


# Brief Intimate Partner Violence Perpetration Screening Tools: A Scoping Review

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Maxine Davis<sup>1</sup>  and Diana M. Padilla-Medina<sup>1</sup> 

## Abstract

Recent research findings indicate that patients are willing to disclose their use of violence to health-care providers if asked. Health-care providers have a unique opportunity to screen their patients for intimate partner violence (IPV) perpetration; however, given the time constraints and limited personnel within medical offices and emergency-care facilities, instrument brevity is critically important. The development and evaluation of tools to screen for IPV perpetration in health-care settings, particularly brief instruments, is limited by the lack of adequate guidelines, clear institutional policies for screening, and reviews of the available literature. Given the need for validated measurement tools, we assessed the psychometric properties of measurement tools designed to quickly detect IPV perpetration by conducting a scoping review. Our search identified five measures meeting eligibility requirements. Inclusion criteria required that study information be published in a peer-reviewed journal, be published in English or Spanish languages, contain 10 or less items, report psychometric testing results, require no additional information, and be designed to detect IPV perpetration. We searched subject-specific databases and the bibliographies of relevant publications to identify studies. As part of appraising and synthesizing the evidence, we found most measures to have good reliability and validity. Most measures contained 2–5 items. Most studies were conducted in the United States and utilized an adequate sample size. There were considerable differences in how each of the measures determined a positive or negative screening. Gaps in the literature and areas for future research pertained to sample diversity, invariance testing, and practice guidelines for implementation.

## Keywords

assessment, batterers, disclosure of domestic violence, domestic violence, mental health and violence, violent offenders

## Empirical Research

In the United States, intimate partner violence (IPV) is recognized as a serious public health problem with considerable health, reproductive, psychological, social, and economic costs and consequences (Black, 2011; Breiding, Chen, & Black, 2014; Warshaw, Brashler, & Gil, 2009). The prevalence rates, costs, and consequences vary by race, ethnicity, and sexual orientation (Breiding et al., 2014; Halpern, Spriggs, Martin, & Kupper, 2009; Halpern, Young, Waller, Martin, & Kupper, 2004); however, every community is negatively impacted by IPV. National investigation reveals that on average, 24.3% of women and 13.8% of men will experience physical violence by an intimate partner during their lifetime, while 9.4% of women and 2.2% of men will experience sexual violence. In contrast, both men and women have similar lifetime prevalence rates of psychological aggression victimization at 48.0% (Breiding et al., 2014). A recent nationally representative sample of males revealed that 19.2% of men were physically abusive toward their current intimate partner (Singh, Tolman, Walton, Chermack, & Cunningham, 2014). Williams, Ghandour, and

Kub (2008) critically reviewed 47 articles examining the prevalence of adolescent and adult females that perpetrated IPV and found that the prevalence rate for physical violence among adult women ranged from 13.0% to 68.0%. These staggering victimization prevalence rates in combination with the data on self-reported use of violence indicate that IPV perpetration is of paramount concern.

The damage of IPV on the health and mental health of victims has been well-documented (Coker, Smith, Bethea, King, & McKeown, 2000; Devries et al., 2013; Dutton et al., 2006). However, research indicates that there are negative health outcomes for perpetrators as well, yet these are less discussed. The impact of IPV on perpetrators has been linked to depression, psychiatric disease, suicidality, alcohol use,

<sup>1</sup> University of Texas at Arlington, TX, USA

### Corresponding Author:

Maxine Davis, School of Social Work, University of Texas at Arlington, 211 S Cooper Street, Arlington, TX 76019, USA.  
Email: maxine.davis@uta.edu

illegal drug use, and high-risk sexual behavior (Penti, Timmons, & Adams, 2018; Sesar, Dodaj, & Šimić, 2018). Likewise, IPV perpetration is also associated with poor physical health of those who act abusively. Men who perpetrate IPV have been found to have significantly more physical symptoms from irritable bowel syndrome, insomnia, digestive problems, and substance use disorders (Singh et al., 2014).

The American Medical Association and the Joint Commission recommend routine screening for IPV victims in emergency- and primary-care settings; however, there is no recommendation to screen for IPV perpetration. Health-care providers primarily focus on assessing patients for IPV victimization, despite evidence that IPV victimization screening in health-care settings does not necessarily translate to better patient outcomes (McLennan & MacMillan, 2016). Traditionally, efforts have not been focused on screening individuals who could be at risk of perpetrating IPV or those recently engaged in perpetrating IPV (Gerlock, Grimesey, Pisciotta, & Harel, 2011), even though such a strategy has potential to start a process that may facilitate violence cessation.

A number of studies have found that patients disclose their IPV perpetration while receiving health services (Chang et al., 2011). Research has also demonstrated that men and women would feel comfortable disclosing IPV perpetration or victimization if questioned by a health-care provider (Daugherty & Houry, 2009). However, in spite of the willingness to report, the literature indicates that medical professionals struggle with how to identify and respond when presented with such disclosures and/or they notice behaviors that may be indicative of IPV perpetration (Daugherty & Houry, 2009; Gerlock et al., 2011; Pentti, Tran, Timmons, Rothman, & Wilkinson, 2017). The process of screening for IPV perpetration in the health-care system thus far has been done haphazardly, without agreed upon guidelines on the specific questions that providers should ask patients (Daugherty & Houry, 2009; Gerlock et al., 2011). Considering that in the United States, emergency departments and primary-care providers are a substantial source of care for perpetrators (Coben & Friedman, 2002; Lipsky & Caetano, 2011), it is necessary to assess IPV perpetration and the risk thereof in health-care settings. Screening patients for IPV perpetration and connecting them to relevant interventions or resources to obtain help is critically important in reducing the harm of IPV perpetration on victims and improving perpetrators' own health. An important step in screening for IPV is developing psychometrically robust tools that allow providers to systematically assess for IPV perpetration across health-care settings. The literature has highlighted that the lack of a systematic process in screening for IPV perpetration is a barrier to early identification and referral of perpetrators (Gerlock et al., 2011).

