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Intimate Partner Violence and Mental Health Among Italian Adolescents: Gender Similarities and Differences

Patrizia Romito[1], Lucia Beltramini[1], and Vicenta Escribà-Agüir[2]

Abstract

Only a few studies have analyzed the health impact of intimate partner violence (IPV) on male and female adolescents, taking into account other kinds of violence that can affect their health. In this study, 43.7% of female adolescents and 34.8% of males reported IPV; females reported more psychological and sexual IPV, with no differences for physical IPV. Controlling for family and sexual violence and other confounding factors, female adolescents exposed to IPV had significantly higher adjusted odds ratios (AORs) for depression, panic attacks, eating problems, and suicidal ideation. For male adolescents, only the OR of eating problems almost reached statistical significance.

Keywords

adolescents, gender differences, intimate partner violence, mental health

Intimate partner violence (IPV) among adolescents is a serious problem, linked to violence in adult relationships (Lehrer, Buka, Gortmaker, & Shrier, 2006; Manchikanti Gomez, 2010) and to mental health problems that may linger into the future (Lindhorst & Oxford, 2008; Weissman, Wolk, & Goldstein, 1999). Adolescence also represents an opportunity for learning new skills and modifying harmful habits, including relationship violence. Programs have been developed to prevent adolescent IPV, with some encouraging, but preliminary, results (World Health Organization [WHO], 2010).

Adolescent IPV, also called teen dating violence, is widespread. In North America, 10% to 25% of high school students experience physical or sexual coercion within a dating

[1]University of Trieste, Trieste, Italy
[2]Centre for Public Health Research-Valencia, CIBER Epidemiología y Salud Pública (CIBERESP), Department of Nursing, University of Valencia, Spain

Corresponding Author:
Patrizia Romito, Department of Life Sciences, Psychology Unit, University of Trieste, Via Weiss 2, 34134 Trieste, Italy.
Email: romito@univ.trieste.it

relationship, with higher estimates found when emotional abuse is considered (Wekerle & Wolfe, 1999; White, 2009). In one of the few studies in Southern Europe, 15% of adolescent boys and 12% of adolescent girls had experienced high levels of physical IPV (Menesini & Nocentini, 2008).

Notwithstanding the frequency and consequences of adolescent IPV, some aspects of the phenomenon, such as gender differences, are still poorly known (Hickman, Jaycox, & Aronoff, 2004; White, 2009). Studies have shown that adolescent girls perpetrate as many or more violent acts against their partners than adolescent boys (Foshee, 1996; Malik, Sorenson, & Aneshensel, 1997; Rivera-Rivera, Allen-Leigh, Rodrìguez-Ortega, Chávez-Ayala, & Lazcano-Poncel, 2007), leading some researchers to conclude that girls are as violent as or more violent than boys (Archer, 2000). However, most of these studies use a narrow definition of IPV, with only one or a few questions on mild physical violence (White, Hall Smyth, Koss, & Figueredo, 2000), but without including sexual or psychological abuse. This is a striking omission, as sexual violence in dating relationships is widespread: Among high school students in Québec, 54% of females and 13% of males had experienced sexual abuse from a partner, with females experiencing more severe types of violence (Poitras & Lavoie, 1995). As for emotional partner violence, studies with adult samples have shown that it is as harmful as physical abuse (Coker et al., 2002; Romito, Molzan Turan, & De Marchi, 2005; Yoshihama, Horrocks, & Kamano, 2009). The few studies that have included sexual and emotional violence in the definition of IPV show that, while about the same proportion of adolescent boys and girls had experienced *some* violence at some point in their lives, girls had experienced significantly higher levels of *severe* violence (Molidor & Tolman, 1998). In addition, female adolescents report more negative reactions and more emotional distress to IPV than their male counterparts (Molidor & Tolman, 1998; Romito & Grassi, 2007). These differences in results depend in part on how violence is defined and measured, a task that may be difficult, involving the separation of personal beliefs from technical aspects (Cook, Gidycz, Koss, & Murphy, 2011; Schwartz, 1997; White, 2009). Moreover, even when a measure of violence is methodologically appropriate, it is possible that young men and women responding affirmatively to the same question have not had the same experience because of the different social positions of the two genders. As White et al. (2009) points out, even when prevalence rates are similar, this is not indicative of women's and men's IPV being the same (Anderson, 2002). For instance, previous work has shown that sexual coercion against a male by a female peer is experienced as less stressful or terrifying than the same category of violence perpetrated by a male against a female peer (Krahè, Scheinberger-Olwig, & Bieneck, 2003).

