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ORIGINAL ARTICLE

When Disclosure Isn't the Goal: Exploring Responses to Partner Violence Victimization Screening and Universal Education among Youth and Adults

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Abstract

Efforts to connect intimate partner violence (IPV) and teen dating violence (TDV) survivors with services rely heavily on victimization screening, despite extensive evidence that many will not disclose abuse even with the best-available screening tools. This study examines how two forms of brief IPV/TDV intervention (screening and universal education) affect important outcomes other than disclosure, including participants' perceptions of options and resources for addressing IPV/TDV and maintaining safety. This study applies regression models and inductive qualitative analysis to survey data from adults ($N = 646$) and youth ($N = 648$) and accompanying qualitative interview data to explore participants' perceptions of safety-related resources and options after completing a set of randomly assigned brief IPV/TDV interventions. Brief IPV/TDV interventions (including screening and universal education) may influence safety options and connection to resources, even in the absence of disclosure. The brief interventions examined in this study supported participants' awareness of available resources and sparked personal reflection and insight. Organizational-level outcomes included stronger community partnerships, increased capacity for communicating about IPV/TDV, and expanded services for survivors. These outcomes appeared to be strongly shaped by how staff approached IPV/TDV-related interactions with participants. Implementation of brief IPV/TDV interventions in the context of high school and community-based relationship education programs represent a promising strategy for promoting safety and safety-related empowerment among youth and adult survivors. Future research should continue to examine outcomes of such interventions beyond disclosure.

Keywords Intimate partner violence · Teen dating violence · Screening · Universal education · Disclosure

Introduction

Intimate partner violence (IPV) is the most common form of violence in the United States (Sumner et al., 2015). Efforts to connect IPV survivors with formal services have focused overwhelmingly on "screening," that is, the use of standardized protocols to ask individuals about IPV and teen dating violence (TDV) experiences and make referrals for those who disclose abuse.[1] Such strategies have an important shortcoming, however: They rely on survivors to disclose their experiences in order to be connected to services, though an immense body of evidence indicates that many survivors will opt not to disclose, even with the best-available tools (Arkins et al., 2016). Still, and despite a call from some advocates and scholars to acknowledge the limits of "disclosure-based

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[1] We use the term "screening" to refer to tools and protocols for identifying the presence of IPV and TDV victimization in order to better serve patients or clients. This is sometimes referred to as "assessment" (to convey that it is intended to guide service *provision*, not to include or exclude individuals from services). We use "screening" in this article for consistency with the broader research literature on tools and protocols for identifying IPV and TDV and to distinguish the very brief, structured interactions that were tested in this study from the kind of in-depth IPV/TDV assessments that would be conducted by a professional victim advocate.

practice" (Miller & McCaw, 2019), little research has examined how systematic, structured conversations about IPV and TDV (including universal education and traditional, questionnaire-style screening tools) might influence outcomes other than disclosure. The current study draws on qualitative and quantitative data collected during a randomized field test of IPV and TDV screening and universal education tools to address this gap.

Background

Scope and Impact of Partner Violence Victimization in the United States

Americans face a higher risk of violence from an intimate partner than any other form of violent victimization (Black et al., 2011). Almost one in four women (23%) and one in six men (14%) has experienced severe physical assault from an intimate partner in their lifetimes (Smith et al., 2017), while 9% of women and 0.5% of men have been sexually assaulted by a partner (Breiding, 2015). Further, most youth who date (69%) experience some form of physical violence, sexual coercion, controlling behavior, or psychological aggression from a dating partner (Taylor & Mumford, 2016).

Partner violence victimization causes far-reaching harm to individuals, families, and the nation. Youth who experience TDV are more likely to experience symptoms of depression and anxiety; engage in risky behaviors like smoking, binge drinking, and drug use; and exhibit antisocial behaviors like lying, theft, and bullying; and are at elevated risk for suicidal ideation. Those who experience partner violence before the age of 18 are more likely to experience violence in their adult relationships (CDC, 2021). Forty-one percent of adult women who survive IPV and 14% of adult male survivors experience physical injuries; many others face physical or behavioral health problems and economic consequences, which can linger for years or decades after the violence ends (Black et al., 2011; Bosch et al., 2017; Breiding, 2014; Dillon et al., 2013). Half of all women who are murdered and one in six homicide victims overall are killed by an intimate partner (CDC, 2021).

The impacts of partner violence not only linger over the life course of a victim; they are intergenerational. Children who are directly or indirectly exposed to IPV against a parent can experience severe consequences throughout childhood and well into adulthood (Carpenter & Stacks, 2009; Ehrensaft et al., 2003; Wood & Sommers, 2011). At a national level, partner violence exacts a steep human and economic price. The World Health Organization has estimated that partner violence costs Americans approximately 3.2% of the United States gross domestic product each year (Waters et al., 2005). More recent Centers for Disease Control and Prevention (CDC) estimates suggest an even steeper price, placing the lifetime economic burden of partner violence at $3.6 trillion (including victims' medical treatment, victims' and perpetrators' lost productivity, adjudication of perpetrators, and victim property loss or damage) (Peterson et al., 2018).

Connecting Survivors with Support

Most survivors of IPV/TDV rely on informal, private strategies for managing the abuse (Goodman et al., 2003). Individual approaches, including placating or physically resisting the perpetrator, do not require survivors to disclose the abuse to anyone outside the family nor incur the potential risks of retaliation that may be associated with disclosure or formal help-seeking (Dugan et al., 2003). However, the more a survivor relies on these approaches, the greater the risks of revictimization become (Goodman et al., 2005). Other survivors seek emotional or practical help within their personal networks by discussing their experiences with family or friends. Little is known about the effectiveness of these informal supports. However, research with partner violence survivors who tell family members or friends about their experiences suggests that not all will react supportively and some will disbelieve, misunderstand, or blame the survivor; minimize the abuse; or encourage the survivor to tolerate it (Rivas et al., 2013; Sylaska & Edwards, 2014, 2015).