Recently, loose guidelines have been published on how physicians should intervene if a patient discloses perpetrating IPV (Penti et al., 2018). Jaeger, Spielman, Cronholm, Applebaum, and Holmes (2008) developed a set of IPV screening recommendations for use in primary health-care setting, when inquiring about male patients relationship status, and presence of

violence in the context of the relationship. If the patient responds positively to the presence of violence, the health-care provider should assess for lethality and safety and should then respond to the patient with direct counseling and referral to resources. They suggested its integration into routine primary care of male patients age 14 and older. However, few empirically sound measurement tools have been developed to assist providers in actually screening for risk or perpetration of IPV.

In recent years, researchers have started to develop and validate instruments and tools to assess for IPV perpetration in health-care settings for men and women (Kraanen, Vedel, Scholing, & Emmelkamp, 2013; Portnoy et al., 2018). Portnoy et al. (2018) developed an IPV screening instrument for use with women veterans in medical settings. Crane, Rice, and Schlauch (2018) evaluated a brief screening instrument to facilitate the rapid and early identification of IPV perpetration in a college sample. However, the development and evaluation of instruments and tools to screen for IPV perpetration in health-care settings, particularly brief instruments, is limited by the lack of adequate guidelines (Sprague et al., 2012), clear institutional policies for screening IPV (Kraanen et al., 2013), and reviews of the available literature. Much of the research on the development of screening tools and instruments for health-care settings has occurred in the last few years, and the reviews of the literature that have been conducted precede the development of these screening tools and instruments (Fogarty & Brown, 2002; Rabin, Jennings, Campbell, & Bair-Merritt, 2009; Thompson, Basile, Hertz, & Sitterle, 2006). An up-to-date systematic assessment of the literature on the screening tools and instruments for IPV perpetration with an emphasis on primary health-care settings is therefore overdue.

## The Present Study

Comprehensive reviews of IPV perpetration screening instruments and tools used in health-care settings are limited. We were unable to locate a synthesis of the psychometric properties for perpetration screening instruments and tools. Considering these gaps in the literature, this study aims to systematically summarize brief IPV perpetration screening instruments and tools, which may be relevant for use in health-care settings, as well as provide a discussion of the instruments' validity and reliability.

## Purpose/Overview of a Scoping Review

There are various methods used to synthesize knowledge; however, a scoping review is unique because it allows for a preliminary assessment of research when a body of literature is still in its early stages of development (Grant & Booth, 2009). In contrast to a systematic review or meta-analysis, the quality of evidence is not evaluated nor are the results of selected studies statistically analyzed within a scoping review. Instead, broader research questions are addressed with the purpose of

identifying research gaps and making recommendations for future research by examining the extent, nature, and range of a research activity (Arksey & O'Malley, 2005). A scoping review is also different from content analyses that may focus on identifying frequency of themes across studies.

## Method

### Step 1: Identify Research Question and Operationalize Definitions

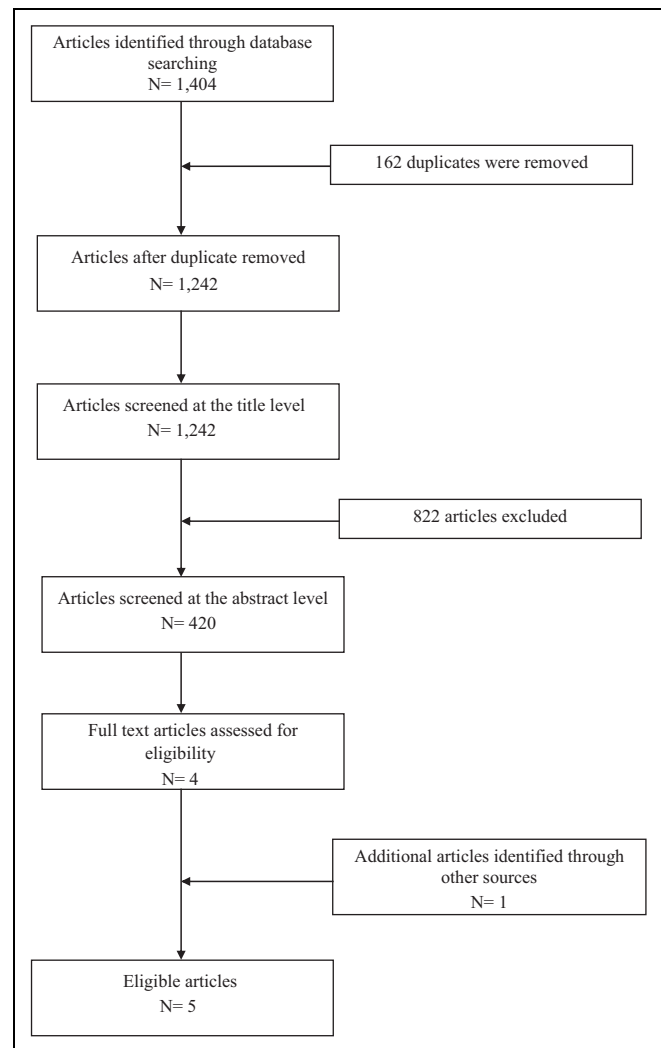
The initial goal of the investigation was to conduct a systematic review; however, given the small sample size, a scoping review was conducted, and the following research question was examined: *What is the state of empirical literature on reliable and valid rapid screening tools assessing IPV perpetration or risk of perpetration?*

### Step 2: Inclusion and Exclusion Criteria

Measures were not excluded if they were capable of examining both victimization and perpetration; however, measures solely assessing victimization were excluded. Inclusion criteria were restricted to IPV perpetration screening tools that (1) were rapid/brief<sup>1</sup> (10 items or items) or designed for use in health-care settings (i.e., emergency room, primary care provider, urgent care), (2) reported psychometric testing results in English or Spanish, (3) required no additional or collateral information to use the tool, (4) published in a peer-reviewed journal.

