doll Experiment and mirror neurons (Bandura et al., 1961, 1963; Bonini et al., 2022)
Level of Theory Development	• Theory was developed over several years between 1961 through 1977 (Bandura, 1973, 1977, 1978; Bandura et al., 1961, 1963) • Bandura went on to further refine and develop this theory (Bandura, 1986) • This theory is utilized extensively throughout multiple fields of study and within health (Godin et al., 2008; Lin & Chang, 2018; Tougas et al., 2015; Winett et al., 2008) • Further expanded and refined by others (Nicholson & Higgins, 2017)
Reality Convergence	• As previously mentioned, this theory builds well on the tenants from which it was derived • Able to predict behaviours in the literature, converging with reality (Dewar et al., 2013; Hamilton et al., 2016; Sharma et al., 2005) • However, unable to predict others as previously mentioned
Utility	• The theory has been and can be used to generate hypotheses which are researchable (Godin et al., 2008; Lin & Chang, 2018; Tougas et al., 2015; Winett et al., 2008)
Significance	• The literature derived from this theory does influence the ways in which nursing is practiced (Godin et al., 2008; Lin & Chang, 2018; Tougas et al., 2015; Winett et al., 2008)

Discrimination	• This theory is utilized in a variety of fields and is not limited to nursing • Has been studied in medicine, nursing, education, psychology, sociology, criminology to name a few (Bethards, 2014; Chen et al., 2015; Deaton, 2015; Fox, 2017; Su et al., 2010)
Scope of Theory	• Scope of the theory is wide, given that it accounts for learning of all behaviours, not simply those seen in adolescent dating violence
Complexity	• This theory is not overly complex, it contains an appropriate number of variables to explain the concepts and does not have an extensive number of processes involved to explain behaviours

Note. Adapted from Barnum's Criteria for Theory Evaluation (Bredow, 2013)

Table A3: Attachment Theory Analysis

Clarity	• Children need to develop a healthy relationship with a primary caregiver in order to facilitate normal development (Fletcher et al., 2016)
	• Attachment is the bond created between the infant and the primary caregiver
	• Attachment forms primarily between the primary caregiver, in most instances, the mother and the child, however it can be any caregiving figure who provides consistent responsive social interactions
	• As infants begin to age, they begin to form secondary attachments to other figures similar to the primary caregiver, which allows them to explore their surroundings
	• Attachment is initially formed instinctively to promote survival and consists primarily of physical connection between the infant and caregiver
	• Within the theory, alarm occurs when there is perceived fear or danger from the infant/child
	• Anxiety occurs when there is anticipation or fear of becoming separated from the primary caregiver which can result in sadness and anger when the caregiver is unresponsive, unavailable or separated
	• As children age, physical proximity to the caregiver becomes less important and less of a threat to their security
	• Threats to security consist of prolonged absence, communication failures, emotional unavailability and rejection in youth and adults
	• Experiences with caregivers in infancy and childhood develop systems of thought, dubbed "internal working models of social relationships" which become the basis for how someone will interact in relationships later in life
	• There are 4 patterns of attachment articulated within the theory
	• Secure
	  o Occurs when parents are available and meet the needs of a child in an appropriate and attentive manner
	  o Child feels comfortable with the caregiver
	  o Promotes exploring surroundings
	• Avoidant
	  o Child avoids their caregiver
	  o Occurs when children feel they cannot rely on their caregiver in times of distress
	  o Occurs when the caregiver does not respond to the infant
	  o Fosters difficulty with intimacy later in life
	• Ambivalent
	  o Child is very demanding of the caregiver and remains distressed even when consoled by the caregiver

	◦ Occurs when the caregiver responds unpredictably with violence ◦ Leads to clinginess and distrust in relationships in adulthood • Disorganized ◦ Children are fearful of their caregiver ◦ Occurs in abusive homes ◦ Children have no predictable pattern of behaviour in response to their caregiver
Consistency	• The theory maintains its definitions and ideologies throughout its iterations (Fletcher et al., 2016) • There is some inconstancy regarding some terminology, the categories for attachment styles, while the definitions remain consistent are known to go by different titles EX. Dismissive-avoidant, anxious-avoidant vs avoidant
Adequacy	• Hypothesized that anxious attachment styles perpetrate DV in order to get the partner to pay more attention within the relationship (Spencer et al., 2021) • Avoidant attachment styles perpetrate DV to prevent partners from getting too close (Spencer et al., 2021) • Cannot account for DV perpetration in those who had stable caregivers in infancy and the lack thereof in those who had unstable caregivers • Accounts for how childhood abuse leads to greater likelihood of abuse later in life • Cannot account for gender differences in DV perpetration/victimization (Gibby & Whiting, 2023) • Fails to account for other factors influencing DV such as poverty and culture (Gibby & Whiting, 2023) • Does not account for individualistic patterns of thought which contribute to IPV such as the idea of controlling the partner and sense of entitlement within the relationship (Gibby & Whiting, 2023)
Logical Development	• The theory combines a variety of concepts from evolutionary biology, psychology, cognitive sciences and ethology (Fletcher et al., 2016) • Arguments supported by observations of how children react when taken away from their mothers in infancy • Also supported by Ainsworths research regarding observations of Ugandan and American mother-child dyads
Level of Theory Development	• The theory has been around since the 1980s (Bowlby, 1980)

	• Further refined by the original author and another contributor, Mary Ainsworth (Bretherton, 1992) • There have been many studies on attachment theory by many researchers (Gibby & Whiting, 2023; Harlow, 2021; Hayslett-Mccall & Bernard, 2002; Hunter & Maunder, 2001; Khodabakhsh, 2012; Kokkonen et al., 2014; Petersen & Koehler, 2006)
Reality Convergence	• The theory is able to explain a variety of DV behaviours, however like Bandura's theory it does not account for the same circumstances mentioned above
Utility	• The theory has been used to generate nursing research (Hunter & Maunder, 2001; Khodabakhsh, 2012; Kokkonen et al., 2014)
Significance	• Research using this theory has led to practice changes, specifically with regards to a couples approach to therapy (Gibby & Whiting, 2023), however there are significant safety concerns with couples therapy and it is not a recommended approach (VEGA Project, 2016)
Discrimination	• This theory is utilized in a variety of fields and is not limited to nursing (Harlow, 2021; Hayslett-Mccall & Bernard, 2002; Petersen & Koehler, 2006)
Scope of Theory	• Scope of the theory is wide, given that it accounts for learning of all behaviours, not simply those seen in adolescent dating violence
Complexity	• There are no more variables than necessary to explain the theory • Variables are congruent and make sense with each other

Note. Adapted from Barnum's Criteria for Theory Evaluation (Bredow, 2013)

Table A4: Postmodern Feminism Analysis

Clarity	• The theory contains very specific jargon which can make it difficult to understand when initially read (Genz & Brabon, 2017)
	• Rejects the idea of a universal view of what constitutes a woman/feminism
	  o If a universal truth is applicable to all women, it minimizes individual experience
	  o Universal truths stem from patriarchal ideas entrenched within society
	• Embraces individual experiences of women
	  o Accounts for the fact that intersectionality affects each person differently, therefore universal truths cannot be applicable to all women
	• Male bias ingrained within language is inextricably linked to communication, perception and societal structures
	• Gender stereotypes and sex are constructed through language which can be represented differently depending on the society, their constructs and their languages
	• The restrictions that language places on gender/sex restricts the subsequent roles and expectations within patriarchal societies

Consistency	• The theory maintains definitions throughout and the definitions are also maintained within other schools of thought such as philosophy (Genz & Brabon, 2017)
Adequacy	• Able to account for intersectionality seen within DV and that intersecting systems of oppression and control further affect how someone experiences DV • States that DV perpetration/victimization is based on power dynamics o Perpetration of violence is a way to control the partner and exert patriarchal ideologies
Logical Development	• Stems from feminism and postmodernism schools of thought • Rejects tenants from first and second wave feminism to state that the language utilized in society continues to reinforce the patriarchy and embraces individual experiences
Level of Theory Development	• The tenants of feminism have been around for a significant period of time, and postmodern feminism emerged in the 1990s as a branch of third wave feminism (Genz & Brabon, 2017) • Multiple, independent researchers have applied and utilized this theory (Bice et al., 2019; Ironside, 2001; Nosek et al., 2010; Quiros & Berger, 2015; Rogers-Clark, 2002)

Reality Convergence	• Able to explain DV perpetration • Able to account for situations such as those with a history of violence who do not perpetrate violence in adulthood/youth • Accounts for the intersectionality in which DV is perpetrated (Genz & Brabon, 2017)
Utility	• This theory has been used to generate researchable hypotheses by nursing scholars (Aranda, 2006; Glass & Davis, 2004; Ironside, 2001; Rogers-Clark, 2002)
Significance	• There have been numerous studies conducted which inform nursing practices and how nursing care should be altered due to postmodern feminist theory (Bice et al., 2019; Nosek et al., 2010; Quiros & Berger, 2015)
Discrimination	• This theory is utilized in a variety of fields and is not limited to nursing
Scope of Theory	• Scope of the theory is wide, given that it accounts for societal structures, not simply behaviours seen in adolescent dating violence
Complexity	• There are no more variables than necessary to explain the theory • Variables are congruent and make sense with each other