Although there is general agreement that violence has a negative impact on health (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002), little empirical data exist linking IPV with health outcomes in adolescents, and those that are available are mostly from female-only samples (Silverman, Raj, Mucci, & Hathaway, 2001). The physical consequences of IPV are more serious for girls than for boys (Molidor & Tolman, 1998). Concerning mental health, young women tend to be more seriously affected, or affected in more domains, than young men (Romito & Grassi, 2007). Others have found that female victims consider suicide more often than males (Coker et al., 2000; Olshen, McVeigh, Wunsch-Hitzih, &

Rickert, 2007; Roberts, Klein, & Fisher, 2003). A serious limitation of most of these studies is that they do not consider other kinds of violence that may also affect the health of adolescents. Parental violence or neglect in childhood, for instance, is linked to subsequent victimization—IPV or sexual aggression—in both genders (Fergusson, Horwood, & Lynskey, 1997; Foshee et al., 2008; Laporte, Jiang, Pepler, & Chamberland, 2011; Romito & Grassi, 2007; Wolfe, Scott, Wekerle, & Pittman, 2001). Without taking these other types of violence into account, it cannot be concluded that the excess of mental health problems exhibited by adolescent victims of IPV is to be attributed to IPV and not to the other abuse.

Clearly, a better understanding of the links between IPV and health among male and female adolescents is crucial to prevent further damage to health and promote well-being in young people as well as to extend our knowledge of IPV. It is also important to shed some light on the similarities and differences in the ways violence may affect the health of both genders. In the literature, there are two competing hypotheses: (a) the "female—or differential—vulnerability hypothesis," which states that women or girls are more vulnerable to the effects of violence (Breslau, Chilcoat, Kessler, Peterson, & Lucia, 1999), and (b) the "contextual vulnerability hypothesis" (or "differential exposure hypothesis"), which contends that if women present more mental health problems, it is because they experience more (and more severe) violence and not because they are more fragile (Pimlott-Kubiak & Cortina, 2003). One study explored the contextual vulnerability hypothesis in a sample of university students (Romito & Grassi, 2007). Female students were slightly more likely than male students to report family violence, directly experienced or witnessed, and physical/psychological IPV; they were significantly more likely to report sexual violence and significantly less likely to report abuse from—mostly male—fellow students. In both genders, the more violence, the higher the risk of health problems; the most pronounced increase in the risk of mental suffering occurred in presence of between three and four/five types of violence, the latter category containing mostly females. Controlling for each type of violence, the effects of family violence were similar for males and females, while the effects of more gendered types of violence—sexual violence, IPV and peer abuse—were more severe for young women (Romito & Grassi, 2007). On the whole, these results support the Pimlott-Kubiak and Cortina's hypothesis of a situational—rather than a female—vulnerability to violence: When women report more health problems, it is because they have been subjected to more or more severe violence. While in the scientific world, the controversy is far from settled as regards the differential vulnerability and the differential exposure hypotheses, and more generally between gender similarities versus gender differences in people's psychological characteristics and reactions, the general public and many professionals working with youth or with victims of violence seem to be captivated by the idea of fundamental gender differences, with important consequences (for the professionals) in their daily professional practice (Hyde, 2005).

The present study tries to overcome some of the aforementioned shortcomings. Inspired by the differential exposure perspective, we hypothesize that female adolescents experience more, and more severe, IPV than their male peers. Consequently, we expect to find more pervasive and more severe health effects of IPV in female than in male victims.

More specifically, the study aims to

compare the frequency and characteristics of IPV types and subjective reactions to it, by gender, in a sample of male and female high school students in Italy;
analyze separately, by gender, the links between any IPV and various mental health indicators in this sample, controlling for parental maltreatment and for sexual violence by other perpetrators; and
given that adolescent IPV is still poorly recognized and dealt with in Italy, to increase awareness and knowledge about IPV among young people, teachers, and health professionals in the region where the study was carried out and propose preventive measures.

Methods

Procedure and Sample

This cross-sectional study was carried out in a region of northern Italy and involved high school seniors from 16 schools. The sample aimed to be representative of the various geographical areas of the region and the different types of schools. The study was based at five sites: four administrative centers plus a municipality in a rural area. At each site, one high school for each type (scientific or literary, technical, or vocational) was randomly selected, and within each school, one or two classes of seniors were also randomly selected. All the school heads were personally contacted by the researchers; the study was explained to them and their collaboration was requested. The heads then presented the study to the "Consiglio di classe," a body made up of representatives of teachers and parents, and asked for their permission to take part. One school refused to participate, and two were unable to participate due to organizational difficulties; they were replaced by other schools with similar characteristics.