### Step 3: Identify Relevant Studies

We conducted a systematic search of studies, limited to works published in peer review journal articles from 1982 to 2018. The following combination and sequence of terms were used to search for studies: "Measurement OR Screening OR Measuring OR Tool OR Scale OR Psychometric test AND Intimate Partner Violence OR Intimate partner abuse OR Domestic violence OR Dating violence (abstract) AND Primary care OR Physician OR emergency room OR nurses OR hospital OR urgent care OR brief AND perpetration OR risk of perpetration OR perpetrator (all text)." We performed the search within the following 10 subject specific databases: Academic Search Complete, Family Studies Abstracts, Health Source: Nursing/Academic Edition, Humanities Full Text (H.W. Wilson), MedLatina, MEDLINE, PsycARTICLES, Psychology and Behavioral Sciences Collection, PsycINFO, Social Work Abstracts. The initial search yielded 1,404 potential studies. Of these, 162 were duplicate studies and were removed prior to screening titles and abstracts. We screened the titles of 1,242 articles and reviewed the abstracts of 420 articles. Our abstract screening identified four potentially eligible abstracts for which we reviewed the full text. In addition, the research team also conducted a hand search by reviewing the references of notable publications. Cochrane and Campbell libraries were also scanned as a technique to locate any existing reviews that were relevant to the topic of interest. Through this method, we



**Figure 1.** Flowchart for selection of eligible research articles.

identified one additional potentially eligible abstract, for which we also reviewed the full text. Following the full-text review, a total of five studies meeting the inclusion criteria were identified through these procedures (see Figure 1).

Two authors determined the eligibility and quality of each study by independently reading publications and assessing them for inclusion in the study. The two authors then discussed which pieces of data to extract from the studies reviewed and built consensus on which aspects were most pertinent to include in this review.

### Step 4: Charting Data

The next stage of the work involved "charting" key items of information obtained from the primary research reports being reviewed. Charting (Ritchie & Spencer, 1994) involves a technique for synthesizing and interpreting qualitative data by organizing material according to key issues and themes, a similar process was borrowed and used in this work. In a systematic review, this process may be called "data extraction" and in

meta-analysis, may involve specific statistical techniques (Arksey & O'Malley, 2005). The authors decided to include general information about the study and specific information such as study population, research setting, psychometric properties, unique findings, and suggestions for future research. See Tables 1 and 2 for the key study attributes reviewed. The synthesis of data included a mixture of tabulation and narration. Final analysis was descriptive and comparative in nature (Grant & Booth, 2009).

### *Step 5: Collating, Summarizing, and Reporting Results*

Rhodes and colleagues (2009) unnamed 8-item perpetration screening tool was developed to be administered in the waiting room of an emergency department. Authors provided psychometric properties for item numbers 2, 5, 6, and 8 (see Appendix). These 4 items were reported to demonstrate good to moderate sensitivity (70–95.5%) when compared to the revised Conflict Tactics Scale (CTS-2); however, specificity values were weak (44.7–50.6%). The latter is concerning because it may translate to an overburden of valuable health service resources. The study sample size was by far the largest of the studies reviewed and contained a majority African American demographic, both unique characteristics compared to other studies. Using this tool approximately, 6% of the sample screened positive for IPV perpetration. However, the study provided the most limited psychometric property test results, when compared to other measures examined.

Developed by Ernst and colleagues (2012), the Perpetrator Rapid Scale (PERPS) is a 3-item screening tool designed to capture IPV in a busy hospital emergency room. Among the studies included in this review, it had the shortest reported administration time and least amount of questions. Of the publications reviewed, this study contained the most ethnically diverse sample and was the only instrument administered bilingually. However, the authors did not have enough participants who completed the instrument in Spanish to conduct any invariance test across language. Although the sample was diverse, the authors did not report conducting invariance testing between the Hispanic and Caucasian populations included in the study. With a sensitivity of 66%, the measure was weak in correctly identifying people who perpetrate physical IPV/A. Using the Physical Abuse of Partner Scale (Garner & Hudson, 2000) as the comparison measure, specificity was strong at 93%. A unique strength of the PERPS study was the testing across paper/pencil versus computer formats. The authors reported findings that there was no difference in which format participants considered “easier” or “more confidential.” However, participants who took the computer method found their entry method to be faster than those who took the paper method. Using this tool, approximately 22% of the sample screened positive for IPV perpetration.

The Jellinek Inventory for Assessing Partner Violence (J-IPV; Kraanen et al., 2013) is a 4-item screening device that was developed to assess IPV perpetration and victimization in patients entering substance abuse (SA) treatment. The authors

conducted two independent studies to assess the validity of the J-IPV, with the second study validating the findings of the first study. Using this tool, approximately 40% of the sample screened positive for “any” IPV perpetration and 16.8% screened positive for “severe” IPV perpetration. The psychometric testing reported strong sensitivity for both “any IPV” and “severe IPV” perpetration, ranging from 80% to 100% when compared to the CTS-2. Similarly, the test reported strong specificity ranging from 79% to 91% for both “any IPV” and “severe IPV.” This suggests that the test is able to accurately identify patients who are perpetrating IPV versus those who are not. A unique feature of this measure is its ability to simultaneously screen for both victimization and perpetration during an SA treatment facility intake session. Compared to the other measures, J-IPV was the only one able to differentiate between “any” and “severe” IPV.