Note. Adapted from Barnum's Criteria for Theory Evaluation (Bredow, 2013)

Appendix B: Search Strategies for the Critique of Existing Systematic Reviews On Dating Violence

B1: OVID: Medline Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) 1946 to February 27th, 2023

1. exp Adolescent/ or exp Child/
2. (adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*).tw.
3. exp Intimate Partner Violence/
4. ((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) adj3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV).tw.
5. Exp Patient Education as Topic/ or exp Education/ or exp Patient Education Handout/ or exp Sex Education/ed
6. Exp education, nonprofessional/ or exp health education/
7. exp spatial learning/ or exp learning/ or exp e-learning/ or exp problem based learning/ or exp associative learning/ or exp reversal learning/ or exp motor learning/ or exp network learning/ or exp distance learning/ or exp latent learning/ or exp verbal learning/ or exp collaborative learning/ or exp learning aid/ or exp virtual learning environment/ or exp mobile learning/ or exp experiential learning/ or exp social learning/ or exp self-directed learning/ or exp game-based learning/ or exp vocal learning/
8. exp communication/ or exp communications media/
9. exp social marketing/ or exp social media/ or exp social network/
10. exp early intervention, educational/ or exp health education/ or exp secondary prevention/
11. ((Bystand* or education or digital or health or prevent*) adj3 (program* or intervention* or evaluat*)).tw.
12. ((social media or gami* or simulat*) adj3 (program* or intervention* or evaluat*)).tw.
13. (system* review) OR (review).tw.
14. or/1-2
15. or/3-4
16. or/5-12
17. 13 and 14 and 15 and 16

B2: Cochrane Systematic Review

1. (adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*).tw.
2. ((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) adj3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV).tw.
3. ((Bystand* or education or digital or health or prevent* or learn* social media or gami* or simulat*) adj3 (program* or intervention* or evaluat*)).tw.
4. (system* review) OR (review).tw.

5. 1 AND 2 AND 3 AND 4

B3: APA PsychInfo 1806 to January Week 4 2023

1. (adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*).tw.
2. exp Intimate Partner Violence/ or exp Dating Violence/
3. ((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) adj3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV).tw.
4. exp Family Life Education/ or exp Nontraditional Education/ or exp Compensatory Education/ or exp Affective Education/ or exp Cooperative Education/ or exp Multicultural Education/ or exp Elementary Education/ or exp Client Education/ or exp High School Education/ or exp Middle School Education/ or exp Distance Education/ or exp Education/ or exp Health Education/ or exp Secondary Education/ or exp Sex Education/
5. Exp teaching methods/
6. exp Electronic Learning/ or exp Intentional Learning/ or exp Social Emotional Learning/ or exp Unsupervised Learning/ or exp Verbal Learning/ or exp Computer Supported Collaborative Learning/ or exp Nonverbal Learning/ or exp Adaptive Learning/ or exp Perceptual Learning/ or exp Asynchronous Learning/ or exp Latent Learning/ or exp Spatial Learning/ or exp Reward Learning/ or exp Social Learning/ or exp Self-Regulated Learning/ or exp Blended Learning/ or exp Service Learning/ or exp Digital Game-Based Learning/ or exp Experiential Learning/ or exp Mobile Learning/ or exp Sequential Learning/ or exp Incidental Learning/ or exp Cooperative Learning/ or exp Collaborative Learning/ or exp School Learning/ or exp Discrimination Learning/ or exp Implicit Learning/ or exp Observational Learning/ or exp Skill Learning/
7. exp Communication/ or exp Social Media/ or exp Advertising/
8. exp Computer Applications/ or exp Digital Technology/
9. exp Group Intervention/ or exp Family Intervention/ or exp School Based Intervention/ or exp Early Intervention/ or exp Violence Prevention/
10. ((Bystand* or education or digital or health or prevent* or learn* social media or gami* or simulat*) adj3 (program* or intervention* or evaluat*)).tw.
11. (system* review) OR (review).tw.
12. or/2-3
13. or/4-10
14. 1 and 12 and 13 and 11

B4: Embase 1974 to February 27th, 2023

1. exp adolescent/ or exp child/

2. (adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*).tw.
3. exp partner violence/ or exp dating violence/
4. ((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) adj3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV).tw.
5. exp health education/ or exp continuing education/ or exp secondary education/ or exp patient education/ or education/ or exp school health education/
6. exp social marketing/ or exp social media/ or exp social network/
7. exp communication technology/ or exp digital technology/ or exp educational technology/
8. exp spatial learning/ or exp learning/ or exp e-learning/ or exp problem based learning/ or exp associative learning/ or exp reversal learning/ or exp motor learning/ or exp network learning/ or exp distance learning/ or exp latent learning/ or exp verbal learning/ or exp collaborative learning/ or exp learning aid/ or exp virtual learning environment/ or exp mobile learning/ or exp experiential learning/ or exp social learning/ or exp self-directed learning/ or exp game-based learning/ or exp vocal learning/
9. exp early intervention/ or exp primary prevention/ or exp prevention/ or exp secondary prevention/ or exp prevention study/
10. ((Bystand* or education or digital or health or prevent* or learn*) adj3 (program* or intervention* or evaluat*)).tw.
11. ((social media or gami* or simulat*) adj3 (program* or intervention* or evaluat*)).tw.
12. (system* review) OR (review).tw.
13. or/1-2
14. or/3-4
15. or/5-11
16. 13 and 14 and 15 and 12

B5: Emcare 1995 to February 27th, 2023

1. exp adolescent/ or exp child/
2. (adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*).tw.
3. exp partner violence/ or exp dating violence/
4. ((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) adj3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV).tw.
5. exp health education/ or exp continuing education/ or exp secondary education/ or exp patient education/ or education/ or exp school health education/
6. exp social marketing/ or exp social media/ or exp social network/
7. exp communication technology/ or exp digital technology/ or exp educational technology/

8. exp spatial learning/ or exp learning/ or exp e-learning/ or exp problem based learning/ or exp associative learning/ or exp reversal learning/ or exp motor learning/ or exp network learning/ or exp distance learning/ or exp latent learning/ or exp verbal learning/ or exp collaborative learning/ or exp learning aid/ or exp virtual learning environment/ or exp mobile learning/ or exp experiential learning/ or exp social learning/ or exp self-directed learning/ or exp game-based learning/ or exp vocal learning/
9. exp early intervention/ or exp primary prevention/ or exp prevention/ or exp secondary prevention/ or exp prevention study/
10. ((Bystand* or education or digital or health or prevent* or learn*) adj3 (program* or intervention* or evaluat*)).tw.
11. ((social media or gami* or simulat*) adj3 (program* or intervention* or evaluat*)).tw.
12. (system* review) OR (review).tw.
13. or/1-2
14. or/3-4
15. or/5-11
16. 13 and 14 and 15 and 12

B6: CINAHL

S1(MH "Adolescence") OR (MH "Child")

S2 TX (adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*)

S3 (MH "Dating Violence") OR (MH "Intimate Partner Violence")

S4 TX ((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) N3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV)

S5 (MH "Education, Non-Traditional+") OR (MH "Educational Technology") OR (MH "Learning Methods+") OR (MH "Teaching+") OR (MH "Curriculum+") OR (MH "Health Education+")

S6 (MH "Social Media+") OR (MH "Communications Media+") OR (MH "Telecommunications+") OR (MH "Internet+") OR (MH "Computer Communication Networks+") OR (MH "World Wide Web+")

S7 (MH "Gamification")

S8 (MH "Computer Simulation+") OR (MH "Simulations+")

S9 TX ((Bystand* or education or digital or health or prevent* or learn* social media or gami* or simulat*) N3 (program* or intervention* or evaluat*))

S10 TX (system* review) OR (review)

S11 S1 OR S2

S12 S3 OR S4

S13 S5 OR S6 OR S7 OR S8 OR S9

S14 S10 AND S11 AND S12 AND S13

B7: ERIC 1966 to February 27th, 2023

(adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*) AND

((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) NEAR/3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV) AND

((Bystand* or education or digital or health or prevent* or learn* or social or media or gami* or simulat*) NEAR/5 (program* or intervention* or evaluat*)) AND

(system* review) OR (review)

B8: Web of Science February 27th, 2023

(adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*) AND

(intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) NEAR/3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV AND

