STANDING STRONG AGAINST GENDER-BASED VIOLENCE

Ursula Wagner
School of Social Service Administration
The University of Chicago

Abstract

Gender-based violence (GBV) includes all forms of violence that specifically and disproportionately target women and girls, including dating violence, domestic violence, and sexual assault. It is a problem of epidemic proportions in the United States. However, efforts currently being funded and implemented to alleviate this problem either address the violence after the fact or attempt to prevent it using strategies that are not optimally beneficial because they intervene too late, do not reach enough people, and do not address risk factors empirically shown to lead to GBV. This paper presents an alternative intervention strategy known as STRONG. The strategy's three essential tenets—(1) initiation in early childhood, (2) universal-level prevention, and (3) targeting of sexists attitudes, GBV-supporting beliefs, and rigid gender role socialization—are derived from a solid evidence base. Problems with existing programs, advantages of the proposed STRONG program, and obstacles to STRONG's practical implementation are also addressed.

The Centers for Disease Control and Prevention (CDC) identifies violence against women as a broad category encompassing "intimate partner violence, sexual violence, and other forms of violence against women committed by acquaintances or strangers" (2009a). Within the category of intimate partner violence, the CDC includes physical violence, sexual violence, emotional abuse, and threats. Violence against women—including effects of bodily injuries, sexual and reproductive health issues, risky behaviors on the part of the victims, and death—is a serious and pervasive public health problem that takes a severe mental, physical, social, and economic toll on individuals and society. Violence *prevention* is garnering increased attention from social workers, researchers, and the federal government. In 1994, the US Congress enacted the

Violence Against Women Act (VAWA), which provides both support and prevention measures around domestic violence, sexual assault, dating violence, and stalking. The law was reauthorized in 2000 and again in 2004, and each renewal has introduced more comprehensive measures addressing these forms of GBV (U.S. Department of Justice: Office of Violence Against Women 2010). On the state level, spousal rape became a crime (USDOJ: OVW 2010) mandatory arrest laws, which sought to ensure that police called to investigate domestic violence would have to make an arrest, were introduced (Hirschel 2008). Nonetheless, according to the CDC (2009a), approximately 1.5 million women in the United States still experience 4.8 million cases (CDC 2009b) of intimate-partner violence in the form of rape and/or physical assault each year. Because of the low reporting rates of crimes such as intimate violence and rape, even these statistics do not reflect the extent of the problem of violence against women and girls (CDC 2009b; 2009c).

Those addressing the issue from the fields of social work and anti-violence projects are increasingly turning their energies to school-based efforts that seek to stop problems like acquaintance rape and teen dating violence before they start. Many of these efforts, though significant, start in middle school or even as late as high school, at which point the data show that much of the targeted youth population has *already* been engaging in the dating and sexual activities that are a setting for GBV (Kinsman, Romer, Furstenberg, and Schwarz 1998; CDC 2007; 2009d). Other prevention programs, such as the Child Assault Prevention Project, do target children in younger grades. However, these programs have rarely been evaluated for efficacy, and they are limited in that they seek not to prevent anyone from eventually committing GBV, but rather to teach small children to recognize and protect themselves from sexual assault by adults (Hébert and Tourigny 2004). Along the same lines, there are programs aimed at women in domestic violence shelters designed to prevent their revictimization, but by far the most widespread initiatives are traditional prevention efforts designed to keep identified perpetrators of GBV; there is very little evidence to show either of these approaches reduces GBV (Wathen and MacMillan 2003).

All this speaks to the fact that we are still not addressing GBV before it starts. This paper first looks at existing GBV-prevention models, then draws upon the evidence base to identify program components likely to lead successful GBV prevention, and finally proposes a model for a program based upon this body of evidence. The proposed program, called Steps toward Respect in Our Next Generation, or "STRONG," is conceptualized as a universal measure to prevent GBV by instilling a sense of respect for women and girls in school children, starting with those who are very young.

The program aims to keep the next generation of children and youth from growing up with beliefs and attitudes empirically proven to be precursors of intimate-partner violence and sexual assault. It should be noted that this program model, while evidence-based, has yet to be tested in the field.