Therefore, formal interventions represent an important resource for supporting survivor safety. Specialized forms of cognitive behavioral therapy, case advocacy (delivered onsite in a crisis shelter and as a form of aftercare), and legal advocacy (particularly navigating the civil legal system to obtain a protective order) have been shown to improve survivors' quality of life after abuse and to reduce the risk of revictimization (Arroyo et al., 2017; Bell & Goodman, 2001; Sullivan & Bybee, 1999; Sullivan et al., 2018; Xie & Lynch, 2017). Yet reliance on self-referral to such interventions is likely to miss many survivors, who may lack information about what constitutes abuse, familiarity with what services are available, or resources needed (such as transportation or a telephone not monitored by the perpetrator) for accessing them. To help bridge this gap, practitioners and researchers have developed and tested a variety of strategies for giving individuals a chance to disclose IPV and connect them with services. These include traditional "screening" (often involving a short, standardized questionnaire with a validated cutoff) and universal education (typically the review or distribution of information about IPV and available resources to all individuals in a setting).

Brief interventions that include screening and some form of referral or resource education for those who disclose abuse victimization are effective at reducing later violence (Bair-Merritt et al., 2014). A qualitative meta-analysis further suggests that interventions with repeated opportunities (but not pressure) for disclosure and the provision of information and

support, and encounters that occur in a safe and secure environment are welcomed by survivors (Feder et al., 2006). However, research on whether such efforts support participants' well-being in other ways is sparse and inconclusive (Nelson et al., 2012). For example, one randomized, longitudinal study found that an intervention in which providers offered IPV/TDV screening and/or a resource list to all patients had no effect on patients' later physical and mental health-related quality of life (Klevens et al., 2012). Another notable gap is that, although similar efforts to address TDV show promise, most such initiatives have focused on reaching adult populations. A randomized trial in a school health setting found that universal education with adolescents reduced later TDV among those who reported it at baseline (Miller et al., 2015). Though various group-based relationship education models for youth are being tested in schools, systematic initiatives to give youth the opportunity to talk about relationship experiences with a trusted adult and information on where they can get help remain relatively uncommon and understudied.

Beneath these specific gaps lies an even more fundamental problem. Brief IPV/TDV intervention strategies (and research on their effectiveness) generally focus on victimization disclosure as the primary outcome: the proportion of individuals who indicate having experienced abuse and the accuracy of a given tool in differentiating individuals who have experienced IPV or TDV from those who have not. Yet an extensive body of evidence—from psychometric testing of standardized screening tools to qualitative research with survivors—suggests that regardless of the tool, setting, or approach, many survivors will choose not to disclose experiences with abuse to a professional (Miller & McCaw, 2019). Reasons for nondisclosure include fear of consequences, fear of retaliation, concerns about removal of children, and shame. Perhaps even more worrisome is the possibility that the cohort of survivors who opt not to disclose is likely to include some of those in most danger who may be most in need of support to consider their situations and to access resources (see, for example, Johnson et al., 2014). As such, the conventional focus on disclosure-based practice will necessarily fail some survivors (Miller & McCaw, 2019).

Structured interactions about IPV and TDV (including universal education and the administration of questionnaire-style screening tools) could offer an opportunity to support survivor safety regardless of whether individuals choose to disclose. Some partner violence scholars propose safety-related empowerment as the overarching goal of IPV/TDV-related intervention. According to Goodman and colleagues, safety-related empowerment has three dimensions: an individual's internal resources relevant to safety, expectations of support, and assessment of likely tradeoffs of efforts to achieve safety (Goodman et al., 2015). The concept was developed for understanding the experiences of survivors receiving case advocacy or other intensive victim services (not for brief, universal interventions like screening and universal education that are implemented with general populations). Two of its three dimensions, however—internal resources and expectations of support—could also be relevant to understanding how members of a general population (not only self-identified abuse survivors but those who might identify or experience abuse in the future) respond to brief interventions of this nature.

The concepts of survivor-defined practice and survivor-centered services are also helpful for considering how participant-staff interactions during a brief IPV/TDV intervention might support goals other than disclosure. Kulkarni describes a "survivor-centered, full-frame, culturally specific, and trauma informed" approach to IPV service delivery as defined by "power sharing, authentic survivor-advocate relationships, individualized services, and robust systems advocacy" (Kulkarni, 2018, p. 1). Goodman and colleagues' related concept of survivor-defined practice refers to provider-client interactions that are "shaped by clients' goals for themselves, offered in the spirit of partnership, and sensitive to the unique needs, contexts, and ways of coping of individual survivors and their families" (Goodman et al., 2016b, p. 165). While the specific form and context of provider-client interaction that these concepts were developed to describe (that is, ongoing victim advocacy with current abuse survivors) differs from the form and context in which universal education and questionnaire-style IPV/TDV screening tools are typically implemented, both concepts appear relevant for considering the possible collateral benefits (or lack thereof) of these low-touch, universal strategies.

The Role of School and Community-Based Relationship Education

Screening and universal education for IPV/TDV have been primarily implemented and studied in the context of health care delivery (Bair-Merritt et al., 2014; Basile et al., 2007; Chang et al., 2005; Feder et al., 2011; Miller et al., 2011; Miller et al., 2017; Trabold, 2007). Health care settings, particularly prenatal clinics and emergency departments, are well suited to this purpose because many see a disproportionate number of IPV/TDV survivors and because health care providers increasingly recognize the corrosive effects of IPV/TDV on physical and mental health (Elizabeth Miller & McCaw, 2019). They also present some potential drawbacks, including the severe time constraints on patient-provider interactions and uncertainty on the part of some patients regarding whether IPV/TDV is relevant to their medical care (e.g., Kataoka & Imazeki, 2018). However, brief IPV/TDV interventions have been much less applied, and much less studied, outside of the medical context.