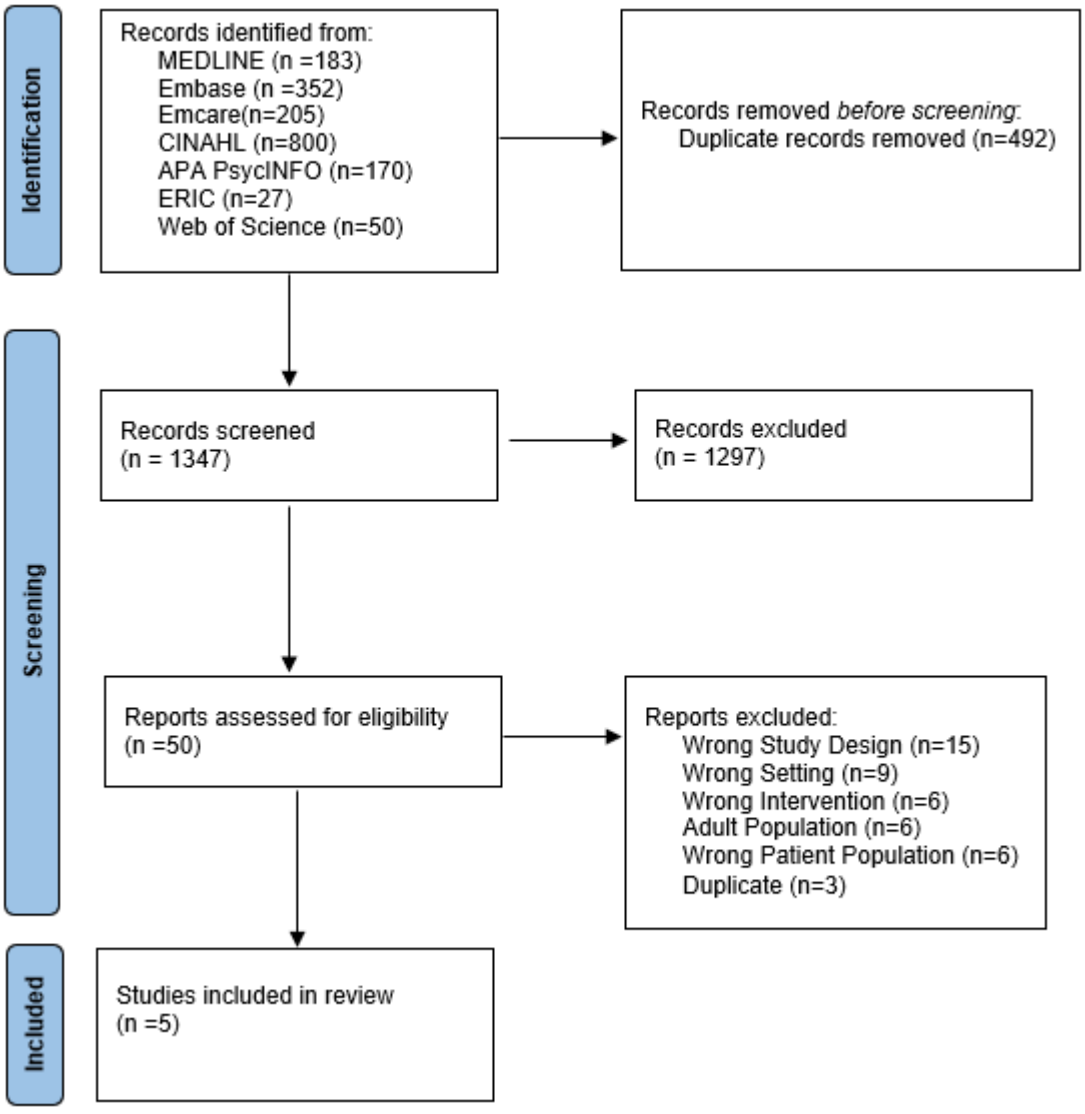
(Bystand* or education or digital or health or prevent* or learn* or social or media or gami* or simulat*) NEAR/5 (program* or intervention* or evaluat*) AND

(system* review) OR (review)

Appendix C: PRISMA Flow Diagram of Systematic Reviews for Critique

Figure 4

PRISMA Flow Diagram of Systematic Reviews



Note. Diagram demonstrates the screening and selection of studies for inclusion in the review from the literature search (Page et al., 2021).

Appendix D: Search Strategies

D1: OVID: Medline Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R) 1946 to March 14th, 2023

1. exp Adolescent/ or exp Child/
2. (adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*).tw.
3. exp Intimate Partner Violence/
4. ((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) adj3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV).tw.
5. Exp Patient Education as Topic/ or exp Education/ or exp Patient Education Handout/ or exp Sex Education/ed
6. Exp education, nonprofessional/ or exp health education/
7. exp spatial learning/ or exp learning/ or exp e-learning/ or exp problem based learning/ or exp associative learning/ or exp reversal learning/ or exp motor learning/ or exp network learning/ or exp distance learning/ or exp latent learning/ or exp verbal learning/ or exp collaborative learning/ or exp learning aid/ or exp virtual learning environment/ or exp mobile learning/ or exp experiential learning/ or exp social learning/ or exp self-directed learning/ or exp game-based learning/ or exp vocal learning/
8. exp communication/ or exp communications media/
9. exp social marketing/ or exp social media/ or exp social network/
10. exp early intervention, educational/ or exp health education/ or exp secondary prevention/
11. ((Bystand* or education or digital or health or prevent*) adj3 (program* or intervention* or evaluat*)).tw.
12. ((social media or gami* or simulat*) adj3 (program* or intervention* or evaluat*)).tw.
13. randomized controlled trial.pt. or randomized.mp. or placebo.mp. (McMaster Health Knowledge Refinery, 2022c)
14. or/1-2
15. or/3-4
16. or/5-12
17. 13 and 14 and 15 and 16

D2: Embase 1974 to March 14th, 2023

1. exp adolescent/ or exp child/
2. (adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*).tw.
3. exp partner violence/ or exp dating violence/
4. ((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) adj3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV).tw.
5. exp health education/ or exp continuing education/ or exp secondary education/ or exp patient education/ or education/ or exp school health education/

6. exp social marketing/ or exp social media/ or exp social network/
7. exp communication technology/ or exp digital technology/ or exp educational technology/
8. exp spatial learning/ or exp learning/ or exp e-learning/ or exp problem based learning/ or exp associative learning/ or exp reversal learning/ or exp motor learning/ or exp network learning/ or exp distance learning/ or exp latent learning/ or exp verbal learning/ or exp collaborative learning/ or exp learning aid/ or exp virtual learning environment/ or exp mobile learning/ or exp experiential learning/ or exp social learning/ or exp self-directed learning/ or exp game-based learning/ or exp vocal learning/
9. exp early intervention/ or exp primary prevention/ or exp prevention/ or exp secondary prevention/ or exp prevention study/
10. ((Bystand* or education or digital or health or prevent* or learn*) adj3 (program* or intervention* or evaluat*)).tw.
11. ((social media or gami* or simulat*) adj3 (program* or intervention* or evaluat*)).tw.
12. Random:.tw.
13. placebo:.mp.
14. double-blind:.tw. (McMaster Health Knowledge Refinery, 2022a)
15. or/1-2
16. or/3-4
17. or/5-11
18. or/12-14
19. 16 and 17 and 18 and 15

D3: Emcare 1995 to March 14th, 2023

1. exp child/ or exp adolescent/
2. (adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*).tw.
3. exp partner violence/ or exp dating violence/
4. ((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) adj3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV).tw.
5. exp school health education/ or exp health education/ or exp secondary education/ or exp education program/ or exp education/ or exp primary education/ or exp sexual education/ or exp patient education/
6. exp social marketing/ or social media/ or exp social network/
7. exp communication technology/ or exp digital technology/ or exp educational technology/
8. exp problem based learning/ or exp game-based learning/ or exp network learning/ or exp vocal learning/ or exp distance learning/ or exp associative learning/ or exp latent learning/ or exp mobile learning/ or exp temporal difference learning/ or exp verbal learning/ or exp self-directed learning/ or exp virtual learning environment/ or exp experiential learning/ or exp learning/ or exp reversal learning/ or exp e-learning/ or exp collaborative learning/ or exp learning aid/
9. exp primary prevention/ or exp prevention/ or exp secondary prevention/ or exp prevention study/or exp early intervention/

10. ((Bystand* or education or digital or health or prevent* or learn* social media or gami* or simulat*) adj3 (program* or intervention* or evaluat*)).tw.
11. Random:.tw.
12. placebo:.mp.
13. double-blind:.tw. (McMaster Health Knowledge Refinery, 2022a)
14. or/1-2
15. or/3-4
16. or/5-10
17. or/11-13
18. 14 and 15 and 16 and 17

D4: APA PsychInfo 1806 to March Week 2 2023

1. (adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*).tw.
2. exp Intimate Partner Violence/ or exp Dating Violence/
3. ((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) adj3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV).tw.
4. exp Family Life Education/ or exp Nontraditional Education/ or exp Compensatory Education/ or exp Affective Education/ or exp Cooperative Education/ or exp Multicultural Education/ or exp Elementary Education/ or exp Client Education/ or exp High School Education/ or exp Middle School Education/ or exp Distance Education/ or exp Education/ or exp Health Education/ or exp Secondary Education/ or exp Sex Education/
5. Exp teaching methods/
6. exp Electronic Learning/ or exp Intentional Learning/ or exp Social Emotional Learning/ or exp Unsupervised Learning/ or exp Verbal Learning/ or exp Computer Supported Collaborative Learning/ or exp Nonverbal Learning/ or exp Adaptive Learning/ or exp Perceptual Learning/ or exp Asynchronous Learning/ or exp Latent Learning/ or exp Spatial Learning/ or exp Reward Learning/ or exp Social Learning/ or exp Self-Regulated Learning/ or exp Blended Learning/ or exp Service Learning/ or exp Digital Game-Based Learning/ or exp Experiential Learning/ or exp Mobile Learning/ or exp Sequential Learning/ or exp Incidental Learning/ or exp Cooperative Learning/ or exp Collaborative Learning/ or exp School Learning/ or exp Discrimination Learning/ or exp Implicit Learning/ or exp Observational Learning/ or exp Skill Learning/
7. exp Communication/ or exp Social Media/ or exp Advertising/
8. exp Computer Applications/ or exp Digital Technology/
9. exp Group Intervention/ or exp Family Intervention/ or exp School Based Intervention/ or exp Early Intervention/ or exp Violence Prevention/
10. ((Bystand* or education or digital or health or prevent* or learn* social media or gami* or simulat*) adj3 (program* or intervention* or evaluat*)).tw.
11. Double-blind.tw.
12. random: asigned.tw.
13. control.tw. (McMaster Health Knowledge Refinery, 2022b)
14. or/2-3
15. or/4-10