Data collection took place in October 2007. The research assistants presented the study and handed out self-administered, anonymous questionnaires during class time, stressing the students' right not to participate. The questionnaire was distributed to all students, who placed it in a closed box when they had completed it. Whether they participated or not, every student was given a letter with the name of the researchers, and a list of local resources for young victims of violence or psychological distress. All participants gave their oral informed consent. Three students refused to participate; 732 questionnaires were collected, of which 6 were incomplete and were discarded. The final sample contained 726 respondents (330 males and 396 females). This represents 9% of all the high school seniors in the region (*MIUR*, 2008). Analyses were carried out on the 259 males and 327 females who had ever been in a couple relationship. The study was approved by the University of Trieste's Ethics Committee.

Measurements

Depressive symptoms. Depressive symptoms in the past month were measured using the General Health Questionnaire (GHQ; Goldberg, 1972), in its 12-item version. To select a

group of more seriously distressed adolescents, we chose a cutoff point of > 5 (Romito & Grassi, 2007): students were considered "depressed" when they gave a "pathological" answer to at least six of the GHQ items. In the analyses, a dichotomous variable was used: depressed (GHQ > 5) and not depressed (GHQ < 6). Internal consistency of GHQ12 in this sample was calculated by Cronbach's alpha value ($\alpha = .85$).

Symptoms of panic attacks. Students were asked whether they had experienced anxiety crisis or panic attacks in the previous year, described, according to the *Diagnostics and Statistical Manual of Mental Disorders*, 4th ed. (*DSM-IV*; American Psychiatric Association, 1994), as episodes of intense fear or discomfort, which might include rapid heartbeat, feelings of suffocation, nausea, fear of losing control, or dying. Answers were *no, once or twice*, or *more often*, and were recoded dichotomously as no or yes.

Eating problems. Students were asked how often they eat without being able to stop, eat until they feel sick, self-induce vomiting, use laxatives or diuretics, monitor their weight. Answers were *every day or almost, once or twice a week, once or twice a month, less often*, or *never*. Another question asked whether they had been on a diet in the past year. Answers were *constantly, very often, once or twice*, or *no*. We constructed the indicator "mild eating problems" (Killen et al., 1994) to include those respondents who presented at least one of the following: eating without being able to stop or making themselves sick at least once or twice a month, using laxatives or diuretics at least once or twice a week, monitoring their weight every day, dieting at least very often.

Suicidal ideation. Students were asked whether they had ever thought of committing suicide. Answers were yes or no.

IPV. Students who answered that they had been in a couple relationship or had "gone out" regularly with someone were asked to respond to a list of nine items regarding abusive behavior by a partner or an ex-partner. The questions were rooted in a conceptual framework recognizing dating violence as involving emotional and verbal abuse, dominating behavior, and physical and sexual aggression (Hickman et al., 2004; Johnson, 1995) and had been used in a previous Italian study with university students (Romito & Grassi, 2007). Six items concerned domination and psychological violence (preventing the partner from doing certain things, making scenes, controlling, strongly criticizing, insulting, threatening him or her), two items concerned physical violence (slaps and shoves, punches and kicks), and one item concerned exerting pressure, and threatening or blackmailing to obtain sex. Two more items were added—one on sexual aggression and one on rape—drawn from the list on sexual violence (see below), when respondents indicated that the perpetrator was a partner or ex-partner. Answers for these questions were: *no; yes, in the past; yes, now; yes, now and in the past*. The timing of violence was asked to help respondents with remembering; given the limited numbers of the sample, in all the analyses, answers were recoded yes or no.

From these 11 items, we constructed a measure called "any IPV." To avoid inflating the frequency of IPV with situations where only one item of psychological abuse was reported, the category "No IPV" included respondents who had reported no violence at all or who had reported only one item of psychological violence. The category "any IPV" included respondents who had experienced at least one item of sexual or physical violence or at least two items of psychological violence.

Respondents who reported having experienced "any violence" were asked about their reactions to it, from a list of nine items: whether or not they were afraid, angry, humiliated, felt guilty, experienced physical or psychological pain, laughed, retaliated, were unconcerned.