School- and community-based relationship education offers an alternative setting for implementing IPV/TDV screening and universal education. The CDC suggests that relationship education programming is a promising approach for preventing and responding to IPV (Niolon et al., 2017). Healthy marriage and relationship education (HMRE) programming, funded by the Office of Family Assistance (OFA) in the Administration for Children and Families at the U.S. Department of Health and Human Services, offers a range of services, including healthy relationship education in high schools and marriage and relationship skills-building for adult couples. HMRE programs have been shown to improve the quality and stability of intimate and co-parenting relationships and reduce the use of destructive behaviors during conflict (Gardner & Boellaard, 2007; Rhoades, 2015). These programs reach broad, racially and socioeconomically diverse populations who report above-average rates of IPV (McKay et al., 2016; Smith et al., 2017). As a condition of funding, federal authorizing legislation requires a commitment from HMRE programs to "consult with experts in domestic violence or relevant community domestic violence coalitions in developing the programs and activities" (Social Security Act 42 U.S.C. 603). These programs are an ideal context for testing brief IPV/TDV intervention approaches. Like health care providers, relationship educators have an opportunity to connect with survivors who may not self-identify as such or may not be able to connect to abuse-specific resources on their own. Such efforts might also benefit from the topical coherence of offering a brief IPV/TDV intervention in the context of healthy relationship education. In addition, it is possible that implementing brief IPV/TDV interventions might precipitate organizational-level shifts among HMRE programs and the local domestic violence agencies with which they partner; however, this possibility has not been explored in prior research.

Key Gaps and Current Study Focus

Within a growing body of work on brief interventions for understanding and addressing IPV and TDV victimization, important gaps persist. First, strategies for reaching youth with universal education and TDV screening have received less emphasis in research and practice than those targeting adults. Second, prior research has focused heavily on assessing the effectiveness of strategies for eliciting disclosure and has attended less to whether these efforts might be associated with positive or negative outcomes other than disclosure. For example, the extent to which staff-participant interactions in the context of universal education and questionnaire-style IPV/TDV screening reflect survivor-defined and survivor-centered practice or are associated with safety-related empowerment has not been evaluated. Third, prior research and intervention have occurred primarily in the health care context. Less attention has been paid to alternative intervention contexts (such as school- and community-based relationship education courses) that could offer distinct advantages relative to medical settings. The potential organizational-level benefit to such organizations of implementing brief IPV/TDV interventions has also not been explored. Addressing these gaps, the current study aims to answer the following questions:

1. Other than disclosure (or lack of disclosure), what are the outcomes of IPV/TDV victimization screening and universal education from the perspectives of HMRE participants, staff and their local domestic violence agency partners?
2. What factors do participants and staff see as shaping the outcomes of IPV/TDV victimization screening and universal education?

Methods

Participants

This study involved a partnership with four HMRE programs funded by OFA: two in the Midwest, one in the Northeast, and one in the Southeast. The sites were selected for their commitment to addressing IPV/TDV and their capacity for enrolling sufficient samples and managing potential safety concerns related to implementing IPV/TDV screening and universal education. Three of the programs delivered relationship education classes to individual adults and adult couples in community settings. Two of the programs delivered classroom-based healthy relationship courses in public and parochial high schools. One program served both youth and adults. Each site received a stipend for their efforts and incentives for study participants. Approval for the study was obtained from the IRB at the research organization leading the study and from the local IRBs overseeing the HMRE programs.

Adult program participants were invited to participate in the study if they were English-speaking, aged 18 or older (or legally emancipated minors), and not incarcerated or in court-mandated substance use treatment. Of the 646 adult participants who enrolled in the study and completed the first brief IPV intervention session, 522 (81%) completed the second and 478 (74%) completed the third. Youth program participants were invited to participate in the study if they were English-speaking, aged 13 or older, and received parent permission. Between 91% and 93% of students who enrolled in the study ($N = 648$) participated at each of the three brief IPV/TDV intervention sessions. Table 1 presents the characteristics of study participants.

Table 1 Demographic characteristics of adult ($N = 646$) and youth ($N = 648$) samples

Characteristic	Adult sample frequency, %	Youth sample frequency, %
Sex and Gender Identity[a]		
Male	30.9	43.4
Female	69.1	56.6
Cisgender	99.5	97.1
Not cisgender	0.5	2.9
Race/Ethnicity		
White	36.4	32.8
Black	19.5	26.7
Hispanic/Latinx	18.0	23.8
Native American	16.6	6.2
Other race or multiple races	9.6	10.5
Educational Attainment		
Less than high school	23.3	NA
High school diploma or GED	40.5	NA
More than high school	36.2	NA
Grade 9	NA	58.5
Grade 10	NA	25.0
Grade 11	NA	9.2
Grade 12	NA	7.4
Sexual Orientation[b]		
Heterosexual	89.5	81.0
Gay/Lesbian/Bisexual/Other	10.5	19.0
Employment and Income		
Working	49.3	NA
Income under $500/mo.	45.4	NA
Income $500–$2000/mo.	36.5	NA
Income over $2000/mo.	18.1	NA
Receiving public assistance	54.9	NA

[a] Assigned sex was obtained from program administrative data. Gender identity was asked of youth in one site (only) and is not mutually exclusive of indication of assigned sex

[b] Sexual orientation was asked of youth in one site (only)

The samples were largely cisgender[2]; whereas more than two-thirds of the adult sample identified as female, the youth sample was more evenly balanced between male- and female-identified participants. The samples were racially and ethnically diverse, including sizeable proportions of Native American adults and youth. Most (81%) adult participants were 25 years old or older and most had completed at least a high school diploma or GED; youth participants were primarily in 9th or 10th grade. The adult sample was socioeconomically diverse and included a sizable proportion of low-income participants and participants receiving public assistance. Adult participants reported a mix of relationship situations and household compositions; 52% reported being in a steady relationship and 55% reported living with children. Nearly 90% of the adult sample and more than 80% of the youth sample identified as heterosexual.