16. or/11-13
17. 1 and 14 and 15 and 16

D5: EBM: Cochrane Central Register of Controlled Trials 1991 to February 2023

1. exp adolescent/ or exp child/
2. (adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*).tw.
3. exp Intimate Partner Violence/
4. ((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) adj3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV).tw.
5. exp Health Education/ or exp Competency-Based Education/ or exp Sex Education/ or exp Patient Education as Topic/ or exp Education, Nonprofessional/ or exp Education, Public Health Professional/
6. exp communication/ or exp communications media/
7. exp curriculum/ or exp education, distance/ or exp gamification/ or exp mentoring/ or exp teaching/or exp educational technology/ or exp audiovisual aids/
8. exp Discrimination Learning/ or exp Social Learning/ or exp Reversal Learning/ or exp Self-Directed Learning as Topic/ or exp Verbal Learning/ or exp Avoidance Learning/ or exp Spatial Learning/ or exp Association Learning/ or exp Problem-Based Learning/
9. exp Early Intervention, Educational/ or exp Internet-Based Intervention/ or exp Early Medical Intervention/ or exp Psychosocial Intervention/
10. exp Secondary Prevention/ or exp Primary Prevention/
11. ((Bystand* or education or digital or health or prevent* or learn* social media or gami* or simulat*) adj3 (program* or intervention* or evaluat*)).tw.
12. randomized controlled trial.pt. or randomized.mp. or placebo.mp.
13. or/1-2
14. or/3-4
15. or/5-11
16. 12 and 13 and 14 and 15

D6: CINAHL 1981 to March 14th, 2023

S1(MH "Adolescence") OR (MH "Child")

S2 TX (adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*)

S3 (MH "Dating Violence") OR (MH "Intimate Partner Violence")

S4 TX ((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) N3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV)

S5 (MH "Education, Non-Traditional+") OR (MH "Educational Technology") OR (MH "Learning Methods+") OR (MH "Teaching+") OR (MH "Curriculum+") OR (MH "Health Education+")

S6 (MH "Social Media+") OR (MH "Communications Media+") OR (MH "Telecommunications+") OR (MH "Internet+") OR (MH "Computer Communication Networks+") OR (MH "World Wide Web+")

S7 (MH "Gamification")

S8 (MH "Computer Simulation+") OR (MH "Simulations+")

S9 TX ((Bystand* or education or digital or health or prevent* or learn* social media or gami* or simulat*) N3 (program* or intervention* or evaluat*))

S10 (randomized controlled trials OR MH double-blind studies OR MH single-blind studies OR MH random assignment OR MH pretest-posttest design OR MH cluster sample OR TI (randomised OR randomized) OR AB (random*) OR TI (trial) OR (MH (sample size) AND AB (assigned OR allocated OR control)) OR MH (placebos) OR PT (randomized controlled trial) OR AB (control W5 group) OR MH (crossover design) OR MH (comparative studies) OR AB (cluster W3 RCT)) NOT ((MH animals+ OR MH animal studies OR TI animal model*) NOT MH human) (McGill Library, 2023)

S11 S1 OR S2

S12 S3 OR S4

S13 S5 OR S6 OR S7 OR S8 OR S9

S14 S10 AND S11 AND S12 AND S13

D7: ERIC 1966 – March 14th, 2023

(adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*) AND

((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) NEAR/3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV) AND

((Bystand* or education or digital or health or prevent* or learn* or social or media or gami* or simulat*) NEAR/5 (program* or intervention* or evaluat*)) AND

(randomi?ed control* trial OR control* clinical trial OR random*)

D8: Web of Science March 14th, 2023

(adolescen* or teen* or preteen* or pre-teen* or young people or young person* or youth* or juvenile*) AND

((intimate or date or dating or relationship* or partner* or nonstranger* or non-stranger*) NEAR/3 (violen* or abuse* or aggress* or assault* or coerc* or manipulat* or injur*) or ADV or TDV or IPV or DV) AND

((Bystand* or education or digital or health or prevent* or learn* or social or media or gami* or simulat*) NEAR/5 (program* or intervention* or evaluat*)) AND

(randomi?ed control* trial OR control* clinical trial OR random*)

Appendix E: Title & Abstract Screening Form

Inclusion Criteria	
	Ages 10-18
	RCT, Quasi-RCT
	Intervention targets dating violence
Exclusion Criteria	Aged 19 + or under age 10
	Intervention targets other forms of violence (e.g., domestic violence)

Appendix F: Full-text Review Screening Form

Inclusion Criteria	
	Ages 10-18
	Provided education for DV
	RCT, Quasi-RCT
	Violence perpetrated by a former, current, or future romantic partner
Exclusion Criteria	
	Non-Randomised Trial
	Age 19+ or under age 10
	Study duplication
	Full-text unavailable
	No standard care comparator
	Not Dating Violence and/or multiple types of violence
	Secondary Study
	Education Provided Does Not Address DV
	Includes secondary/tertiary approaches

Appendix G: Cochrane Characteristics of Included Studies Data Extraction Form

Study Information		
	Title	
	Author(s)	
	Year of Publication	
	Study Dates	
	Study Design	
	Location of Study	
	Source of Funding	
	Responsible party for participant enrolment	
	Unit of Randomization	
	Method of Randomization	
	Responsible party for randomization	
	Method of Allocation Concealment	
	Responsible party for intervention assignment	
Participants		
	Population Traits	
	Study Setting	
	Sample Size	
	Method of calculating sample size	
	Inclusion Criteria	
	Exclusion Criteria	

	Number of Withdrawals/Dropouts after randomization (with reasons)	
Statistical Analysis	Methods used for primary outcome analysis	
	Methods used for secondary outcome analysis	
	Methods used for any subgroup analysis	
Outcome(s)		
	Reported Results	
	How & When outcomes were measured?	
	Measurement Scale (if applicable)	
	Any changes to trial outcomes after the study commenced?	
Follow Up Length		
Trial Limitations		
Trial Registration Number		
Notes		

Note: This data extraction tool is based on the Cochrane Characteristics of included studies (Higgins et al., 2022).

Appendix H: Template for Intervention Description and Replication Data Extraction Form

Intervention		
	Name of the Intervention	
	Number of Participants	
	Rationale Behind the Intervention	
	Providers (Who? Level of Expertise? Training provided?)	
	Mode of Delivery (Ex. In Person, Telephone, Internet etc)	
	Group or Individual	
	Location of Intervention (Ex. School, Doctors Office, ED etc) & any relevant features of the location	
	Frequency of Intervention	
	Schedule of Intervention Delivery	
	Duration of Intervention (Each session and overall)	
	Intensity/Dose of Intervention	
	Any personalization to the intervention?	
	Any modifications over the course of the study? (Describe the changes)	
Control		
	Name of the Comparator	
	Number of Participants	

	Rationale Behind the comparator	
	Providers (Who? Level of Expertise? Training provided?)	
	Mode of Delivery (Ex. In Person, Telephone, Internet etc)	
	Group or Individual	
	Location of comparator (Ex. School, Doctors Office, ED etc) & any relevant features of the location	
	Frequency of comparator	
	Schedule of comparator Delivery	
	Duration of comparator (Each session and overall)	
	Intensity/Dose of comparator	
	Any personalization to the comparator?	
	Any modifications over the course of the study? (Describe the changes)	

Note: This data extraction tool is based on the Template for Intervention Description and Replication Checklist (Hoffmann et al., 2014).