Family violence. Students were asked four questions about whether they had directly experienced or had witnessed psychological (being insulted, denigrated, repetitively controlled) or physical (being slapped or kicked, beaten up, hit with an object, or other aggression) violence within the family. Answers were *no; yes, in the past; yes, now; yes, now and in the past*. These were subsequently recoded yes or no. As preliminary analyses showed significant correlations between the four types of family violence, respondents were included in the category of "any family violence" if they had directly experienced or witnessed at least one act of physical or psychological violence.

Sexual violence. Students were asked two questions: Has it ever happened that someone, using physical strength, threatening or blackmailing you, or when you were drunk or drugged: (a) fondled you, or made you fondle him or her, showed him or herself without clothes, or made you show yourself; showed you pornographic material or took pictures of you when undressed? (b) forced or attempted to force sex (rape or attempted rape) on you? A list of 15 perpetrators was provided. Students were categorized as having suffered "sexual violence" if they answered positively to at least one item, provided that the perpetrator was not a partner or ex-partner.

Statistical Analysis

We performed descriptive analyses, separately by gender, to determine the frequency of IPV, subjective reactions to it, other types of violence (family and sexual), and health outcomes.

To quantify the strength of the associations between IPV and mental health indicators, a stepwise logistic regression model was adjusted for each mental health indicator, controlling separately by gender for the factors associated with IPV. Adjusted odds ratios (AOR) and 95% confidence intervals (CI) were the measures of association obtained after fitting these models. A p value less than .05 was considered statistically significant. Statistical analyses were performed with the SPSS software package, version 15.

Results

Characteristics of the Sample

The distribution of sociodemographic characteristics, mental health indicators, and violence experiences other than IPV are shown in Table 1. There were no gender differences in the indicators of social position (place of birth, type of school, and mother's education); males were slightly older and more likely to be living with both parents. Female students were significantly more likely to experience "any family violence" and sexual violence. Symptoms of depression and of panic attacks, mild eating problems, and suicidal ideation were all significantly more frequent among female than among male students.

Table 1. Description of the Sample: Sociodemographic Characteristics, Mental Health Indicators, and Violence Experiences[a].

		Male Students (n = 259) (n) %	Female Students (n = 327) (n) %	
Sociodemographic characteristics				
Age: *M* (*SD*)		18.37 (0.81)	18.24 (0.76)	p = .05
Born in Italy	Yes	(235) 91.1	(301) 92.0	
	No	(23) 8.9	(26) 8.0	*ns*
Living arrangement	With both parents	(215) 85.3	(255) 78.2	
	Not with both parents	(37) 14.7	(71) 21.8	p = .02
Mother's education	University	(54) 20.8	(47) 14.4	
	High school	(102) 39.4	(120) 36.7	
	Less than high school	(93) 35.9	(147) 45.0	
	Do not know	(10) 3.9	(13) 4.0	*ns*
Type of high school	Scientific or literary	(87) 33.6	(115) 35.2	
	Technical	(96) 37.1	(127) 38.8	
	Vocational	(76) 29.3	(85) 26.0	*ns*
School site	Trieste	(84) 32.4	(98) 30.0	
	Udine	(102) 39.4	(50) 15.3	
	Gorizia	(23) 8.9	(63) 19.3	
	Pordenone	(16) 6.2	(61) 18.7	
	Tolmezzo	(34) 13.1	(55) 16.8	p < .001
Mental health indicators				
Depression	No	(242) 93.8	(259) 79.2	
	Yes	(16) 6.2	(68) 20.8	p < .001
Panic attack	No	(214) 82.9	(190) 58.5	
	Yes	(44) 17.1	(135) 41.5	p < .001
Eating problems	No	(190) 73.9	(172) 53.1	
	Yes	(67) 26.1	(152) 46.9	p < .001
Suicidal ideation	No	(216) 83.7	(223) 68.2	
	Yes	(42) 16.3	(104) 31.8	p < .001
Violence experiences				
Any family violence	No	(179) 69.1	(182) 55.7	
	Yes	(80) 30.9	(145) 44.3	p = .001
Sexual violence[b]	No	(219) 86.2	(249) 78.2	
	Yes	(35) 12.8	(74) 21.8	p = .003

[a]Among those who ever been in a couple relationship (n = 586).
[b]Any perpetrator, excluding a sentimental partner.