Procedures

The research team provided a two-day in-person training to HMRE program staff on all study procedures. Program staff reviewed the participant consent form with adult program participants during individual intake appointments and collected hardcopy signed consent forms from the participants. Members of couples who were participating in the program together were recruited individually for the study. To maximize safety for individuals who are likely to be more seriously impacted and endangered by partner violence victimization (Black et al., 2011; Cho et al., 2020; Lagdon et al., 2014), female partners in different-sex couples were recruited for

[2] Cisgender refers to individuals whose gender identity matches their sex assigned at birth.

the study first and asked permission for staff to recruit their male partner. Adult participants completed the first brief IPV intervention immediately after providing consent.

Program staff distributed study permission forms to parents of all youth program participants (including youth older than 18, due to high school data collection protocols). Parents needed to be able to read English or Spanish to provide permission for minors. Youth aged 13–17 were asked to sign an assent form and youth aged 18 or older were asked to sign a consent form. On the day of the first data collection session, program staff read the assent form aloud to groups of youth and collected hardcopy signed assent or consent forms. All participants were able to decline study participation and still participate in HMRE programming if they desired.

To enable comparisons among the brief IPV/TDV intervention tools, each tool was offered to study participants in random order over the course of the HMRE program, which ranged in duration from 3 weeks to 3 months. Figure 1 shows the overall study design, whereby the full youth and adult samples in each site were offered each of the three tools in random order over the course of three intervention sessions. Each screening or universal education session took 5 to 10 min and was usually implemented during normal programming time. Participants received a $5 gift card after completing each session, and adult participants received an additional $5 gift card if they completed all three. The brief interventions were spaced at least two days apart; on average, the time between the first and third completed intervention was 60 days for adults and 32 days for youth.

At two of the adult-serving sites, each of the brief IPV/TDV interventions were completed via individual interactions with an HMRE program staff member in a private space. Staff administered the questionnaire-style tools and recorded verbal responses on a tablet. At the third adult-serving site and at the youth-serving sites, participants self-administered the two questionnaire-style tools on tablets in a group (i.e., in a school classroom or an HMRE class setting) with program staff supervision. Participants who were assigned the universal education conversation moved to a private space for an individual interaction with an HMRE staff member. At all sites, staff used a tablet to guide the universal education conversation and showed and gave participants a "safety card" with information about healthy and unhealthy relationship behaviors and local and national resources. Program staff also provided the research team with demographic data for each study participant that was collected during program intake.

After completing the first brief IPV/TDV intervention (whichever of the three it was), all adult participants and youth at one site used the tablet to self-administer questions about their gender identity and sexual orientation that were not collected during program intake. At the end of the third brief IPV/TDV intervention, all participants self-administered an outcome survey about their comfort, knowledge, and perceptions of the tools, resources, and IPV/TDV-related interactions they had with HMRE program staff. Data were transmitted automatically to the research team in electronic form. These additional surveys generally took less than 5 min.

A subsample of study participants were invited to participate in a qualitative interview after they had completed the three intervention sessions and the outcome survey, as shown in Fig. 1. The research team also conducted onsite qualitative interviews with HMRE program staff and their local domestic violence program partners (not shown). Interviews explored how participants and service providers viewed the process and outcomes of IPV/TDV screening and universal education. Nine adult participants; eight youth participants; six HMRE program leadership team members; 16 HMRE program staff (including administrative coordinators, case managers, and facilitators); and five domestic violence program staff were interviewed in total. All interviews were digitally audio

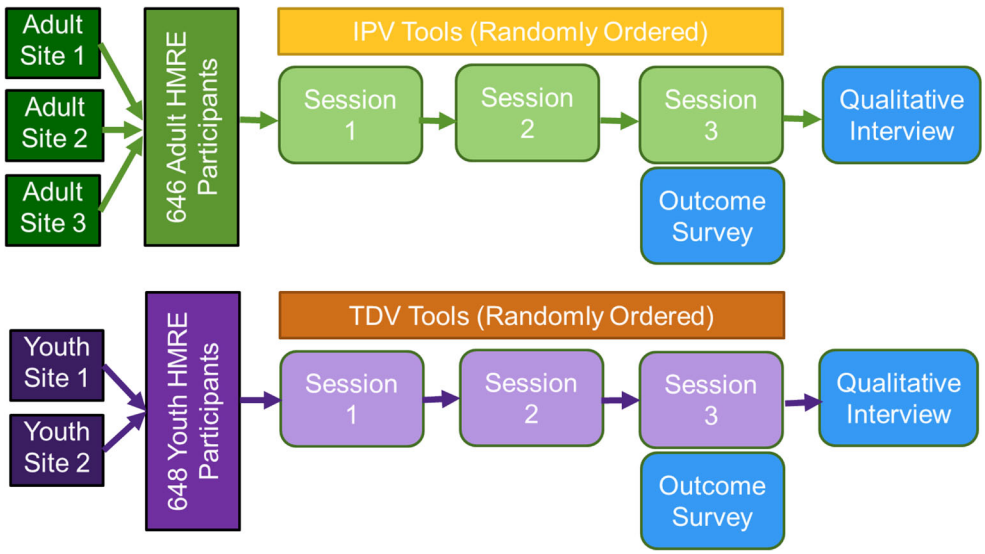

Fig. 1 Study design overview

recorded. A professional transcriptionist prepared de-identified, verbatim transcripts for each interview.