Appendix I: Table of Excluded Studies

Table I: Excluded Studies

Study	Reason for Exclusion
(Aarø et al., 2014)	Education Provided Does Not Address DV
(Abebe et al., 2017)	Non-Randomized Trial
(Abebe et al., 2018)	Not Dating Violence and/or multiple types of violence
(Abebe et al., 2018)	Study Duplication
(Alexander et al., 2014)	Non-Randomized Trial
(Ball et al., 2012)	Non-Randomized Trial
(Banyard et al., 2019)	Non-Randomized Trial
(Baumann, 2006)	Full-text Not Available
(Black et al., 2012)	Non-Randomized Trial
(Boduszek et al., 2019)	Education Provided Does Not Address DV
(Boyce et al., 2023)	Education Provided Does Not Address DV
(Bush et al., 2021)	Secondary Study
(Carrascosa et al., 2019)	Non-Randomized Trial
(Coker, Banyard, et al., 2017)	Non-Randomized Trial
(Coker et al., 2020)	Secondary Study
(Coker et al., 2022)	Non-Randomized Trial
(Collibee et al., 2021)	Includes Secondary/Tertiary approaches
(Connolly et al., 2015)	Not Dating Violence and/or multiple types of violence
(Cook-Craig et al., 2014)	Non-Randomized Trial
(Daigneault et al., 2015)	Not Dating Violence and/or multiple types of violence
(DeGannes, 2009)	Wrong Age Group
(DeGue et al., 2021a)	Wrong Age Group
(DeGue et al., 2021a)	Study Duplication
(K. M. Edwards et al., 2019)	Not Dating Violence and/or multiple types of violence
(Katie M. Edwards et al., 2019)	Not Dating Violence and/or multiple types of violence
(Katie M. Edwards et al., 2019)	Study Duplication
(Elias-Lambert et al., 2010)	Non-Randomized Trial
(Estefan et al., 2021a)	Not Dating Violence and/or multiple types of violence
(Estefan et al., 2021b)	Study Duplication
(Fawson, 2013)	Non-Randomized Trial
(Feder et al., 2018)	Wrong Age Group
(Fernández-González, Calvete, & Sánchez-Álvarez, 2020)	Non-Randomized Trial
(Florsheim et al., 2011)	Wrong Age Group
(Foshee et al., 1996)	No Standard Care Comparator
(Foshee, 1998)	Includes Secondary/Tertiary approaches
(Foshee et al., 1998)	Includes Secondary/Tertiary approaches
(Foshee et al., 2000)	Includes Secondary/Tertiary approaches
(Vangie A. Foshee et al., 2004)	Includes Secondary/Tertiary approaches
(Foshee et al., 2005)	Includes Secondary/Tertiary approaches
(Foshee et al., 2012)	Includes Secondary/Tertiary approaches

(Foshee et al., 2014)	Includes Secondary/Tertiary approaches
(Foster, 2022)	Non-Randomized Trial
(Gibbs et al., 2018)	Wrong Age Group
(Gibbs et al., 2018)	Study Duplication
(Goesling & Alamillo, 2023)	Education Provided Does Not Address DV
(Gonzalez-Guarda et al., 2015)	Wrong Age Group
(Heyman et al., 2019)	Wrong Age Group
(Hill et al., 2022)	Non-Randomized Trial
(Huntington et al., 2022)	Education Provided Does Not Address DV
(Jaffe et al., 1992)	Non-Randomized Trial
(Jaime et al., 2016)	No Standard Care Comparator
(Jaycox et al., 2007)	Study Duplication
(Jaycox, McCaffrey, Weidmer Ocampo, et al., 2006)	Non-Randomized Trial
(Jewkes et al., 2019)	Not Dating Violence and/or multiple types of violence
(Jouriles et al., 2019)	No Standard Care Comparator
(Jouriles et al., 2009)	Non-Randomized Trial
(Kalokhe et al., 2021)	Wrong Age Group
(Kan et al., 2021)	No Standard Care Comparator
(Kervin & Obinna, 2010)	Non-Randomized Trial
(Kilburn et al., 2018)	Not Dating Violence and/or multiple types of violence
(Langhinrichsen-Rohling & Turner, 2012)	Includes Secondary/Tertiary approaches
(Lavoie et al., 1995)	No Standard Care Comparator
(Levesque et al., 2016)	No Standard Care Comparator
(Levesque et al., 2017)	Non-Randomized Trial
(Levesque et al., 2017)	Study Duplication
(Markham et al., 2017)	Non-Randomized Trial
(Mathews et al., 2016)	Not Dating Violence and/or multiple types of violence
(McCauley et al., 2014)	Non-Randomized Trial
(McLeod et al., 2015)	Non-Randomized Trial
(Meiksin et al., 2019)	Non-Randomized Trial
(Meiksin et al., 2020)	Non-Randomized Trial
(Mennicke et al., 2021)	Secondary Study
(Mennicke et al., 2021)	Study Duplication
(Mennicke et al., 2022)	Not Dating Violence and/or multiple types of violence
(Miller et al., 2011)	Non-Randomized Trial
(Miller et al., 2012)	Wrong Age Group
(Miller et al., 2012)	Study Duplication
(Miller et al., 2013)	Wrong Age Group
(E. Miller et al., 2015)	Includes Secondary/Tertiary approaches
(S. Miller et al., 2015)	Non-Randomized Trial
(S. Miller et al., 2015)	Study Duplication
(Miller, Jones, Culyba, et al., 2020)	Not Dating Violence and/or multiple types of violence
(Miller, Jones, Ripper, et al., 2020)	Wrong Age Group

(Munoz Maya et al., 2013)	Full-text Unavailable
(Munoz-Rivas et al., 2019)	Full-text Unavailable
(Murta et al., 2020)	Wrong Age Group
(Niolon et al., 2016)	Non-Randomized Trial
(Niolon et al., 2019)	Wrong Age Group
(Niolon, 2021)	Non-Randomized Trial
(Odgers & Russell, 2009)	Non-Randomized Trial
(Oscos-Sanchez et al., 2013)	Education Provided Does Not Address DV
(Parlak & Canel, 2021)	Non-Randomized Trial
(Peskin et al., 2014)	Wrong Age Group
(Peskin et al., 2019)	Wrong Age Group
(Ranney et al., 2019)	Not Dating Violence and/or multiple types of violence
(Ravi et al., 2019)	Non-Randomized Trial
(Reidy et al., 2017)	Non-Randomized Trial
(Rizzo et al., 2018)	No Standard Care Comparator
(Rizzo et al., 2018)	Study Duplication
(Rizzo et al., 2018)	Study Duplication
(Rosenman et al., 2020)	Not Dating Violence and/or multiple types of violence
(Rothman et al., 2006)	Non-Randomized Trial
(Rothman et al., 2020)	Does not provide DV education
(Salazar & Cook, 2006)	Not Dating Violence and/or multiple types of violence
(Sanchez-Cesareo, 2003)	Non-Randomized Trial
(Sánchez-Jiménez et al., 2018)	Non-Randomized Trial
(Sargent et al., 2017)	No Standard Care Comparator
(Scull et al., 2020)	Education Provided Does Not Address DV
(Segura et al., 2023)	Non-Randomized Trial
(Stark et al., 2018)	Not Dating Violence and/or multiple types of violence
(Tang et al., 2022)	Non-Randomized Trial
(Taylor et al., 2017)	No Standard Care Comparator
(Taylor et al., 2015)	Secondary Study
(Taylor et al., 2010b)	Not Dating Violence and/or multiple types of violence
(Vives-Cases et al., 2019)	Non-Randomized Trial
(Vivolo-Kantor et al., 2019)	Wrong Age Group
(Vivolo-Kantor et al., 2021)	Wrong Age Group
(Vivolo-Kantor et al., 2021)	Study Duplication
(Vivolo-Kantor et al., 2021)	Study Duplication
(Wan & Bateman, 2007)	Non-Randomized Trial
(Waterman et al., 2021)	Not Dating Violence and/or multiple types of violence
(Waterman et al., 2021)	Study Duplication
(Weber et al., 2023)	Non-Randomized Trial
(Weisz & Black, 2001)	Non-Randomized Trial
(Wolfe et al., 2003)	Not Dating Violence and/or multiple types of violence
(Wolfe et al., 2003)	Study Duplication
(Zhang, 2022)	Non-Randomized Trial

Appendix J: TIDieR Summary Tables of Included Studies

Table J1: Avery-Leaf et al., 1997 TIDieR Summary

Name of the Intervention	None mentioned, simply referred to as 5 session curriculum
Number of Participants	102
Rationale Behind the Intervention	• Attitudes towards violence influence use of violence in intimate relationships • Negative communication behaviours such as blaming, limited social supports, coercive negotiation and negative affect all contribute to violence in dating relationships • Violence prevention should address communication skills and attitudes towards violence in order to effect violence prevention • There is also social context to consider given the level of male to female perpetrated violence o Female to male perpetrated violence also needs to be accounted for and cannot be given traditional feminist perspectives • Intervention treats aggression as a multi-determined phenomena (social and psychological) • Recognizes that both females and males can perpetrate and be victims of violence
Materials Provided? Describe materials provided to participants, needed for intervention delivery or needed to train facilitators	Not reported
Procedure? Describe each of the procedures, activities or processes used in the intervention	Goals of the curriculum • Show how gender inequality may foster violence and promote equity in dating relationships • Challenge attitudes towards violence as a way to resolve conflicts • Identify positive communication skills (negotiation and conflict resolution) • Provide support resources for victims of aggression

	• Provided information on alternatives to violent dating relationships
Providers (Who? Level of Expertise? Training provided?)	Health teachers 8 hr training conducted by the first two authors 1 week prior to the curriculum implementation Session consisted of information about dating violence and how to implement the curriculum
Mode of Delivery (Ex. In Person, Telephone, Internet etc)	In person
Group or Individual	Group
Location of Intervention (Ex. School, Doctors Office, ED etc) & any relevant features of the location	School health class
Frequency of Intervention	Once a day
Schedule of Intervention Delivery	5 days
Duration of Intervention (Each session and overall)	Not reported
Intensity/Dose of Intervention	Not reported