Prevalence and Reactions to IPV

Overall, 43.7% of females and 34.8% of males had experienced some IPV (Table 2). While there were no significant differences in physical violence, female students experienced significantly more psychological and sexual violence by a partner than male students. Whereas the same proportion in both genders reported no psychological abuse at all, males were more likely to report only one type, while females were more likely to have suffered 3 to 6 types of abuse. For both genders, the most reported kind of psychological abuse was, "My partner controls me, wants to know what I am doing, and who I am with" (data not shown). Female students were significantly more likely to have suffered sexual aggression from their partners, and especially two or three types of violence.

Reactions to having suffered "any IPV" widely differed by gender (Table 3). Females more often reported fear, humiliation, physical and psychological pain, and anger, while males more often answered that they had felt guilty, had laughed, and that they "did not care."

Restricting the analyses to respondents who had experienced physical or sexual aggression showed a similar trend, except that there were no gender differences in feeling guilty or angry; 8% of males and 29% of females had felt physical pain (data not shown).

Associations Between Social Characteristics, Family Violence, Sexual Violence, and IPV

For female students, family violence, sexual violence by perpetrators different from the partner, not living with both parents, type of school, and school location were all significantly associated with IPV. For male students, only family violence and sexual violence were significantly associated with IPV (Table 4).

Impact of IPV on Mental Health

Table 5 displays the associations between IPV and mental health indicators by gender. Controlling for family and sexual violence and for living arrangements, type and location of schools, female students who had experienced IPV have significantly higher AOR for all the mental health problems: 2.54 for depression, 1.86 for symptoms of panic attacks, 1.9 for mild eating problems, and 2.44 for suicidal ideation.

For male students, the picture is slightly different. Percentages of symptoms of panic attacks, eating problems, and suicidal ideation were significantly higher among those who reported IPV, while there was no significant effect for depression. Multivariate analyses further reduced the apparent association of IPV with male adolescents' health: After controlling for family and sexual violence only the OR of reporting eating problems almost reached statistical significance (OR = 1.83, 95% confidence interval [95% CI] = 0.99-3.4).

Table 2. Prevalence of Intimate Partner Violence[a].

	Male Students (n = 259) (n) %	Female Students (n = 327) (n) %	
Psychological violence/domination			
0	(96) 37.2	(123) 37.6	
1 type	(85) 32.9	(80) 24.5	
2 types	(56) 21.7	(71) 21.7	
3-6 types	(21) 8.1	(53) 16.2	$p = .01$
Physical violence			
0	(233) 90.3	(284) 86.9	
1 type	(21) 8.1	(35) 10.7	
2 types	(4) 1.6	(8) 2.4	*ns*
Sexual violence			
0	(234) 92.1	(279) 85.6	
1 type	(16) 6.3	(26) 8.0	
2/3 types	(4) 1.6	(21) 6.4	$p = .01$
Any intimate partner violence			
No[b]	(165) 65.2	(183) 56.3	
Yes	(88) 34.8	(141) 43.7	$p = .02$

[a]Among those who ever had a couple relationship (n = 586).
[b]Includes those with no violence or with only one item of domination/psychological abuse.

Table 3. Reactions to Intimate Partner Violence.

	Male Students (n = 88) (n) %	Female Students (n = 141) (n) %	
I was afraid	(8) 9.3	(42) 31.1	$p < .001$
I felt guilty	(34) 39.5	(28) 20.7	$p = .004$
I felt humiliated	(20) 23.3	(55) 40.7	$p = .005$
Physical pain	(3) 3.5	(18) 13.3	$p = .01$
Psychological pain	(21) 24.4	(58) 43.0	$p = .003$
I grew angry	(43) 50.0	(82) 60.7	$p = .03$
It made me laugh	(45) 52.3	(34) 25.2	$p < .001$
I did not care	(37) 43.0	(24) 17.8	$p < .001$
I retaliated in kind	(21) 24.4	(38) 28.1	*ns*

Table 4. Factors Associated With Intimate Partner Violence Among Male and Female Students.

	Male Students (n = 259)		Female Students (n = 327)	
	n	% With Intimate Partner Violence	n	% With Intimate Partner Violence
Living arrangement				
With both parents	72	34.1	102	40.5
Not with both parents	14	40.0	39	54.9
		ns		p = .02
Type of high school				
Scientific or literary	30	35.7	38	33.6
Technical	35	37.2	56	44.4
Vocational	23	30.7	47	55.3
		ns		p = .009
School site				
Trieste	30	36.6	48	49.5
Udine	36	35.6	19	38.8
Gorizia	10	45.5	27	42.9
Pordenone	4	26.7	34	56.7
Tolmezzo	8	24.2	13	23.6
		ns		p = .005
Any family violence				
No	45	25.9	57	31.5
Yes	43	54.4	84	58.7
		p < .001		p < .001
Sexual violence[a]				
No	64	29.4	96	38.7
Yes	24	68.6	43	58.1
		p < .001		p = .002

[a]Any perpetrator, excluding a sentimental partner.