Tools and Measures

Brief IPV/TDV Intervention Tools Selection of questionnaire-style IPV and TDV victimization screening tools was guided by a systematic review of research literature on commonly used tools for inviting IPV and TDV disclosure in 2016 and consultation with researcher and practitioner experts as well as federal staff. The four selected questionnaire-style tools (two for adults and two for youth) measured physical violence, sexual coercion, psychological aggression, and controlling behavior in the past year. For adult participants, one tool included the five-item Universal Violence Prevention Screen (UVPS; e.g., "Within the past year has a partner slapped, kicked, pushed, choked, or punched you?"; Heron et al., 2003) and ten scaled items adapted from the Women's Experiences of Battering (WEB; e.g., "I feel owned and controlled by him or her."; Smith et al., 1995), adapted to be gender neutral. The other tool consisted of the 15-item Intimate Justice Scale (IJS; "It is hard to disagree with my partner because she or he gets angry."; Jory, 2004).

For youth participants, one tool consisted of two items adapted from the Fragile Families Study (FF; e.g., "During the past 12 months, how many times did someone you were dating or going out with try to keep you from seeing or talking with your friends or family?"; Reichman et al., 2001) and two items from the Youth Risk Behavior Survey (YRBS; e.g., "During the past 12 months, how many times did someone you were dating or going out with physically hurt you on purpose?"; CDC, 2016). The other tool consisted of 11 scaled questions about individuals' and their dating partners' behavior. Each question was asked in two parts, for example, "I insulted a partner with put-downs" and "A partner insulted me with put-downs"; only victimization items were used for this analysis. This tool was adapted from the short form of the Conflict in Adolescent Dating Relationships Inventory (CADRI; Fernandez-Gonzalez et al., 2012) to omit items about sexual coercion and to include additional items on controlling behavior and the use of technology to control or cause harm.

The universal education tool was informed by a review of published literature on procedures for open-ended IPV/TDV disclosure opportunities and protocols for universal education. Adapted from the Futures Without Violence model (n.d.) in collaboration with researcher and practitioner experts, the tool guided a one-on-one conversation between HMRE staff and participants about healthy and unhealthy relationships, IPV/TDV concerns, and available resources. This tool offered examples of controlling behavior, physical violence, sexual coercion, and psychological aggression and engaged participants in conversation about these examples. Staff recorded whether participants raised any IPV/TDV-related concerns.

Outcome Surveys The supplemental questions that participants answered after their third intervention session measured their perceptions of the tool and several dimensions of survivor-centered practice and safety-related empowerment. Single items assessing comfort with the screening questions or universal education conversation and perceived privacy were adapted from a pilot test of instruments used to evaluate a family strengthening program. Four items assessing personal agency and mutual respect with staff (e.g., "[Program] staff respect my privacy") were drawn from the Trauma-Informed Practice scales (Goodman et al., 2016a) and the Survivor-Defined Practice Scale (Goodman et al., 2016b). An additional item assessing comfort discussing intimate relationship challenges with staff was adapted from a measure of self-efficacy to implement harm reduction strategies (Tancredi et al., 2015). Two items adapted from the Measure of Victim Empowerment Related to Safety (Goodman et al., 2015) assessed dimensions of internal resources (i.e., comfort asking for help to stay safe) and expectations of support (i.e., whether the participant knew how to access a variety of safety-related resources specific to youth or adults). Finally, an item adapted from the Decisional Conflict Scale (Eden et al., 2015) asked whether the participant knew their options for keeping themselves safe. Demographic items captured participants' assigned sex, gender identity, race/ethnicity, educational attainment, and sexual orientation. In addition, adult participants answered questions about their current employment, monthly income, receipt of public assistance, romantic relationship and cohabitation status, and parental status.

Analytic Approach

All analyses were conducted separately for the adult and youth samples. The quantitative analysis applied descriptive statistics to examine how participants experienced and perceived the brief IPV/TDV interventions and the outcomes (other than disclosure) that were associated with these experiences. To reduce the number of comparisons, we conducted a principal components analysis and examined correlations among the items for each sample. Only one principal component emerged consistently in both samples, which included the four items measuring the participant's sense of agency and of mutual respect with staff. A composite score for each sample was created by taking an average across items; internal reliability (alpha) for this set of items was .71 for youth and .76 for adults. For both samples, we also combined items about the safety-related resources that a participant knew how to access. This composite was created by summing all resource knowledge items; "none of the above" answers were scored 0. Among the remaining five items, almost all correlations were

below .2, and so these items were analyzed separately. All of these items were coded dichotomously; scaled items were collapsed to be dichotomous (highest response category vs. else) because of skewed distributions.

The randomized design meant that approximately one-third of each sample answered the questions in reference to each of the three brief intervention tools. We leveraged this variation to examine differences in participants' responses according to the tool with which they were associated. We used ordinary least squares regression (for continuous outcomes) and logistic regression models (for dichotomous outcomes) in Stata version 15.1 (Stata Corp LP, 2017) to determine whether the mean values for each of these measures differed significantly across three groups: those who answered the questions in reference to each of the questionnaire-style tools, and those who completed it in association with the universal education conversation. We also compared responses by whether participants disclosed IPV or TDV during any of the brief IPV/TDV intervention sessions. Because of significant differences between the sites on several responses, we controlled for site in all models. Given that there were seven domains per analysis for each sample, the critical alpha was adjusted (using a Bonferroni correction) to .05/7 = .007.