Any personalization to the intervention?	Not reported
Any modifications over the course of the study? (Describe the changes)	Not reported
Planned Fidelity How is intervention adherence assessed and by whom? Strategies to improve fidelity	Not reported
Actual Fidelity (if assessed) Describe the extent to which the intervention was delivered as planned	Not reported

Table J2: Coker, Bush, et al., 2017 TIDieR Summary

Name of the Intervention	Green Dot
Number of Participants	39,081 total Intensive Bystander Training Y1: 8.3% Y2: 11.1% Y3: 12.6% Y4: 13.2%
Rationale Behind the Intervention	Theory driven, based on bystander psychology, diffusion of innovation theory and sexual violence perpetrator traits Green Dots: bystanders are trained to recognize violent behaviours and situations and how to intervene Red Dots: Possible behaviours and social norms which may lead to violence
Materials Provided? Describe materials provided to participants, needed for intervention delivery or needed to train facilitators	Reported that there were Green Dot workbooks for students, but did not detail their contents
Procedure? Describe each of the procedures, activities or processes used in the intervention	50 minute school wide presentation delivered by educators every year Y2 onwards used the "popular opinion leaders" strategy 12-15% of the student body maximizes diffusion of an intervention Leadership qualities identified by school staff in conjunction with educators • Students who were respected, followed and emulated • These students invited to participate in a 5 hr intensive training • Other students allowed, space permitting

	• Training consisted of building skills to prevent aggression, addressing barrier to intervening on DV, patterns of perpetration which can inform bystander responses, ideas for how to diffuse the messages to their peers • Training also consisted of intervening in behaviours and confronting social norms which predispose violence, such as alcohol and drug use, sexual coercion, harassment and joking about violence
Providers (Who? Level of Expertise? Training provided?)	Rape Crisis Educators All female Received 4 days of training by the Green Dot developers on program implementation
Mode of Delivery (Ex. In Person, Telephone, Internet etc)	In person
Group or Individual	Group
Location of Intervention (Ex. School, Doctors Office, ED etc) & any relevant features of the location	School
Frequency of Intervention	Yearly speeches "at least" 2 sessions of training in Y2 onwards reported
Schedule of Intervention Delivery	Y1: 1 schoolwide introductory speech Y2: 1 bystander training session
Duration of Intervention (Each session and overall)	Speech was 50 minutes long Bystander training was 5 hours long
Intensity/Dose of Intervention	Not reported

Any personalization to the intervention?	None reported
Any modifications over the course of the study? (Describe the changes)	None reported
Planned Fidelity How is intervention adherence assessed and by whom? Strategies to improve fidelity	Research staff and developer reviewed audio recordings of the educators training and provided ongoing, individual feedback to the educators throughout the trial based on continued recordings of the training sessions
Actual Fidelity (if assessed) Describe the extent to which the intervention was delivered as planned	Audio recordings of the training sessions were reviewed by the developer and researchers • Marked how well they adhered to the curriculum and connected with their audience

Table J3: Dos Santos et al., 2019 TIDieR Summary

Name of the Intervention	Not Reported
Number of Participants	47
Rationale Behind the Intervention	• Biological Model • Cognitive Social Theory • Social Network Theory • Bystander Intervention Model
Materials Provided? Describe materials provided to participants, needed for intervention delivery or needed to train facilitators	Intervention support guide • Contents detail DV and skills to manage • Does not detail other content information
Procedure? Describe each of the procedures, activities or processes used in the intervention	Session 1 o Differentiate between healthy and unhealthy relationships and discuss their traits o Discuss DV nature, prevalence, causes, consequences and dynamics in relation to health o Activities include dynamic reading of a comic book story and evaluation of the relationship's quality o Content includes ▪ Types of relationships: long term, short term and one night ▪ TRaits of relationships: rewards from relationships, time spent with partner, intimacy, conceptions of power and boundaries, problematic behaviours (jealousy, betrayal, lack of support, conflicts) o DV warning signs Session 2 o Map social network to aid with identifying a network of help o Identify positive and negative influences within friend network o Foster emotional support, guidance and counseling in the identified network o Activity: construction of the social network map o Content Includes

	▪ Role of friends in the development and maintenance of dating relationships and how they can protect against violence ▪ How peer network changes and the relationship to friends changes as relationships emerge ▪ Traits of a friend network: size, density, dispersion, composition and heterogeneity ▪ Traits of the relationships: function, reciprocity, commitment, level of contact, history and versatility ▪ Functions of friendships: help, validation. Companionship, security ▪ Functions of peer who intervene in DV and who oppose gender roles Session 3 o Undermine romantic myths and develop attitudes which promote bystanders to intervene o Encourage behaviour modeling and mobilize helping behaviours o Teach empathy and incentivize empathetic communication in response to DV o Activity: Video debate about the bystander approach in DV and exercising empathy o Content Includes: ▪ Friends as potential bystanders and preferred sources of help in relationships ▪ DV Roles (victim, aggressor, bystander) ▪ Stages of Bystander Intervention ▪ Awareness ▪ Definition ▪ Responsibility ▪ Plan ▪ Action ▪ Barriers to intervening How to start being an active rather than passive bystander
Providers (Who? Level of Expertise? Training provided?)	Clinical psychology doctorate student • Training on delivering group interventions, DV, peer intervention and spectator approach ▪ No additional training provided
Mode of Delivery (Ex. In Person, Telephone, Internet etc)	In person
Group or Individual	Group

Location of Intervention (Ex. School, Doctors Office, ED etc) & any relevant features of the location	Classroom
Frequency of Intervention	Once per week
Schedule of Intervention Delivery	Over 3 weeks
Duration of Intervention (Each session and overall)	90 minutes
Intensity/Dose of Intervention	Not reported
Any personalization to the intervention?	Not reported
Any modifications over the course of the study? (Describe the changes)	Not reported
Planned Fidelity How is intervention adherence assessed and by whom? Strategies to improve fidelity	Not reported
Actual Fidelity (if assessed) Describe the extent to which the intervention was delivered as planned	Not reported

Table J4: Jaycox, McCaffrey, Eiseman, et al., 2006 TIDieR Summary

Name of the Intervention	Ending Violence
Number of Participants	1428 (1384 included in analysis), from 10 high schools
Rationale Behind the Intervention	Based on social learning theory Reverses acceptance of violence through providing education on the legality of DV and increasing help seeking through providing education on information and resources
Materials Provided? Describe materials provided to participants, needed for intervention delivery or needed to train facilitators	Not reported
Procedure? Describe each of the procedures, activities or processes used in the intervention	Session 1: Domestic Violence Basics • Prevalence and consequences of DV • Attorney client confidentiality • Video: Introduction to Break the Cycle and overview of DV • Forced Choice questions: Knowledge and myths related to DV • Abuse Discussion: physical, sexual and emotional • Cycle of Violence Discussion: Three stages to abuse often observed in potentially abusive relationships • Exercise related to barriers in getting help: reasons why victims of abuse have difficulty leaving relationship Session 2: Domestic Violence Law • Discussion of legal options: Two legal systems to protect victims of DV, criminal and civil justice • Crime & restraining order game: rights and responsibilities under domestic violence civil and criminal law Session 3: Legal Process, Safety Planning and Healthy Relationships • Explanation of Restraining Orders: How to use civil law to obtain a restraining order

	• Role Play: Mock hearing for restraining order, how the court process works • Safety Planning Exercise: Ways victims can increase their safety
Providers (Who? Level of Expertise? Training provided?)	Bilingual, bicultural attorneys working with Break the Cycle
Mode of Delivery (Ex. In Person, Telephone, Internet etc)	In person
Group or Individual	Group
Location of Intervention (Ex. School, Doctors Office, ED etc) & any relevant features of the location	Health classes
Frequency of Intervention	3 consecutive days
Schedule of Intervention Delivery	Over 1 week
Duration of Intervention (Each session and overall)	Not reported
Intensity/Dose of Intervention	Not reported
Any personalization to the intervention?	Not reported
Any modifications over the course of the study? (Describe the changes)	Not reported

Planned Fidelity How is intervention adherence assessed and by whom? Strategies to improve fidelity	Assessed by an expert through classroom observation (10%) Self reported assessments of fidelity by implementers
Actual Fidelity (if assessed) Describe the extent to which the intervention was delivered as planned	Experts observed 10% of classrooms and rated the content coverage, and quality of presentations delivered 69% of the curriculum was coverage completely, 26% was partially covered and 5% was not covered Only six sessions were rated as a little engaged, all other were rated as moderately to extremely engaging Only 11 sessions were rated as a little cooperative or compliant, all others were rare

Table J5: Joppa et al., 2016 TIDieR Summary

Name of the Intervention	Katie Brown Educational Program (KBEP)
Number of Participants	172
Rationale Behind the Intervention	Based on Social Learning Theory • Modifying cognitions and behaviours will help students develop healthy relationships • Staff model communication skills in session 4 to better adhere to SLT
Materials Provided? Describe materials provided to participants, needed for intervention delivery or needed to train facilitators	Worksheets, handouts Manual provided to instructors
Procedure? Describe each of the procedures, activities or processes used in the intervention	Session 1 • Understanding Violence • Presentation on the 5 types of violence • Targets knowledge Session 2 • Relationship wants and needs • Agree/disagree dating game • Targets attitudes of self-efficacy Session 3 • Expectations in Dating relationships • Discussion about fair and unfair dating expectations • Knowledge of self-efficacy attitudes