The perpetration screening tool (PST) (Crane, Rice, & Schlauch, 2017) is a 4-item screening device which was developed as a brief instrument for identifying high-risk adolescent and young adult populations. Three samples of college students were recruited to provide survey data that would allow authors to evaluate the psychometric properties of a rapid perpetration screening tool. The authors administered an IPV assessment measure to an initial sample in order to identify a critical subset of items that would best detect IPV perpetration, maximizing sensitivity. The initial subset of items was borne out of existing measures. Data collected from two additional samples were used to cross-validate the psychometric properties of the resulting rapid screening tool. Using the CTS-2 as a comparison, across three samples, the sensitivity of the measure ranged from 90% to 97.8%, while the reported specificity ranged from 96.6% to 98.5%, indicating a good measure of accuracy. Using this tool, in the first sample, 20.8% of the sample screened positive for IPV perpetration. In the second and third samples, 19.7% and 12.7%, respectively, screened positive. The authors cross-validated the instrument for men and women, indicating that the assessment tool would be appropriate to use regardless of participant gender. The authors also reported strong concurrent validity by correlating the screening tool with an initial set of 16 violence perpetration items. The screening tool adequately assessed the construct it purported to assess, as indicated by the correlations between the PST and well-established risk factors for IPV perpetration.

Portnoy and colleagues (2018) developed a modified version of the commonly used Extended Hurt/Insult/Threaten/Scream IPV screening tool (E-HITS). E-HITS was originally designed to capture IPV victimization (Chan, Chan, Au, & Cheung, 2010; Sherin, Sinacore, Li, Zitter, & Shakil, 1998); however, Portnoy and her colleagues (2018) redesigned the wording of the tool in order to assess perpetration. Of the studies examined in this review, the measure was the only tool opting to use a multiple response option, capturing frequency of each behavior (i.e., never, rarely, sometimes, often, frequently). The study was also the only one that reported investigating the acceptability and appropriateness of the potential screening tool. The majority of participants “reported they

**Table 1. Basic Study Information.**

Authors and Year	Tool Name	Number of Items	Sample Question Wording	Time	Language	Setting	Method Administered	Population Tested	Sample Size	Sex/Gender	Racial/Ethnic/Nationality Distribution	Type of IPV Examined	Author Recommendations for Future Research
Portnoy et al. (2018)	Modified E-HITS	5	In the past 6 months, how often have you done the following to a past or current intimate partner: physically hurt him or her, for example, pushed, shoved, slapped, punched, kicked, or beat-up (Response options: 1 = never to 5 = frequently)	2 min	English	Administered to a national sample on a web-based survey	Web-based survey	Women veterans	n = 187	100% Women	72% non-Hispanic White; 10.6% African American; 11.7% Hispanic/Latino; 5% Multi-ethnic/Other	Sexual, physical and psychological (hurt, insult, threaten, scream, pressure sex)	Future research should (1) examine accuracy and acceptability in veteran men, civilians, and "within the context of patients seeking clinical care"; (2) examine differences in self-report methods (e.g., paper, computer, tablet); (3) identify factors that "may improve willingness to disclose and accept help"; and (4) evaluate providers' perceptions of the tool, response protocols following screening, and intervention
Ernst et al. (2012)	PERPS	3	Have you ever pushed or shoved or poked your partner violently? (response options: yes/no)	<1 min	English, Spanish	A single busy emergency room (ER)	Paper/pencil and computer	Emergency department patients	n = 214	62% female; 38% male; 6% unknown	Hispanic 40%; Caucasian 39%; American Indian 6%; Other 6%; African American 3%	Physical abuse	Investigate whether a brief IPV intervention and educational program is possible in an ER setting. Further study of the tool in other ERs and medical offices would be valuable.
Crane et al. (2017)	PST	4	Please indicate if the following has occurred in the past 6 months: I threatened to hit or throw something at my partner (response options: yes/no)	N/A	English	Students enrolled in an introductory college psychology course; in university lab or online a place of convivence	Sample 1: written paper form; Samples 2 and 3: online/self-directed	College students	Sample 1 (n = 260); Sample 2 (n = 238); Sample 3 (n = 158)	Men and women	Sample 1: 82.6% Caucasian females; Sample 2: 87.4% Caucasian females; Sample 3: 84.8% Caucasian males	Physical violence	Further research is required to determine whether response rates will drop with direct, oral administration.

(continued)

Table 1. (continued)

Authors and Year	Tool Name	Number of Items	Sample Question Wording	Time	Language	Setting	Method Administered	Population Tested	Sample Size	Sex/Gender	Racial/Ethnic/Nationality Distribution	Type of IPV Examined	Author Recommendations for Future Research
Kraanen, Vedel, Scholing, and Emmelkamp (2013)	J-IPV	2 <sup>a</sup>	Conversely, has it occurred in the past year that the partner got so out of hand that you acted in a threatening way to your partner, or threatened to hurt him or her? (response options: yes/no)	2 min	Dutch		In-person structured interview	Substance abuse treatment facility (intake)	Study 1 (n = 98); Study 2 (n = 99)	Study 1: 70% male 30% female; Study 2: 66% male; 33% female	95% Dutch; 1.5% Other European; 4.6% Other outside of Europe	Developed to detect physical IPV	(1) Include larger samples in order to narrow the 95% confidence limit of sensitivity and specificity. (2) Obtain collateral data from participants' partners on the CTS2. (3) The order in which the J-IPV items are addressed would be interesting to study. (4) It would be of interest to study psychometric properties of the J-IPV to detect emotional IPV and extend the J-IPV in order to detect sexual IPV. (5) Investigate whether adding a third response category to the J-IPV (e.g., "sometimes") may lower the threshold to admit IPV perpetration and/or victimization.
Rhodes et al. (2009)	N/A	8	Do you think there are times when you think it is OK to physically hurt your partner? (response options: yes/no)		English	Patients in emergency department waiting room (public hospital/trauma center)	Computer	Emergency department patients	n = 712	100% male	9.2% White; 87.7 African American; 0.4 Hispanic; 0.4 Asian; 2.3 Other	Developed to detect physical and sexual IPV perpetration by assessing controlling behaviors, attitudes, and actions	None

Note. IPV = intimate partner violence; E-HITS = Extended Hurt/Insult/Threaten/Scream IPV screening tool; PERPS = Perpetrator Rapid Scale; J-IPV = Jellinek Inventory for Assessing Partner Violence; CTS-2 = Revised Conflict Tactics Scale.