The research team prepared a qualitative codebook with deductive codes informed by prior research and the study research questions. The team coded each transcript in ATLAS.ti (Muhr, 1991), adding inductive codes to capture emergent themes. Example deductive codes included "tool content," "responses to intervention," and "partnerships" (pertaining to the first research question) and "setting," "timing," and "staffing" (pertaining to the second research question). Example inductive codes added during the coding process included "contextual influences" and "building rapport and approachability." We then ran structured queries using Boolean language to extract coded textual data on research question one; this included perceived outcomes of the sessions (other than disclosure), including both individual experiences and organizational-level changes. We ran additional Boolean queries to extract data on research question two, focused on examining factors associated with the outcomes identified.

Query results were separated into analytic "bins" corresponding to the sub-groups of primary analytic interest. Since one of the two main study objectives was to identify factors that influenced perceived outcomes of the brief IPV/TDV interventions, we examined differences by site (to the extent that experiences of the three tools might be related to various aspects of sites' approaches to administering them), by role (to understand whether program participants, program staff, and local domestic violence program partners had similar or differing perspectives), and by sample (to examine areas of commonality or difference between youth and adults). The strongest themes related to each of the two research questions were identified within each analytic bin and compared across groups. A file documenting all evident themes, the text passages that substantiated them, and any areas of subgroup difference was prepared and reviewed by the research team. Identified themes (and their organization within each research question) were clarified as needed and finalized by consensus.

Results

Qualitative analysis suggested that most HMRE and domestic violence program staff had initially approached the brief IPV/TDV intervention as a means to an end: a way of identifying victims and survivors to refer them for further services and help to ensure their safe participation in the HMRE program. Over the course of implementation, however, many came to view it as an end in itself and an integral aspect of fulfilling the program's mission. We first present results pertaining to research question one, "*Other than disclosure (or lack of disclosure), what are the outcomes of IPV/TDV victimization screening and universal education from the perspectives of HMRE participants, staff and their local domestic violence agency partners?"* This sub-section includes findings from qualitative interviews with youth and adult participants, HMRE program staff, and their local domestic violence program partners as well as results of logistic regression using outcome survey data from youth and adult participants. It identifies both individual-level and organizational-level outcomes of the protocols. Next, we present results related to research question two, "*What factors do participants and staff see as shaping the outcomes of IPV/TDV victimization screening and universal education?"* This sub-section focuses on themes identified in qualitative interviews with youth and adult participants, HMRE program staff and their local domestic violence program partners. It highlights the role of service delivery context, participant-staff rapport, and staff demeanor when administering the tools.

Outcomes of Brief IPV/TDV Intervention (Research Question One)

Individual-Level Outcomes Individuals who participated in the screening and universal education sessions had a variety of responses to the tools beyond disclosure (or a lack of disclosure) of IPV/TDV. Qualitative analysis revealed a number of commonalities across sites and across sub-groups of interviewees in perceived outcomes of the tools. There was strong consensus that the tools sparked personal reflection and insight, supported participants' awareness of available resources, and sometimes prompted a sense of awkwardness or discomfort, particularly for those who disclosed abuse. Within this general convergence, perspectives on individual-

level outcomes sometimes differed by the interviewee's role–whether a participant, an HMRE staff person, or a domestic violence program staff person. This section explores these commonalities and differences.

While HMRE program staff had expected resistance or negative responses to the brief IPV/TDV interventions, they reported a strikingly positive reception from youth and adults alike. Participants described the interventions as a valuable and supportive experience. Whether or not they had chosen to disclose any personal experiences with abuse, they consistently perceived them as worthwhile. As one young person commented, "This is a pretty important subject. I wouldn't want to be in an abusive relationship. I would want to know how to spot it and how to get out if I was."

Participants and staff all shared the perception that the brief IPV/TDV interventions gave participants a structured opportunity to consider their own relationship experiences. As one youth explained, "Some things they ask you can actually help make you think about whether or not it's worth it if you're in a relationship that sounds like that. They basically ask you what you think. You have to think about it for a second." Staff and participants described the questionnaire-style screening tools as especially valuable in this regard. Participants repeatedly expressed that answering the closed-ended questions in these short tools had provided them with a chance to reflect and gain perspective on their relationships.

> You fill this [tool] out, and then, you realize, when you're answering these questions, like, you start to feel like, "What's normal?" You know? And then, you fill this out, and it's like, "Yeah, he did do this. And yeah, this happened. And yes, I do feel this way." And then, you start to think, "You know what? There's a problem here." (HMRE program participant)

Among adults, the questionnaire-style tools also provided an opening for dialogue with staff about sensitive relationship issues. Such conversations often arose indirectly. Participants had a harder time answering questions with more extensive or precise response options; for example, Likert style responses versus yes/no questions. Their careful consideration of these options (as when a participant asked a staff member for insight about which response option would best reflect a certain situation) often prompted dialogue.