	Session 4 • Communication skills • Role play aggressive, passive and assertive communication • Targets knowledge on communication skills Session 5 • Cycles of violence and their warning signs • Discussion of warning signs of abuse in a dating relationship • Targets knowledge attitudes Uses modeling, observational learning, discussions, role play Each session includes a lecture, discussion, group and individual work, handouts and worksheets Topics addressed include; types of violence, rights in relationships, personal power and self-esteem, responsibility for actions, communication skills, aspects of healthy relationships, dating relationship expectations, media stereotypes of gender roles, conflict resolution, cycles of violence and DV warning signs
Providers (Who? Level of Expertise? Training provided?)	Delivered by a bachelor level paraprofessional employed by KBEP
Mode of Delivery (Ex. In Person, Telephone, Internet etc)	In person
Group or Individual	Group
Location of Intervention (Ex. School, Doctors Office, ED etc) & any relevant features of the location	Highschool health classes
Frequency of Intervention	Once a day

Schedule of Intervention Delivery	Once a day for 5 days in 1 week
Duration of Intervention (Each session and overall)	50-60 minutes
Intensity/Dose of Intervention	Not reported
Any personalization to the intervention?	Not reported
Any modifications over the course of the study? (Describe the changes)	Not reported
Planned Fidelity How is intervention adherence assessed and by whom? Strategies to improve fidelity	Member of the research team completing a checklist of curriculum components during in class observations
Actual Fidelity (if assessed) Describe the extent to which the intervention was delivered as planned	97% adherence to the sessions as per the evaluations

Table J6: Muñoz-Fernández et al., 2019 TIDieR Summary

Name of the Intervention	Dat-e Adolescence Program
Number of Participants	557
Rationale Behind the Intervention	Based on the Dynamic Developmental Systems Model • Abusive behaviours are a result of genetics, individual factors such as behaviours, contextual factors, and beliefs and behaviours acquired from social situations • Also address the relationship interactions and traits between couples in addition to their own factors which may/may not predispose them to violence • Violence is believed to be a consequence of gender norms and attitudes, jealousy, insecure/avoidant attachment styles, poor support and intimacy in relationships and poor coping skills for managing conflict within relationships Dat-e Adolescence is based on the idea that if adolescents can reflect on violence, gender norms, peer influences it will contribute to the development of skills which will facilitate healthy relationships
Materials Provided? Describe materials provided to participants, needed for intervention delivery or needed to train facilitators	Not reported, supposedly comes with detailed manual, describing session aims, standardized instructions and materials for each one according to the authors
Procedure? Describe each of the procedures, activities or processes used in the intervention	First five sessions are led by researchers during school hours Aims of the lessons • Develop knowledge related to love, romantic myths and healthy relationship behaviour • Encourage better emotional regulation, expression and recognition • Promote self- esteem • Improve communication skills • Raise awareness regarding both traditional and cyber forms of violence

	These first 5 lessons include discussion, role-playing, debates and videos. Also includes web-based activities. No further details provided
	
	Last 2 sessions are delivered by one female and one male student
	• Present a conflict or abusive situation
	• Aim of these sessions
	  ○ Raise awareness regarding bystander influences on DV
	  ○ Promote coping strategies in the presence of aggression and conflict resolution skills
	• Activities include group exercises and decision-making games
	Final activity is organized by the schools to cover the key lessons from the intervention
	• Does not specify how, when, by whom or to whom this is delivered

Providers (Who? Level of Expertise? Training provided?)	Researchers- no further details Student Assistants (last 2 sessions) • 2 hours of training per session delivered by the researchers
Mode of Delivery (Ex. In Person, Telephone, Internet etc)	In person & Internet • Reports a web-based platform to complete activities, but no further details
Group or Individual	Group
Location of Intervention (Ex. School, Doctors Office, ED etc) & any relevant features of the location	School
Frequency of Intervention	Not reported
Schedule of Intervention Delivery	Not reported

Duration of Intervention (Each session and overall)	1 hour
Intensity/Dose of Intervention	7 sessions
Any personalization to the intervention?	Not reported
Any modifications over the course of the study? (Describe the changes)	Not reported
Planned Fidelity How is intervention adherence assessed and by whom? Strategies to improve fidelity	Not reported
Actual Fidelity (if assessed) Describe the extent to which the intervention was delivered as planned	Not reported

J7: Navarro-Perrez et al., 2020 TIDieR Summary

Name of the Intervention	The Liad@s app
Number of Participants	35
Rationale Behind the Intervention	-DV is associated with minor institutionalization and research demonstrates that those in RCC are more likely to exhibit violent behaviours in relationships - Intervention addressing romantic myths (which increase the incidence of DV), should reduce the incidence of DV within this population -Aims to reduce sexist ideologies and increase DV awareness through interactive format - Contains activities which promote prosocial behaviours and skills and foster critical and reflective thinking regarding cultural gender norms -This app has previous research which demonstrated a reduction in sexist attitudes in secondary school students
Materials Provided? Describe materials provided to participants, needed for intervention delivery or needed to train facilitators	Introductory presentation done with the same powerpoint and protocol App is available on IOS and Android
Procedure? Describe each of the procedures, activities or processes used in the intervention	Powerpoint presentation was done by the researchers to introduce and explain the intervention within the intervention groups only Researchers then allowed for some time post presentation for individual practice in the app Afterwards the participants in the intervention group played on the app on their own for two weeks • No details on the contents or activities within the app within this report
Providers (Who? Level of Expertise? Training provided?)	Introductory presentation done by the same researcher
Mode of Delivery (Ex. In Person, Telephone, Internet etc)	Online for the use of the app In person presentation introducing the app
Group or Individual	Group presentation and then individual app usage

Location of Intervention (Ex. School, Doctors Office, ED etc) & any relevant features of the location	Residential Care Center for adolescents for the presentation App usage could be anywhere
Frequency of Intervention	Individualized
Schedule of Intervention Delivery	Individualized
Duration of Intervention (Each session and overall)	Individualized
Intensity/Dose of Intervention	Individualized
Any personalization to the intervention?	Participants can interact with the app however they wish as long as they adhere to the participation requirements
Any modifications over the course of the study? (Describe the changes)	None reported
Planned Fidelity How is intervention adherence assessed and by whom? Strategies to improve fidelity	Participants needed to collect a minimum of 2500 points in the game as proof of commitment • Approx. 2hr per week of game play • No details on how this number was chosen
Actual Fidelity (if assessed) Describe the extent to which the intervention was delivered as planned	Did not detail the hours averaged by the intervention participants, or how they confirmed the achievement of the minimum score requirement

Table J8: Taylor et al., 2010a TIDieR Summary

Name of the Intervention	Shifting Boundaries
Number of Participants	29 classrooms in the interaction curriculum 29 classrooms in the law & justice curriculum
Rationale Behind the Intervention	Based on the theory of reasoned action Attitudes and norms towards a behaviour facilitate the change, modification or adaptation of the desired behavior Attitudes towards a behaviour compromise of a belief that a behaviour will lead to a certain outcome, if someone assesses that outcome as good then they will intend or actually carry out the behaviour Attitudes towards behaviour are also compromised of the perceptions of what others around someone believe they should act TRA is based on the concept that intentions to behave are immediate predictors of behaviour and that intent to act will change the likelihood of enacting a particular behaviour Interventions were designed to address TRA components—increased knowledge leads to changes in attitudes which affects behavioural intentions leading to changes in behaviour

Materials Provided? Describe materials provided to participants, needed for intervention delivery or needed to train facilitators	• Detailed lessons plans available to all the instructors will all the handouts required for all the lessons
	  ○ Discussion questions for the class
	  ○ Paper worksheets which can be done individually, in pairs or as a group depending on the assignment
	  ○ Details about timing for all the activities
	  ○ Teacher guides for discussion questions for the class
	• Examples of how to complete certain exercises

Procedure? Describe each of the procedures, activities or processes used in the intervention	Curriculums were delivered once a week in class

Providers (Who? Level of Expertise? Training provided?)	In 2/3 districts the intervention was implemented by the lead educator from the Cleveland Rape Crisis Center (CRCC) and in one of them it was implemented by the lead educator and regular teachers Orientation session and training by the same researcher on the curriculum
Mode of Delivery (Ex. In Person, Telephone, Internet etc)	In person
Group or Individual	Group
Location of Intervention (Ex. School, Doctors Office, ED etc) & any relevant features of the location	School, in class
Frequency of Intervention	Once a week
Schedule of Intervention Delivery	Not reported
Duration of Intervention (Each session and overall)	40 minutes, 5-7 weeks overall
Intensity/Dose of Intervention	5 sessions
Any personalization to the intervention?	None
Any modifications over the course of the study? (Describe the changes)	Not reported

Planned Fidelity How is intervention adherence assessed and by whom? Strategies to improve fidelity	Assessed by instructors at the end of each lesson via a tool created by the research team
Actual Fidelity (if assessed) Describe the extent to which the intervention was delivered as planned	Each class had a fidelity instrument completed by the specialists Fidelity was then examined by the research team Paper states “high” fidelity but does not actually report any statistics related to the fidelity data collected