EXISTING MODELS OF GBV INTERVENTION

Historically, prevention has been a tertiary measure aimed at men identified as perpetrators of abuse (Neil Guterman, class lecture, October 15, 2009). Only recently have programs attempted to implement prevention for those who have not yet committed GBV, targeting young adults and high school students. However, while the CDC (2009a) has identified primary prevention as the strategy of choice for curbing violence against women, a survey of violence against women prevention programs in which the CDC is now involved—by researching, funding, evaluating, monitoring, assisting, proposing, or otherwise supporting them—shows no programs starting in early childhood that address respect for boundaries. For instance, the Choose Respect Campaign disseminates messages promoting healthy relationship styles, but only targets 11- to 14-year-olds (CDC 2009a). The one program cited in the review (above) aimed at preventing younger children from growing up to perpetrate violence, Second Step, stands out for beginning in preschool and continuing through ninth grade. Second Step, however, focuses on preventing general aggression rather than gender-based aggression and hence does not specifically address gender role socialization. Another study reviewed by Schwartz and others (2006) examined a group-based program that did aim to prevent dating violence by means of addressing gender role norms, but this prevention group was conducted with college-aged young adults rather than children (Schwartz, Magee, Griffin, and Dupuis 2004).

Based on a review of available sources, there does not seem to be an existing program in place that addresses gender-role socialization starting with young children as a means of primary prevention of GBV. Although a program incorporating universal-level prevention, onset in early childhood, and the targeting of GBV-supporting beliefs has not yet been implemented or studied as a way of preventing subsequent perpetrating behavior, there is sufficient evidence of the usefulness of each of these elements to suggest that the approach has enough promise to merit pilot-testing.

THE EVIDENCE OF UNIVERSAL INTERVENTION SUCCESS

Evidence for a universal intervention can be drawn from research on the Second Step program described above (Frey et al. 2000). Second Step is

a promising universal, school-based prevention measure implemented with children in pre-K through eighth grade. In randomized controlled studies of the program conducted in private and public schools in both urban and suburban communities, researchers blind to condition observed significant increases in pro-social behavior and significant decreases in verbally and physically aggressive behavior in children receiving the Second Step classes, results that were sustained at the 6-month follow-up.

Theoretical support for a universal measure to prevent GBV can be taken from social support theory or social networking theory, which says that our social relationships inform our conception of what counts as an acceptable behavior or attitude. A corollary of this theory is that violent behavior is embedded socially, through attitudes that normalize and thus perpetuate it. In looking for ways to prevent what is commonly called community violence, researchers such as Robert Sampson (2004) have drawn clear practice implications from social support theory: if violence is embedded in the broader social community, interventions should be directed at the same level (Guterman, class lecture, November 19, 2009). The normative component of social support theory must also apply to people's attitudes about gender roles, which have been linked to GBV (Schwartz et al. 2006).

THE EVIDENCE OF GENDER-ROLE INTERVENTION SUCCESS

In the "Need for Future Research" section of their meta-analysis of studies examining the link between parenting factors and future intimate partner violence, Schwartz and others (2006, 216) recommend that prevention efforts target gender-role socialization, citing many studies that link gender socialization to GBV (Archer 2002; Bookwala, Frieze, Smith, and Ryan 1992; Riggs and O'Leary 1996; Franchina, Eisler, and Moore 2001; O'Neil and Harway 1999; Schwartz, Waldo and Daniel 2005). The latter three studies found a positive correlation between gender-role stress and intimate-partner violence, as conceptualized by Pleck (1981; 1995). According to Pleck, belief in traditional gender roles, especially a "macho" paradigm of masculinity, confine men to mostly aggressive means of self-expression. Finn (1986) also found a strong correlation between a belief in traditional masculine/feminine gender roles and attitudes endorsing the use of physical force by a husband against his wife. Interestingly, Finn found these attitudes to be held by both men and women who subscribed to these roles. Jakupcak, Lisak, and Roemer (2002), also examined the link between sex role ideology and relationship violence. Their results indicate that interventions aimed at decreasing sex

role rigidity *and* increasing distress tolerance and relaxation techniques would be more effective than those that only address ideology.

Studies have tied sexual coercion and sexist attitudes, especially in the form of rape-supporting beliefs (Forbes, Adams-Curtis and White 2004). Forbes and others went so far as to break sexist attitudes down into cognitive and affective categories and found that the affective expression of sexism in the form of generalized hostility toward women was an even stronger predictor of sexual coercion and dating aggression than cognitively-based sexism in the form of subscription to rape myths. Ryan and Kanjorski (1998) found that the enjoyment of sexist humor was positively correlated with men's rape-supporting beliefs and their likelihood to force sex or be psychologically, physically, and sexually aggressive. Sexual harassment, another form of violence against women, also appears to be associated with sexist beliefs. Begany and Milburn (2002) found that men who believed in traditional gender roles as well as men who subscribed to rape-supporting myths and displayed an attitude of hostile sexism were more likely to sexually harass women. The relevance of sexual harassment to an examination of factors that contribute to violence against women is clearly highlighted by Begany and Milburn, who write, "Our results support the argument that sexual harassment as non-physically violent sexual aggression is a part of the same continuum as physically violent sexual aggression" (125). They found the same factors to feed into behavior all along this continuum. The studies discussed here are part of a large body of evidence identifying traditional gender role socialization and sexist attitudes as factors that precede GBV.