> For some reason, you got more feedback when there was a question—because that opened up a conversation. (HMRE program staff member)

Another common reaction to the brief IPV/TDV interventions was safety-related empowerment. Youth and adult participants tended to report strong familiarity with resources for keeping themselves safe. Further, whether they chose to disclose IPV/TDV or not, youth and adults consistently reported feeling that HMRE program staff knew enough about their situations to support them in staying safe. In qualitative interviews, adult and youth participants reported appreciating the information they had received, including those relevant to IPV/TDV as well as resources for other concerns (such as suicidality). In delivering this information to participants, staff worked to destigmatize service-seeking by combining discussion of IPV/TDV resources with general resources (e.g., a local 211 information line) and offering personal connections to such resources when possible:

> "You can text. You can call…I tell them stories of when I've used 211 for like, recycling Christmas lights, and then with [domestic violence program], I do make the personal connections: 'Hey, have you ever heard of [domestic violence program]? Do you know anything about that?'" (HMRE program staff member)

In the context of the study, this information was generally delivered during the universal education conversation, which (due to the study's randomized design) occurred at varying points in service delivery for different participants. However, staff in some sites began offering a copy of the universal education "safety card" (which included a resource list as well as examples of healthy and unhealthy relationship characteristics) to all participants at the beginning of the program. As one explained, "[Abuse] could be there from day one. I would hate to withhold that information." Participants who experienced this conversation reported strong familiarity with the IPV/TDV-related resources that were available to them as well as confidence that they could seek help from HMRE program staff with IPV/TDV issues if they needed it in the future.

Negative reactions to the brief IPV/TDV interventions were rare. Adult participants who did not have IPV/TDV concerns occasionally noted that the conversations seemed repetitive, while youth sometimes wondered if staff were comparing their answers for consistency. The only example of a more severe negative response observed during the study period was an emotional outburst by an adult male participant who was currently receiving services to address IPV perpetration: the participant began crying and slammed a fist on the table at which he and the staff member were seated. More commonly, participants reported a sense of awkwardness or discomfort with the interaction. Participants and staff noted that the universal provision of information and resources was often socially awkward. HMRE program staff observed that the universal education tool was somewhat harder to administer in a "natural" way and did not tend to provoke much conversation. Staff attributed these challenges to the fact that the tool required reviewing two lists of example healthy and unhealthy relationship characteristics with participants, which tended to

set a didactic tone. Staff recounted that participants sometimes volunteered agreement or disagreement with these examples, but otherwise shared little.

> When you're speaking to them [during universal education], it's like there wasn't that much interaction.… I feel like I was lecturing again a little bit. (HMRE program staff member)

In addition, those who disclosed IPV/TDV experiences described general discomfort, regardless of the type of interaction that precipitated the disclosure. Survey results indicated that adults and youth who disclosed abuse during one of the brief IPV/TDV intervention sessions expressed more concern about their privacy and felt less agency and mutual respect with staff immediately after the session than those who did not disclose (see Table 2). While data also indicate that many survivors opted to share their IPV experiences despite these concerns, some did not (see also McKay et al., 2020a, b).

Survey results regarding the potential collateral benefits of the brief IPV/TDV interventions aligned with qualitative interview data. Quantitative analysis indicated that participants reported high levels of safety-related empowerment after completing the sessions. Table 3 presents descriptive statistics on quantitative responses to the questionnaire-style IPV/TDV tools and universal IPV/TDV education. These outcomes differed somewhat by tool, as shown in Table 4. Adults and youth both reported feeling more comfortable with the content of the universal education tool than with the questionnaire-style IPV/TDV tools. Youth additionally reported feeling more agency and mutual respect with staff after universal education than after questionnaire-style TDV interventions. Quantitative analysis also suggested that the universal education conversation (which incorporated explicit discussion of local and national resources and distribution of a card that included this information) appeared particularly valuable for supporting awareness of local and national IPV/TDV resources. Other differences among youth were tool-specific: Youth reported feeling less concerned about privacy after universal education than after completing the CADRI and reported knowing how to access more resources after universal education than after completing the FF/YRBS tool.

Organizational-Level Outcomes At an organizational level, HMRE and domestic violence program staff converged on the perception that collaborating to implement brief IPV/TDV interventions had led to stronger organizational partnerships, increased organizational capacity among HMRE program staff with regard to responding to IPV/TDV, and new service offerings for their shared target populations. While qualitative analysis revealed few differences in views of organizational-level outcomes by role, some differences by site were evident. These areas of convergence and divergence are detailed in this section.

In implementing the brief IPV/TDV interventions, HMRE staff drew on global guidance and training from their local domestic violence programs and often also consulted them on individual cases. The joint focus on addressing IPV/TDV precipitated regular and open communication between HMRE and domestic violence program staff and helped them cultivate a strong mutual understanding of one another's work. Even among organizations with well-established, longstanding partnerships, staff noted that their joint work to implement the brief IPV/TDV interventions had deepened the

Table 2 Responses by IPV/TDV disclosure status

Dependent variable	Independent variable	Coef.	Std. Err.	P>|z|	N
How comfortable were you with the conversation/ questions?	Any IPV disclosure (vs. no IPV disclosure)	−0.428	0.229	0.062	475
	Any TDV disclosure (vs. no TDV disclosure)	−0.472	0.195	0.015	590
How much of the time were you concerned that someone else might see or hear you answering the questions?	Any IPV disclosure (vs. no IPV disclosure)	−1.189	0.334	0.000*	473
	Any TDV disclosure (vs. no TDV disclosure)	−0.602	0.198	0.002*	587
I am comfortable talking about any challenges I am having in an intimate relationship with a program staff member	Any IPV disclosure (vs. no IPV disclosure)	0.040	0.188	0.833	466
	Any TDV disclosure (vs. no TDV disclosure)	−0.064	0.208	0.760	565
I feel comfortable asking for help to keep safe	Any IPV disclosure (vs. no IPV disclosure)	−0.738	0.277	0.008	473
	Any TDV disclosure (vs. no TDV disclosure)	−0.406	0.196	0.038	574
Do you know your options for keeping yourself safe?	Any IPV disclosure (vs. no IPV disclosure)	−1.027	0.579	0.076	475
	Any TDV disclosure (vs. no TDV disclosure)	−0.743	0.294	0.011	582
Number of resources participants know how to access	Any IPV disclosure (vs. no IPV disclosure)	0.014	0.098	0.890	443
	Any TDV disclosure (vs. no TDV disclosure)	−0.203	0.191	0.290	522
Agency and mutual respect with staff	Any IPV disclosure (vs. no IPV disclosure)	−0.962	0.348	0.006*	477
	Any TDV disclosure (vs. no TDV disclosure)	−0.675	0.177	0.000*	591