Table J9: Taylor et al., 2013 TIDieR Summary

Name of the Intervention	Shifting Boundaries
Number of Participants	Classroom Only: 23 classrooms, 6 schools Building level: 30 classrooms, 8 schools Both: 28 classrooms, 7 schools
Rationale Behind the Intervention	Based on the theory of reasoned action Attitudes and norms towards a behaviour facilitate the change, modification or adaptation of the desired behavior
Materials Provided? Describe materials provided to participants, needed for intervention delivery or needed to train facilitators	Classroom Based • Curriculum with handouts, lesson plans, rubrics, standardized information for teaching and activities Building Based • Templates for restraining orders • Poster templates • Hot spot templates For school level intervention, respecting boundaries agreements given to all students Protocol in place in addition to regular school protocols when students feel that their boundaries were not respected. Action plan documents for both those who violated and felt violated • DVD for how to use RBA/ demonstrate it in action, script of the DVD also provided Teacher codes the hot and cool maps and brings it to the school leadership. It is then up to the school to decide how to respond to the students mapping exercises Posters are placed by staff in areas they deemed appropriate • Posters in English and Spanish

Procedure? Describe each of the procedures, activities or processes used in the intervention	Classroom Based • 6 session curriculum which discussed consequences of DV, related laws, societal gender roles and traits of healthy relationships • Based on law and justice principles Building Based • Temporary building restraining orders • Posters increasing awareness of DV and encouraging reporting to school faculty • Hot spot mapping: students identify any unsafe spots throughout the school on a map and school personnel increase their presence and security in those areas
Providers (Who? Level of Expertise? Training provided?)	Substance Abuse Prevention and Intervention Specialists employed at each school
Mode of Delivery (Ex. In Person, Telephone, Internet etc)	In person
Group or Individual	Group
Location of Intervention (Ex. School, Doctors Office, ED etc) & any relevant features of the location	School, in class
Frequency of Intervention	Once a week
Schedule of Intervention Delivery	Taught over 6-10 weeks depending on the schools schedule
Duration of Intervention (Each session and overall)	40 minutes each session

Intensity/Dose of Intervention	6 sessions Building wide interventions were carried out throughout the same timeframe as the classroom ones
Any personalization to the intervention?	None reported
Any modifications over the course of the study? (Describe the changes)	None reported
Planned Fidelity How is intervention adherence assessed and by whom? Strategies to improve fidelity	Self assessed tools completed at the end of each session by the instructor or by the person implementing the building activity
Actual Fidelity (if assessed) Describe the extent to which the intervention was delivered as planned	Described as “high” fidelity but no reported statistics

Table J10: Temple et al., 2021 TIDieR Summary

Name of the Intervention	Fourth R
Number of Participants	1237
Rationale Behind the Intervention	Social Cognitive Model Designed to present factual information in an interesting fashion Designed to enhance motivation Teaches skills that promote healthy relationships, reduce conflict, risky behaviours and substance use Adapted from Canadian version (Wolfe et al., 2003) which was for 9th grade students Included lessons on mental health Changed references to be more appropriate for American context (Ex. hockey to football) Made more developmentally appropriate for younger age group (do not specify how)
Materials Provided? Describe materials provided to participants, needed for intervention delivery or needed to train facilitators	Not reported
Procedure? Describe each of the procedures, activities or processes used in the intervention	Unit 1: Safety and Injury Prevention • Healthy Relationships (qualities of good friends) • Impact of Bullying and harassment (understanding bullying and the bystander) • Benefits and dangers of technology (how to responsibly use technology) • Stress and how to regulate emotions (identifying stressors and coping strategies) • Decision-making (Identify the problem, Describe how you might solve the problem, Evaluate all possible solutions, Act

	on one of the solutions, Learn from your choices IDEAL, model) • Skills into practice (identifying passive, aggressive and assertive communication) • Practicing Skills and summative activity (delay, refusal, negotiation skills, and assertive communication practice) Unit 2: Substance Use, Addictions and Related Behaviours • Substance Misuse (describe internal and external factors) • Linking substance use to mental health • Connecting body image and substance abuse (short and long term effects of common substances) • Help seeking practices (help seeking, listening and supporting skills) • Researching the impacts of substance use and addictions (impact on family, friends, legal, health and safety) • Presentations on the impacts of substance use and addictions • Practicing substance use and addictions related skills • Practicing Skills and summative activity (role-play exercises) Unit 3: Human Development and Sexual Health • Knowing yourself (goals, values, and other factors influencing decisions) • Research on STI/STDs (prevention and symptoms) • Preventing STI/STDs (Student presentations) • Factors affecting sexual health decisions (scenarios and discussions) • Consent (what is it, when is it and is not communicated) • Communication (partner communication, delay, refusal and negotiation skills) • Culminating activity (written assessment)
Providers (Who? Level of Expertise? Training provided?)	7th grade health teachers Teachers were taught by the study team to deliver the intervention
Mode of Delivery (Ex. In Person, Telephone, Internet etc)	In person
Group or Individual	Mixed-sex groups

Location of Intervention (Ex. School, Doctors Office, ED etc) & any relevant features of the location	School
Frequency of Intervention	Not reported
Schedule of Intervention Delivery	Over a few months
Duration of Intervention (Each session and overall)	45 minutes
Intensity/Dose of Intervention	N/A
Any personalization to the intervention?	None reported
Any modifications over the course of the study? (Describe the changes)	None reported
Planned Fidelity How is intervention adherence assessed and by whom? Strategies to improve fidelity	Teacher completed curriculum fidelity logs and teacher surveys Research staff observed lessons and followed up with teachers to assist in maintaining fidelity
Actual Fidelity (if assessed) Describe the extent to which the intervention	Not reported

was delivered as planned	

Table J11: Wolfe et al., 2009 TIDieR Summary

Name of the Intervention	Fourth R: Skills for Youth Relationships
Number of Participants	968
Rationale Behind the Intervention	Other universal prevention efforts for unsafe sex and substance use take the same approach • Promote well being, positive alternatives, learning skills and help seeking strategies Emphasis on core relationship problems Teaches necessary skills to promote safe decision making Timed to take advantage of natural motivation during this age to learn about lifestyle problems Gives academic credit and incorporated into pre-existing curriculum Both sexes report perpetration so both should be targeted
Materials Provided? Describe materials provided to participants, needed for intervention delivery or needed to train facilitators	Schools received "Youth Safe Schools" manual describing how to incorporate students in school and community violence prevention All lessons had detailed lesson plans, video references, role-playing activities, rubrics and handouts, however details beyond this were not reported No response from authors for protocol request
Procedure? Describe each of the procedures, activities or processes used in the intervention	Unit 1: Personal Safety and Injury Prevention • Focus on healthy relationships (facts about relationships, rights and responsibilities in relationships • Barriers to relationships (types of violence, active listening skills) • Factors contributing to violence (effects of groups on violence, individual differences) • Conflict Resolution (communication styles and scenarios) • Media Violence (Presentations of violence in the media by students) • Conflict resolution skills (responsibilities when terminating a relationship) • Action in school and the community

	Unit 2: Healthy Growth and Sexuality • Healthy sexuality (review of sexuality and myths) • Sexuality in the media (peer pressure to have a partner/sex) • Responsible Sexuality (Communication and healthy relationships) • Preventing pregnancy and STIs • Assertive Skills to handle pressure in relationships (negotiation, delay and refusal skills) • Sexuality responsibilities and consequences (sexual abuse, DV and decision making) • Sexual decision making and community resources (scenarios, researching community resources) Unit 3: Substance Use • Definitions and facts (game to examine students opinions and values) • Effects of substances (physical and nonphysical effects) • Informed choices about smoking (discussion surrounding why adolescents smoke, health and financial costs) • Factors influencing drug use (media, culture and peer pressure) • Skills to avoid being pressured into substance use (negotiation, delay, and refusal) • Practicing skills and Finding resources (role play using skill and decision making model • Coping and the connection between substance use, sex and violence
Providers (Who? Level of Expertise? Training provided?)	Received 6 hours of training taught by an educator and a psychologist Received lesson plans, training videos and role-play demonstrations Received feedback from the educator Implemented the curriculum for at least 1 semester prior to the trial to increase familiarity
Mode of Delivery (Ex. In Person, Telephone, Internet etc)	In person
Group or Individual	Group

Location of Intervention (Ex. School, Doctors Office, ED etc) & any relevant features of the location	School's grade 9 health class Sex segregated
Frequency of Intervention	Not reported
Schedule of Intervention Delivery	Not reported
Duration of Intervention (Each session and overall)	75 minutes each 1575 minutes in total
Intensity/Dose of Intervention	Not reported
Any personalization to the intervention?	Differences in activities and exercises for female and male based classes Specifics not reported
Any modifications over the course of the study? (Describe the changes)	Not reported
Planned Fidelity • How is intervention adherence assessed and by whom? • Strategies to improve fidelity	Teacher reported checklists
Actual Fidelity (if assessed) • Describe the extent to which	89% of the unit 1 intervention lessons were delivered 88% of the unit 2 intervention lessons were delivered 90% of the unit 3 intervention lessons were delivered

the intervention was delivered as planned	According to teacher checklists