<sup>a</sup>The full J-IPV contains 4 items, 2 measuring victimization and 2 measuring perpetration. The psychometric properties of the perpetration questions were assessed separately from victimization questions. The data in this table reflect results from perpetration questions. The tool developers indicate that the questions can be used all together or separately to capture victimization or perpetration.

**Table 2. Tool Specifics and Psychometric Properties.**

Authors and Year	Tool Used for Comparison	Cutoff Recommendations	Sensitivity	Specificity	NPV	PPV	PLR	NLR	Additional Psychometric Testing	% Screened Positive	Unique Findings
Portnoy et al. (2018)	Revised Conflict Tactics Scale (CTS-2)	Recommended cutoff score of 7	71% with a cut score of 7	87% with a cut score of 7	94% with a cut score of 7	51% with a cut score of 7	1.92 with a cut score of 7	0.12 with cut score of 7	$\kappa = .50$ with a cut score of 7; area under ROC curve/predictive accuracy: 0.86 (95% CI, 0.78–0.94)	16.6% (n = 31)	Measure assessed for perceptions of the acceptability and appropriateness of the modified E-HITS questions for use in health-care settings. The majority of women veteran perceived the instrument to be acceptable
Ernst et al. (2012)	Physical Abuse of Partner Scale (PAPS)	Considered positive if any of the three questions answered "Yes"	66%	93%	87%	78%	N/A	N/A	Cronbach's $\alpha$ : 0.68; area under ROC curve: 0.85	22% (n = 47)	Paper versus computer screen format examined for differences in patient preferences. No difference in number of refusals across formats. No difference in number who choose each option, no difference in which was considered "easier" or "more confidential." Computer method found their entry method to be faster that paper method reported. Discordant cases examined (between PERFS and PAPS): more likely to be Caucasian
Crane et al. (2017)	Measures assessing risk factors for IPV: violence victimization (CTS-2); relationship satisfaction (Satisfaction subscale of the investment model scale); binge drinking (Quantity-Frequency Variability Index of Alcohol Consumption); state and anger trait (State-Trait Anger Expression Inventory); aggressivity (Physical Aggression subscale of Aggression Questionnaire)	Identified as partner violent if any one of the four behaviors were endorsed	Sample 1: 92.6%; Sample 2: 97.9%; Sample 3: 90.0%	Sample 1: 96.6%; Sample 2: 97.9%; Sample 3: 98.5	Sample 1: 98.0; Sample 2: 99.5; Sample 3: 98.5	Sample 1: 87.7.0; Sample 2: 97.9 Sample 3: 98.5	N/A	N/A	Cronbach's $\alpha$ : Sample 1: .70; Sample 2: .72; Sample 3: .70; Area under ROC curve: Sample 1: .95; Sample 2: .98; Sample 3: .94	20.8% (n = 54); 19.7% (n = 47); 12.7% (n = 20)	The results indicate that female samples reported comparable rates of IPV perpetration across structured in-person and online written assessment methods. All questionnaires were administered anonymously. The authors concluded that structured, written questions may be more easily understood by clients than unstructured interview questions. Cross-validation among a second female sample and a sample of male participants revealed that the selected items performed well among both females and males

(continued)

Table 2. (continued)

Authors and Year	Tool Used for Comparison	Cutoff Recommendations	Sensitivity	Specificity	NPV	PPV	PLR	NLR	Additional Psychometric Testing	% Screened Positive	Unique Findings
Kraanen, Vedel, Scholing, and Emmelkamp (2013)	CTS-2	To detect any IPV perpetration: cutoff 1; to detect severe IPV perpetration: cutoff 2	Study 1 any IPV perpetration: (.80 with a cut score of 1); Study 2: (.84); Study 1 severe IPV perpetration: (.91 with a cut score of 2); Study 2: (1.00)	Study 1 any IPV perpetration: (.80 with a cut score of 1); Study 2 (.82); Study 1 severe IPV perpetration: (.91 with a cut score of 2); Study 2: (.79)	Study 1 any IPV perpetration: (.78 with a cut score of 1); Study 2: (.89); Study 1 severe IPV perpetration: (.99 with a cut score of 2); Study 2: (.96)	Study 1 any IPV perpetration: (.75 with a cut score of 1); Study 2: (.74); Study 1 severe IPV perpetration: (.56 with a cut score of 2); Study 2: (.60)	Study 1 any IPV perpetration: (4.17 with a cut score 1); Study 2: (4.67); Study 1 severe IPV perpetration: (5.88 with a cut score of 2); Study 2: (4.67)	Study 1 any IPV perpetration: (.24) with a cut score 1); Study 2: (.19); Study 1 severe IPV perpetration: (0) with a cut score of 2); Study 2: (.00)	Area under ROC curve: Study 1 any perpetration: (.86 with a cut score of 1); Study 2: (.86); Study 1 severe IPV perpetration: (.92 with a cut score of 2); Study 2: (.91)	Any IPV 40.1% (n = 79) severe IPV: 16.8% (n = 33)	First study and second study varied in population attributes (relationship length, nationality, and geographical location). More men than women participated in the two studies. However, men are usually overrepresented in substance abuse treatment. Using 98 participants, a lower confidence limit of .65. Ideally, it should be increased up to .70 or .75 for which 204 and 756 participants are needed, respectively. Discriminates between any and severe IPV perpetration and victimization but can be used separately
Rhodes et al. (2009)	CTS-2	Positive response to two or more IPV perpetration questions = positive screening	70–95.5%	44.7–50.6%	N/A	N/A	N/A	N/A	N/A	Perpetration only 6% (n = 40)	None