THE EVIDENCE OF EARLY INTERVENTION SUCCESS

In its literature on teen dating violence, the CDC (2009d) reports that 72 percent of eighth- and ninth-graders "date" in some form and that 25 percent of adolescents report being verbally, physically, emotionally, or sexually abused by a partner each year (2010). Studies since the 1980s have indicated a decrease in age at which youth begin having sex (O'Donnell, O'Donnell, and Stueve 2001). Results from the national Youth Risk Behavior Survey (CDC 2007) show 7.1 percent of youth report having had sexual intercourse *before* age 13. A survey administered to nearly 1400 sixth-graders (mean age of 11.7 years) in the Philadelphia urban area showed even more alarming trends: 30 per cent reported having initiated sexual intercourse before entering the sixth grade, and another 5 per cent reported doing so by the end of the sixth grade (Kinsman et al. 1998). These findings suggest that this is a planned behavior based on cohort norms. If sexual intimacy is starting at a young age, so is peer sexual assault. Among female rape survivors, 25.5 per cent are

first raped before age 12, and 34.9 per cent are first raped between ages 12 and 17. Family violence and child sexual abuse cannot account for all of these cases; 30.4 per cent are first raped by an intimate partner, and 20 per cent are first raped by an acquaintance (CDC 2009b).

Research findings in neuroscience and developmental psychology (Heckman 2006) suggest that the first few years of a person's life can greatly impact that person. Heckman's research was conducted in the field of economics but it documents a phenomenon known as brain plasticity, or the capacity of the brain to have its neural pathways shaped and changed, which is what happens when learning occurs. Although the human brain can make new neural connections in adulthood, it has the highest amount of plasticity in the first few years of life. As children age, neural circuits stabilize and it becomes harder to create new brain pathways (Shonkoff 2006). Systematic research on youth violence prevention programs (Rosenberg and Knox 2005) cite the importance of starting a program early in a child's life, then underscore that it is crucial to continue to implement it throughout later childhood and adolescence.

Dahlberg and Potter (2001) also note that the evidence base strongly favors early interventions. A comprehensive meta-analysis of a wider variety of prevention programs (i.e., not just violence prevention) by Nation and others (2003) draws definitive conclusions about timing. Their findings indicate that early intervention with booster sessions tailored to students' development levels is best.

All three of these reviews also help make the case for implementing prevention measures within systems and environments that are already in place (Dahlberg and Potter 2001; Nation et al. 2003; Rosenberg and Knox 2005). This idea is supported by social resource theory, which states that institutional contexts play a substantial role in shaping a child's lifelong outcomes (Neil Guterman, class lecture, November 19, 2009). This theory tells us that a school environment that condones or fosters GBV increases a child's chance of being a victim or perpetrator, but it also contributes to the theoretical foundation to the implementing of GBV prevention programs.

THE STRONG MODEL

The model described here represents STRONG in its preliminary phase, its design stemming from the empirically validated precursors to GBV outlined above. The following presentation does not attempt to cover every detail of the curriculum and its manner of implementation, but instead presents the program's general layout and a detailed rationale for its design.

STRONG's design begins with the pre-K or kindergarten classroom and a universal curriculum administered in hour-long sessions twice-a-week throughout the school year. The program means to take advantage of young

children's brain plasticity and to intervene before the onset of dating and sexual behaviors that come with puberty. The STRONG curriculum is administered in early childhood and then continues into early adolescence, its curriculum designed for each grade level after kindergarten. From first grade through sixth, students receive ten weeks of weekly hour-long sessions consisting of a booster curriculum that reintroduces the basic concepts while adding new, developmentally appropriate material in the form of factual information, skills training, and illustrative examples presented in class, as well as homework assignments. This curriculum is designed to be taught by students' home classroom teachers, or by trained counselors contracted by the school for this purpose, using a manualized version of the curriculum to make it easier to learn and to increase methodological consistency. By starting in pre-K and adding material in follow-up sessions as students advance in grade level, STRONG's design should prevent a washout effect.

STRONG is designed to intervene on a cognitive level to stop the beliefs and attitudes that have been identified as precursors to GBV, most notably rigid gender-role socialization. Based on Finn's findings (1986) that both men and women subscribe to the rigid gender roles that put them at higher risk for perpetration and victimization, respectively, STRONG is administered to both male and female students. STRONG design targets young children and addresses the following factors known to precede GBV: (1) gender-role stress due to rigid masculine gender-role socialization in males, (2) belief by both males and females in traditional masculine/feminine gender roles, (3) attitudes endorsing the use of physical force by a man against his wife, (4) poor distress tolerance and conflict resolution skills, and (5) sexist attitudes in the form of (a) rape-supporting beliefs, (b) affective hostility, and (c) enjoyment of sexist humor.