Discussion

Among high school seniors in northern Italy, 34.8% of males and 43.7% of females had experienced IPV (psychological, physical, or sexual); in addition, adolescent girls experienced more severe IPV, a fact somewhat obscured by our dichotomous indicator. After controlling for other types of violence and for relevant contextual variables, a strong association was shown between IPV and female students' mental health, with at least doubled AORs of panic symptoms, eating problems, depression, and suicidal ideation. IPV had a negative, albeit lesser, impact on male students as well: The percentages of panic, eating

Table 5. Percentages and Adjusted Odd Ratios for the Association Between IPV and Mental Health Indicators.

	Depression			Panic Attack			Eating Problems			Suicidal Ideation		
	n	%	AOR (95% CI)	*n*	%	AOR (95% CI)	*n*	%	AOR (95% CI)	*n*	%	AOR (95% CI)
Female students[a]												
Any IPV												
No	24	13.1	1	60	33.0	1	68	37.4	1	36	19.7	1
Yes	42	29.8	2.54 (1.36-4.74)	73	52.1	1.86 (1.12-3.08)	82	59.0	1.90 (1.17-3.11)	66	46.8	2.44 (1.40-4.20)
	$p = .000$		$p = .003$	$p = .000$		$p = .01$	$p = .000$		$p = .01$	$p = .000$		$p = .001$
Male students[b]												
Any IPV												
No	8	4.8	1	19	11.5	1	34	20.7	1	22	13.4	1
Yes	8	9.2	1.51 (0.49-4.62)	23	26.4	1.84 (0.89-3.01)	32	36.8	1.83 (0.99-3.40)	20	22.7	1.52 (0.73-3.10)
	ns		*ns*	$p = .003$		*ns*	$p = .005$		$p = .054$	$p = .04$		*ns*

Note: AOR = adjusted odds ratio; CI = confidence interval; IPV = intimate partner violence.
[a]Adjusted by family violence, sexual violence by other perpetrators, school site, type of school, and living with both parents.
[b]Adjusted by family violence and sexual violence by other perpetrators.

problems, and suicidal ideation were significantly higher among those exposed to IPV, but after adjusting for family and sexual violence, only the AOR of eating problems was higher, nearing statistical significance. However, the magnitude of the AOR of males and females for eating problems and panic symptoms were similar, and some of the observed gender differences may be attributable to the lower prevalence of mental health symptoms and IPV among males. Female students' subjective reactions to IPV closely matched their more objectively measured health effects, as 30% to 60% of female victims indicated having felt afraid, humiliated, angry, or hurt psychologically. Male students reported fewer negative reactions, the more frequent answer being "I laughed" and "I did not care." This portrayal of themselves as being unaffected by their girlfriend's violence corresponded only in part to the relevant objective evidence.

While some characteristics of this study—its correlational nature and the relatively small sample—preclude any firm conclusions about the "differential vs. similarity" debate, the results tend to support our initial hypothesis, and the "contextual vulnerability hypothesis": Female adolescents present more mental health problems because they are exposed to more severe partner violence.

The results of our study are partly similar to those of others. The percentage of young people experiencing partner physical violence in this study—9.7% among males and 13.1% among females—is close to that found in a U.S. sample of adolescents, which was 9% and 10%, respectively (Howard & Qi Wang, 2003; Howard, Qi Wang, & Yan, 2007), and in another Italian study (Menesini & Nocentini, 2008).

With regard to gender differences in IPV, our study shows that while there was no difference in physical violence, female students reported more psychological and sexual violence. As most available studies considered only physical violence, comparisons are limited. With one notable exception (Wolfe et al., 2001), studies in North America show that adolescent girls are as physically aggressive as boys or even more so (Archer, 2000; Rivera-Rivera et al., 2007), with the effect tending to decrease with rising age (Archer, 2000). However, when the consequences of physical aggression are measured, adolescent boys are more likely than adolescent girls to have injured their partner (Archer, 2000; Molidor & Tolman, 1998). Other studies find that among dating youth, females report significantly more and more serious sexual victimization than males (Poitras & Lavoie, 1995).