Note. E-HITS = Extended Hurt/Insult/Threaten/Scream IPV screening tool; PERPS = Perpetrator Rapid Scale; IPV = intimate partner violence; PPV = positive predictive value; NPV = negative predictive value; PLR = positive likelihood ratio; NLR = negative likelihood ratio.



would discuss their IPV perpetration experiences with the provider asking these questions” (p. 442). In comparison to the other studies, the E-HITS screening tool was the only measure that sampled an exclusively veteran female population. The tests of specificity and sensitivity demonstrated acceptable levels of accurately identifying and discriminating between perpetrators and nonperpetrators. The tool yielded a sensitivity value of 71% and a specificity value of 87% when compared to the CTS-2. The modified E-HITS was the only tool assessing multiple forms of IPV, namely, psychological abuse. Using this tool, 16.6% of the sample screened positive for IPV perpetration.

In general, there appeared to be a consensus on the most appropriate comparison measure for testing sensitivity and specificity of IPV screening tools. In our review, 4 of the 5 studies used the CTS-2 as the measure of comparison. Most studies used the same comparison tool, strengthening the ability to compare psychometric findings across IPV perpetration screening tools. All but one study reported strong reliability testing, with area under the receiver operating curve (ROC) statistics ranging from .85 to .98.

Across the studies, there was variability in the phrasing of the introductory instructions/questions. Depending upon the cognitive appraisal of the participant, varied introductory instructions may generate different understandings of the question. For example, Portnoy et al. (2018) used “in the past 6 months how often have you done the following to a past or current intimate partner,” while Crane and colleagues (2017) instructed participants to “please indicate if the following has occurred in the past year.” Additionally, some screening tools did not limit the parameters of recent relationships, rather inquired “have you ever” (Ernst et al., 2012).

There was variation in the way tests were administered. Crane et al. (2017) and Ernst et al. (2012) both reported using a completely anonymous sample, whereas the other studies either did not indicate anonymity or participants identity were known via structured interview.

The studies conducted in the United States did not have an ethnically and racially representative sample of the nation’s population. Similarly, the study conducted in the Netherlands (Kraanen et al., 2013) did not render a representative sample. In addition, two of the studies were gender-/sex-specific (Portnoy et al., 2018; Rhodes et al., 2009). The sample attributes of most studies limited the authors’ ability to conduct invariance testing by gender, race, and ethnicity. Nonetheless, given the sample sizes reported, we found that two studies (Crane et al., 2017; Ernst et al., 2012) may have been able to conduct invariance testing by either gender or race and ethnicity, yet did not report such testing.

Three of five studies were administered in English only, and one was administered in Dutch only. Only one study was administered in two languages (Spanish and English); however, the overwhelming majority of the sample elected to take the test in English, meaning that there was not enough variation to conduct invariance tests across languages. Furthermore, none of the publications reported conducting invariance testing across age groups to determine whether people in different

generations interpret the questions differently or similarly. Linguistically speaking, the sentence structure may be understood similarly across age; however conceptually, respondents may perceive the meaning of the language within an item differently depending on the generation in which they were born. Additionally, all studies utilized self-reported data.

## Discussion

This scoping review examined the published literature on brief IPV perpetration screening tools within health-care settings. Our review highlighted the efforts underway that seek to improve IPV screening, ultimately as a way of combating IPV perpetration with referrals to services. For the most part, research, policy, and programs have focused on developing secondary or tertiary responses to IPV, neglecting intervention efforts with perpetrators outside of the criminal justice system (Buzawa & Buzawa, 2003). Screening through health-care settings and subsequent referral to appropriate services may be a useful prevention technique in halting further acts or preventing abusive behaviors from escalating (Daugherty & Houry, 2009; Gerlock et al., 2011). However, the extent to which professionals in the field of IPV will be able to intervene is determined by the validity of screening tools and instruments. To the best of our knowledge, Rhodes and colleagues (2009) pioneered the first psychometric testing of a brief tool to identify IPV perpetration in a health-care setting, establishing the beginning of a very important line of inquiry. The development of instruments could help in determining history of violence perpetration, likelihood of repeat abuse, and/or severity of behaviors (Nicholls, Pritchard, Reeves, & Hilterman, 2013).

To our knowledge, this is the first study to synthesize literature that has explored the soundness of brief IPV perpetration tools. Given the call for attention on preparing health-care providers to appropriately respond to self-reported violence perpetration (Kimberg, 2008), it is important to be aware of existing measures that may help providers identify a population of patients needing behavioral health treatment. Overall, while there were variations between studies, the measures examined all demonstrated acceptable psychometric properties. However, there were considerable differences in the procedures that determined a positive or negative screening. There were also variances in the number of items, populations, and linguistic issues.

Having measures that are psychometrically sound is important, but the brevity and comprehensiveness of the tool are key elements for consideration. Generally speaking, of the studies reviewed, it seems that between 2 and 5 were a standard number of items included in each tool. Consisting of 8 items, Rhodes and colleagues’ (2009) unnamed measure was the longest. However, the authors were unable to locate specific guidelines for the ideal length of rapid screening tools or scientific agreement on what constitutes a short assessment tool within health-care settings.