Gender-role stress. The component of gender role stress, the idea that a macho style of gender socialization limits them primarily to aggressive means of self-expression (Pleck 1981; 1995) will begin with the teacher asking the children (who are not sex-segregated) to give examples of men they admire and to list the reasons they admire them. Based on this exercise, the teacher will lead a discussion on what it means to be a man, guiding the class toward the concept that being a "real man" can look many different ways. The teacher will emphasize non-aggressive traits as desirable qualities for men to have. This list should expand as the children grow older and by sixth grade should include alternative expressions of gender identity and sexual orientation.

Belief in traditional gender roles. Here the teacher will solicit lists of characteristics and roles the children associate with being male

or female, and once again a flexible model with a wide range of possible expressions for each gender should emerge with the teacher's guidance. As the children get older, they will be asked to first give examples of what they think "traditional" roles for men and women are and then to list the advantages and disadvantages of either keeping to or breaking out of these traditional roles. Examples of famous role models who do not conform to these traditional roles will be given, and tolerance for a wide range of roles will be encouraged by the teacher.

Endorsement of physical force. Attitudes endorsing a man's use of physical force against his wife or partner are not addressed directly until the later years of the booster curriculum. The first few years of the curriculum target this factor by focusing on healthy and unhealthy ways for boys to treat girls, creating a classroom environment that does allow for any kind of physical force. The teacher will point out to the children that they may have heard the reason someone has chased, hit, or kicked them is because that person likes him or her, and then explain that this is not an acceptable way to express either positive or negative feelings toward anybody. The teacher will then encourage the class to come up with a list of healthy ways to express such feelings.

Poor distress tolerance. Evidence shows that GBV prevention programs are more effective when they both decrease gender role rigidity and increase distress tolerance and relaxation techniques (Jakupcak et al. 2002). In this section, students at all levels will discuss positive and negative ways to handle distressing situations. The teacher will teach the students age-appropriate techniques to promote healthy ways to relax, stress-soothe, and release stress and healthy conflict resolution techniques will be taught through examples and then practiced using role play, possibly with puppets or action figures. Each year, the students will recall and practice old techniques for distress tolerance and conflict resolution while adding new ones to their repertoire.

Sexist attitudes. Sexist attitudes, especially with regard to rape myths, are to be framed in terms of core values that children can understand without including material parents and educators might deem inappropriately sexual or violent. It is based on a list of oft-cited sexist, rape-supporting, and violence-accepting statements (adapted from Burt 1980) restated in terms a five-year-old could understand and then eventually reexamined in its original form during booster sessions with the older students. Other expressions of sexist attitude associated with future GBV, identified as affective hostility and enjoyment sexist humor, will be a challenge to address in a formal curriculum because it is affective rather

than cognitive. Therefore, STRONG teachers may be trained to watch for and log signs of such hostility as a way to identify students for whom more extensive GBV prevention measure may be indicated.

CONCLUSION

STRONG is not a perfect program design and cannot end the threat of violence against women and girls in this country on its own. As with any proposed program, STRONG may have trouble securing funding. STRONG is potentially controversial and some parents, educators, and elected officials may resist addressing gender roles or the perpetration of sexual and domestic violence with young children. Another challenge is that STRONG acts within the school system, whereas research suggests that it is most desirable for a prevention measure to target multiple social systems (Nation et al. 2003; Rosenbern and Knox 2005).

STRONG's attempts to promote positive messages of respect and tolerance, build on children's strengths, and maintain a developmentally appropriate curriculum are all attempts to minimize backlash against the program. Moreover, the evidence base does indicate that STRONG has the potential to make a significant contribution. STRONG complements existing prevention programs with different areas of focus or modes of administration. With the growing conversation around GBV and the growing consensus in the field that interventions must address violence before the fact to have maximum impact, there has never been a more promising time to put forth a fresh and unique program like STRONG and see where it leads us.

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ABOUT THE AUTHOR

Ursula Wagner is a second-year clinical student in the violence prevention program at the School of Social Service Administration. Since receiving her B.A. in linguistics and German from the University of California, Berkeley, she has taught in Mongolia, provided sexual assault counseling to children and adolescents, and worked as a home visitor for Healthy Families. In Chicago, she has interned at Housing Opportunities and Maintenance for the Elderly (HOME) and Grand Boulevard Federation. She is currently a clinical intern at the Northwestern University Women's Center, where she provides long-term psychotherapy. She plans to dedicate her career to preventing gender-based violence.