There is less disagreement concerning the health outcomes of IPV, with the few available studies all finding that being victimized negatively affects health, with stronger effects for female than for male adolescents. Concerning the physical effects of violence, Molidor and Tolman (1998) found that 4% of males and 48% of females said it "hurt a lot"; 3% and 29%, respectively, said it caused bruises. Regarding suicidal ideation or attempts, some studies found an association with IPV in both genders (Howard & Qi Wang, 2003; Howard et al., 2007), while others (Coker et al., 2000; Olshen et al., 2007; Roberts et al., 2003) found such an association only among adolescent girls. As regards depression, some authors have found an association in both genders (Roberts et al., 2003), but others only among females (Howard et al., 2007). However, none of these studies controlled for the other types of violence usually associated with IPV, making it impossible to know how much of the negative impact of IPV can be attributed to other types of victimization. In the only study controlling for other victimization, among university students, the mental health impact of IPV was greater for the young women than for the young men (Romito & Grassi, 2007).

Limitations and Strengths of the Study

This study has some limitations. The sample was not nationally representative, included only older adolescents, and was relatively small. It is possible that with a larger sample, some of the AORs of the links between IPV and mental health in male students would become statistically significant. However, the study involved 9% of the high school seniors of the region, with an excellent response rate, and is one of the few on this subject in Southern Europe. Another limitation resides in the main independent variable, IPV. After the violence experienced by male and female students was described analytically, in further analysis the 11 items were collapsed into a dichotomous variable. This choice was dictated by concerns about small numbers and resulted not only in greater statistical power but also in a loss of information about the intensity of the violence experienced by male and female respondents. Though insufficiently detailed, this indicator still represents some progress with respect to the single question of mild physical violence used in many studies on adolescent IPV (White, 2009). In addition, as in all cross-sectional surveys, there is no way of knowing whether the negative health outcomes preceded or followed the IPV.

The study has strengths as well. We asked numerous questions about partner violence, including sexual and psychological abuse and domination as well as the subjective

reactions to it, and we considered several indicators of mental health (Coker et al., 2000; Pimlott-Kubiak & Cortina, 2003). The use of multivariate analyses made it possible to determine the associations between IPV and health, isolated from other types of violence and, in the case of girls, from some contextual factors, a significant advancement in comparison to other similar studies.

Our results underline the importance of method. Had we considered only physical IPV, we would have found that male and female students were equally violent; had we not controlled for family and sexual violence, females and males would have appeared as equally affected by IPV; had we considered only depression and suicidal ideation as outcomes in the multivariate analyses, no negative effects would have been found for male adolescents.

With our method, we were able to present a nuanced picture of IPV prevalence and its health associations among youth. The results concerning female adolescents are clearer and more coherent: They suffer more IPV than male adolescents do, and this violence is likely to be more severe (Molidor & Tolman, 1998; Poitras & Lavoie, 1995); when exposed to IPV, they react with more emotional distress and present more mental health problems than males. Adolescent boys suffer less partner violence and are likely to experience this violence as less threatening than that suffered by girls (Black, Tolman, Callahan, Saunders, & Weisz, 2008; Fineran, 2002). However, this result may be affected by underreporting of subjective reactions to IPV. Although there is a trend for victimized boys to report quasi-objective negative health outcomes, they appear to choose to present a tougher image of themselves as being unconcerned by their girlfriends' abuse, in line with the requirements of traditional masculinity (Courtenay, 2000; White, 2009).

To better understand the health consequences of violence on male and female adolescents, we need more longitudinal studies, with larger samples of respondents, and with greater attention to conceptual and methodological issues. This would make it possible to unravel the causal links between events and to identify different patterns and severity of violence. But we also need more qualitative studies to deepen our understanding of the meaning of violence for male and female adolescents (White, 2009). This is particularly urgent as far as male adolescents are concerned. In this study, while statistical, more objective, results show the links between experiencing IPV and some mental suffering, exposed male adolescents preferred to report being unaffected by the violence. Following the dominant model of masculinity, they apparently chose to deny having been a victim along with the feelings of fear, humiliation, and distress attached to it. This denial may represent an obstacle to seeking help, to thoroughly elaborating on the experience and to establishing healthier relationships in the future (Lisak, 1995).