In health-care settings, it is also vital that measurement tools be assessed for appropriateness across diverse populations

(Lipsky, Caetano, Field, & Bazargan, 2005; Stults, Javdani, Greenbaum, Kapadia, & Halkitis, 2015). While none of the studies reviewed had a sample representative of national demographics, Ernst et al. (2012) and Portnoy et al. (2018) reported ethnically and racially diverse sample compositions. The studies reviewed examined a number of different populations across varied settings. Even within the same country, there are often multiple factors that influence how violence is expressed. Investigation into measures validity with specific populations such as women veterans and patients entering an SA treatment program offered unique findings to the literature.

Wording used in stem sentences and phrasing of items varied across studies. While there were similarities in how physical violence was queried, there were also differences in the provided examples of behaviors. IPV is a complex phenomenon, and there is no uniform definition of what specific behaviors constitute different forms of violence and abuse. This seems to have had a direct impact on authors' selection of terms. This is important, given that participants' responses could vary as a function of how items are linguistically constructed (Hardy & Ford, 2014; Schuman & Presser, 1996). Crane et al. (2017) indicated that the PST was designed to detect physical IPV; however, the language of the items selected suggests a possible ability to screen for psychological aggression as well (e.g., the item on "threats"). As IPV perpetration has become less socially acceptable across time, there has been a shift in what constitutes violence, making it even more difficult to use language that is relevant across generations.

The titles of instruments are also important to discuss. The way in which we brand or name an instrument might influence how a patient responds or reacts to the questions. For example, the acronym PERPS may be perceived as a shorthand for "perpetrators" or "perverts," and it may bias how patients respond to questions, if they were to see the title of the tool on a screening sheet. In spite of this concern, a noticeable strength across studies was the effort made by all authors to use gender inclusive or nongendered language in the items and initial instructions.

We identified a number of strengths across studies. We found that most of the studies agreed that the most appropriate comparison measure was the CTS-2. This facilitated the process of testing the sensitivity and specificity of IPV screening tools as a gold standard comparison measure (Archer, 2000) which was needed to conduct these tests and compare properties across studies. Additionally, all of the sample sizes in each study met methodological recommendations for the number of items examined (Floyd & Widaman, 1995).

### *Limitations*

The parameters of our inclusion criteria prevented us from including studies published in languages other than English and Spanish. Another limitation identified was that one of the studies was conducted in the Netherlands, while the others were conducted in the United States. It should be

acknowledged that the manifestation of IPV is expressed differently depending upon culture (Yoshioka & Choi, 2005). While there is value in conducting a full scoping review regardless of the geographic location of the study, we were not able to obtain a set of tools that represented a wide range of countries. Despite conducting a rigorous systematic search and mining references for potential studies, it is also possible that some publications meeting the inclusion criteria were missed. Finally, IPV perpetration is usually underreported in most measures. This issue theoretically extends to the brief tools reviewed in this study, and it is impossible to fully account for respondents who did not truthfully report violence perpetration due to social desirability.

### *Practice Implications and Recommendations*

While developing and validating a screening tool is imperative to detecting perpetrators of violence who are in need of services, it is also important to assess the clinical utility of the screening tool. Portnoy et al. (2018) investigated the acceptability of implementing the modified E-HITS. However, further research is needed to investigate the feasibility and acceptability of implementing other tools in a broader population. It is important to examine whether the barriers identified by health-care providers in the literature (e.g., time, mode of administration, length, negative perceptions of perpetrators, and lack of provider training) are improved by the development and implementation of these brief screening tools (Penti et al., 2017; Sprague et al., 2012). Furthermore, none of the screening tools reviewed included practice guidelines practitioners should follow if a patient screens positive for IPV perpetration as a part of administering the screener. Perhaps such specific instructions were conceptualized or considered but outside of the purview of assessing psychometric properties and therefore excluded from publication. Given the limited literature in this area, it may be useful for authors to include this content in publications in case recommendations may vary across settings or populations.

We found that while attempts to develop psychometrically sound perpetration screening tools are expanding, more research is needed on translating the knowledge gained into improved practice and patient health (Coben & Friedman, 2002). As part of evaluating the clinical utility of screening tools, it is imperative that health-care providers are able to participate in a system that connects patients to treatment. Likewise, caution should be used when relying upon a brief screening tool to determine IPV perpetration, given the limited constructs that are able to be assessed with any intransigent measure (Straus, Hamby, Boney-McCoy, & Sugarman, 1996). Simultaneously, we need to also determine what constitutes the appropriate protocols providers should use for referrals. For example, we must further investigate the question of—is it appropriate to refer all positively screened individuals to the same treatment or are specifically tailored referrals needed. Rhodes and Iwashyna (2009) found evidence that two distinct groups of men with history of IPV perpetration (high violence/

low violence) present in health-care systems, noting that interventions which are targeted at the patients' level of risk may be beneficial in treatment referrals. Screening for perpetration is a fruitless effort, unless patients are able to connect with adequate personnel and have access to beneficial resources. To this end, synergy between doctors, nurses, social workers, case managers, and other related health and mental health professionals needs to be promoted in health-care settings.

Another area requiring attention is patient access to resources after referral. Does screening and referral resolve other barriers to getting treatment or directly translate to increased voluntary enrollment in treatment for IPV perpetration? One structural barrier to accessing treatment for IPV perpetration may be the costs involved, thereby impeding initial participation in treatment and treatment adherence. For example, insurance may not cover the expense of behavioral health interventions, and there is currently no diagnosis for IPV perpetration. Another challenge is the inconclusive evidence on the efficacy of batterer intervention programs (BIPs; Cheng, Davis, Jonson-Reid, & Yaeger, 2019; Arias, Arce, & Vilarino, 2013; Babcock, Green, & Robie, 2004; Davis & Taylor, 1999; Feder & Wilson, 2005; Murphy & Ting, 2010), with some suggesting that BIPs have little or no "program effect." However, in a meta-analysis, Babcock, Green, and Robie (2004) highlighted that although participation in a BIP may only reduce the victim/survivor chance of being reassaulted by 5%, that decrease in violence translates to 42,000 fewer women per year being physically assaulted by an intimate partner. So, while a 5% reduction in likelihood of reassault may seem small, the practical significance is extremely valuable. Clinically, this may also translate to thousands of reduced instances of nonphysical aggression.