The Aftermath of the Study: Communicating the Study's Findings and Beyond

At the beginning of the study we had made a commitment to present the results to the students and the teachers involved in the project. In 2008, we organized meetings in some of the participating schools (in at least one school in each city) and presented the principal results as well as information concerning local services and resources for youth to crowded

audiences of young people and some of their teachers. We also presented and discussed these data in several workshops with educators, health professionals, and policy makers and wrote articles in local newspapers and magazines. The meetings with the students were of great interest. Clearly, for many of them, behavior such as extreme jealousy, control, domination, sexual pressure, and even some physical violence was quite acceptable for couples. Moreover, many of them had strong prejudices against victims of sexual assault and partner violence. In Italy, interventions designed to inform adolescents about violence and prevent IPV are rare, none has been evaluated, and at the time of the study, there was no web-based resource in Italian on this issue. To reach young people, inform them, and open a space for discussion, we decided to develop a website on violence addressed to youth (http://www.units.it/noallaviolenza/; see Noonan & Charles, 2011). Using material drawn from the study, the site addresses different types of violence—family violence, sexual violence, and IPV—informs about health consequences and local resources and discusses current prejudices and misconceptions. The site also contains guidelines for parents and educators. During 2010, a first version was presented and discussed in several focus groups, with a total of 37 adolescents, males and females, aged 11 to 18 years old. Overall, young people found the site terrific; they made some criticisms and were proud to contribute to its improvement. Thanks to their suggestions, we set up the final version, available online from March 2011. The next steps are to present and discuss the site with small groups of young people, at schools and in recreational places.

Implications and Conclusions

Our results confirm that dating violence among young people, far from being just "squabbling," implies great suffering for those involved. Moreover, the strong associations found between IPV, family violence, and other sexual aggressions (Foshee et al., 2008; Laporte et al., 2011; Lehrer et al., 2006; Rivera-Rivera et al., 2007) indicate that a substantial minority of youth are cumulating various experiences of violence and are in urgent need of support and care. Two opposing risks should be avoided. On one hand, care should be taken to avoid hastily concluding that there are no gender differences in adolescent IPV, since young women appear to be more exposed and to suffer more negative health consequences. On the other hand, it would be equally unwise to conclude that adolescent boys are not victimized or that they suffer no ill effects.

With regard to primary prevention, educational settings are the most appropriate. In recent years, several school-based programs to prevent IPV have been developed, implemented, and evaluated in North America, showing that this kind of intervention is feasible and reduces the frequency and severity of violence (WHO, 2010). These programs should now be adapted and tested in other cultures and countries. In addition, well-designed web-based resources should be made available for young people and their parents, as they represent innovative and relatively inexpensive ways to reach a large audience, conveying the idea that IPV, while common, is unacceptable, and giving information about available resources. Most adolescents experiencing IPV do not seek help (Chung, 2007; White, 2009) and do not find support (Black et al., 2008). A web-based resource might make it

possible to reach those youths whose lack of information, shame, or self-blame prevent them from seeking help.

In addition, more effort should be put into training health professionals to identify violence and treat its health effects among adolescents. Educational programs for health professionals working with young people are still scarce, but some were implemented and showed promising results (Abraham et al., 2001; Moskovic et al., 2008).

Adolescence is a key developmental period, during which there is still time to intervene and activate protective factors (Jessor, Turbin, & Costa, 1998; Wekerle & Wolfe, 1999; White, 2009). Prevention, screening, and intervention for adolescents experiencing violence should be a priority in public health and educational settings; prevention and intervention should be gender sensitive and should challenge the trivialization of adolescent IPV (Chung, 2007; Laporte et al., 2011). Parents, educators, and health professionals should be aware of the extent of violence among adolescents and should be ready to discuss gender relationships, violence, and the related suffering in their encounters with adolescent girls and boys.

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Author Biographies

Patrizia Romito, PhD, is a professor of psychology at the University of Trieste, Italy. She has extensive research experience in women's mental health and violence against women. She is the author of *A Deafening Silence: Hidden Violence Against Women and Children* (2008).

Lucia Beltramini, MA, is a psychologist and PhD student in the Department of Psychology, University of Trieste, Italy. She is currently conducting a qualitative study on men's experiences, perceptions, and denial of violence.

Vicenta Escribà-Agüir, PhD, is a medical doctor and epidemiologist at the Centre for Public Health Research, Valencia, and the CIBERESP, Spain. She is also an associate lecturer at the University of Valencia. Her current research program focuses on gender differences in health and violence against women.