Finally, primary-care providers have a powerful voice in getting people to uptake treatment that is necessary to improve one's health. While there is mixed evidence regarding how patient/care provider trust is established, several studies have shown that the level of trust patients have regarding physicians and other health-care providers directly influences decisions to engage in and adhere to recommended treatment (Birkhäuser et al., 2017; Thom, Hall, & Pawlson, 2004). Ultimately, most patients trust their health-care providers to act in their best interest (Pearson & Raeke, 2000), justifying provider involvement in efforts to address this chronic health problem.

### **Future Research**

Two of the measures reviewed included items that assessed noncriminalized forms of abusive behaviors (Portnoy et al., 2018; Rhodes et al., 2009). Given that nonphysical forms of abuse are damaging to health and are often a precursor to physical violence (Karakurt & Silver, 2013), future investigations should also explore how to briefly screen for this type of maladaptive behavior in health-care settings. Portnoy et al. (2018) was the only study that reported testing for acceptability of screening questions and as noted earlier, this was among veteran women. Future research should examine men's and

civilian's perceptions of the appropriateness and acceptability of screening questions.

Upon reviewing the articles, none of the authors provided theoretical or conceptual rationale for including/excluding participants based on gender. Given the differences in how people express violence and aggression across genders and cultures, it is critically important for psychometricians to test for gender and ethnic invariance when it is feasible to do so. Additionally, how participants respond to questions asked by health-care providers may also depend on the method in which the test is administered and the site. Future studies should examine whether or not anonymity yields higher disclosure of IPV perpetration than screening procedures that require identity revelation. Similarly, future research should investigate differences in self-administered tests versus brief structured interviewing. Additionally, future research should test differences across settings, as this may influence respondent comfortability in disclosure.

J-IPV was developed and tested for patients entering an SA facility, but it is also important that future research be done among other populations in order to extrapolate the measures utility in other settings. Finally, given the complexity of relationship experiences and how patients report nuances of their behaviors (Hellmuth, Gordon, Stuart, & Moore, 2013), it may be beneficial for more studies to examine the psychometric properties of multidimensional tools capturing victimization and perpetration. In our review, the J-IPV full instrument was the only tool that contained this capability (when implementing all four items).

## **Appendix**

### ***Modified Extended Hurt/Insult/Threaten/Scream Intimate Partner Violence Screening Tool***

In the past 6 months, how often have you done the following to a past or current intimate partner:

1. physically hurt him or her (e.g., pushed, shoved, slapped, punched, kicked, or beat-up),
2. insult or talk down to him or her (e.g., called him or her names, belittled him or her),
3. threaten him or her with harm,
4. scream or curse at him or her, and
5. forced him or her to have sex or do sexual things (e.g., insisted on sexual activities when he or she didn't want to or used force or threat of force). (Portnoy et al., 2018)

### ***Perpetrator Rapid Scale***

1. Have you ever forced your partner to have sex or hurt your partner during sex?
2. Have you ever pushed or shoved or poked your partner violently?
3. Have you ever hit or punched your partner's arms, body, head, or face? (Ernst et al., 2012)

### Perpetration Screening Tool

Please indicate if the following has occurred in the past year.

1. I threatened to hit or throw something at my partner.
2. I pushed or shoved my partner.
3. My partner had a sprain, bruise, or small cut because of a fight with me.
4. I slapped my partner. (Crane et al., 2017)

### Jellinek Inventory for Assessing Partner Violence

1. Conversely, has it occurred in the past year that the situation with your partner got so out of hand that you acted in a threatening way to your partner or threatened to hurt him or her?
2. And has it occurred in the past year that the situation with your partner got so out of hand that you became physically violent and, for example, slapped, hit or kicked your partner? (Kraanen et al., 2013)

### Unnamed Measure

1. Do you feel like you always need to be in control of your partner?
2. When you get angry, does it make your partner afraid?
3. Have you hit/pushed/shoved your partner?
4. Do you think there are times when it is OK to physically hurt your partner?
5. Have you physically hurt your partner?
6. Are you worried you might physically hurt your partner?
7. Do you think your partner should have sex whenever you want?
8. Have you made your partner have sex when he or she didn't want to? (Rhodes et al., 2009)


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### ORCID iD

Maxine Davis  <https://orcid.org/0000-0003-1653-4464>

Diana M. Padilla-Medina  <https://orcid.org/0000-0003-1958-4969>

### Note

1. Although we could not locate precise guidelines on the length of a rapid/brief tool, given the time constraints of health-care providers, we conceptualized "rapid/brief" assessment tools to contain 10 or less items. This decision was reached upon generally reviewing the number of items contained in quick screening tools.

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### Author Biographies

**Maxine Davis** is an assistant professor at School of Social Work, the University of Texas at Arlington, Arlington, TX. Her research focuses on people who act abusively or use violence within intimate relationships and interventions to help them change their behavior, with particular attention on Black and Latino men. She is guided by former work in Batterer/Partner Abuse Intervention Programs. She hopes to contribute to scholarly work that improves treatment outcomes and service delivery.

**Diana M. Padilla-Medina** is an assistant professor at the School of Social Work, the University of Texas at Arlington, Arlington, TX. She is also a U.S. Fulbright Scholar at Universidad Nacional de Colombia for 2018–2019. Previously, she worked as an assistant professor at the University of Puerto Rico. Her research interests include Latinos, adolescent decision-making, and adolescent romantic relationship violence.