*$p < .007$, the critical alpha for these analyses based on Bonferroni corrections for multiple comparisons

Table 3 Responses to structured IPV/TDV-related interactions

	Questionnaire-STYLE		Conversational
Adult Sample	UVPS/WEB N (%)	IJS N (%)	Universal education tool N (%)
Very comfortable with questions/conversation	106 (69.3)	133 (75.6)	128 (87.7)
Concerned about privacy none of the time	137 (89.0)	150 (87.2)	129 (87.8)
Know options for keeping safe	146 (94.8)	172 (97.7)	139 (95.9)
Strongly agree with comfort talking about intimate relationship challenges	81 (53.6)	90 (52.6)	66 (45.8)
Very comfortable asking for help to keep safe	124 (81.0)	149 (84.1)	125 (86.2)
	Mean (SD)	Mean (SD)	Mean (SD)
Agency and mutual respect with staff[1]	3.94 (0.21)	3.93 (0.27)	3.92 (0.28)
Number of resources participants know how to access[2]	1.43 (1.17)	1.38 (0.98)	1.40 (1.03)
Youth Sample	FF/YRBS N (%)	CADRI N (%)	Universal Education Tool N (%)
Very comfortable with questions/conversation	76 (43.9)	89 (45.6)	147 (65.9)
Concerned about privacy none of the time	116 (68.2)	117 (59.7)	171 (77.0)
Know options for keeping safe	148 (88.6)	165 (85.5)	215 (96.4)
Strongly agree with comfort talking about intimate relationship challenges	45 (27.6)	55 (29.4)	88 (40.7)
Very comfortable asking for help to keep safe	95 (56.9)	112 (59.3)	154 (70.3)
	Mean (SD)	Mean (SD)	Mean (SD)
Agency and mutual respect with staff[1]	3.65 (0.56)	3.64 (0.54)	3.81 (0.40)
Number of resources participants know how to access[2]	1.46 (1.69)	1.71 (1.85)	2.10 (2.12)

[1] Agency and mutual respect with staff is an average of four items on a 1 to 4 scale

[2] Number of resources ranged from 0 to 3 for adults and from 0 to 5 for youth

sense of shared goals. An HMRE program staff member explained that the process "push[ed] us to work closer together, get to know one another's resources better, and get on the same page." In one site, for example, the two organizations cultivated a mutual understanding of their organizational missions and operations through extensive reciprocal training: staff from the local domestic violence program and the HMRE program trained one another on the services they offered and their philosophies and strategies for service provision. HMRE program staff delivered their full healthy relationship curriculum onsite at the domestic violence shelter for all interested staff. Domestic violence program staff helped HMRE program staff to understand how domestic violence advocacy worked and offered coaching on how to describe their services to individuals who might need them. This process built respect among staff in each organization for the other's way of working with their shared communities.

The process also helped to develop the HMRE program's capacity for talking about and responding to IPV/TDV. HMRE staff described some initial discomfort around broaching a sensitive and stigmatized subject directly and repeatedly with participants. Soon, however, many reported that the process of engaging their program participants on the issue of abuse had become relatively comfortable. Indeed, many noted that it leveraged skills they already had as educators, facilitators, and case managers. In addition to promoting skill development, the process of implementing the brief IPV/TDV interventions helped HMRE staff understand the limits of their own working knowledge and built a keen awareness of when (and how) to call on the specialized expertise of a domestic violence advocate. This transformation was apparent to local domestic violence advocates as well. One advocate observed:

> They've really done their homework. They've asked a lot of questions. They've done training on their own… it's not like they struggle or they just make something up. They're very willing to just call and say, 'I don't understand this. Please help me,' and that's one of the best things that has happened. (Domestic violence program staff member)

HMRE program staff and participants often commented in qualitative interviews on the strong, natural fit between addressing IPV and achieving their overall HMRE program goals. As one staff member explained, "It was an extension of our program…We like it to be welcoming, we like it to be safe." Staff were motivated to meet the challenge of fitting

Table 4 Results of OLS and logistic regression comparing responses by tool

Dependent variable	Independent variable	Coef.	Std. Err.	P>|z|	N
How comfortable were you with the conversation/ questions?	UVPS/WEB (vs. UE)	−1.180	0.310	0.000*	475
	IJS (vs. UE)	−0.872	0.310	0.005*	475
	FF/YRBS (vs. UE)	−0.884	0.213	0.000*	591
	CADRI (vs. UE)	−0.862	0.206	0.000*	591
How much of the time were you concerned that someone else might see or hear you answering the questions?	UVPS/WEB (vs. UE)	0.088	0.361	0.808	473
	IJS (vs. UE)	−0.068	0.341	0.841	473
	FF/YRBS (vs. UE)	−0.411	0.231	0.075	588
	CADRI (vs. UE)	−0.811	0.217	0.000*	588
I am comfortable talking about any challenges I am having in an intimate relationship with a program staff member	UVPS/WEB (vs. UE)	0.299	0.234	0.203	466
	IJS (vs. UE)	0.256	0.228	0.260	466
	FF/YRBS (vs. UE)	−0.540	0.226	0.017	566
	CADRI (vs. UE)	−0.492	0.214	0.021	566
I feel comfortable asking for help to keep safe	UVPS/WEB (vs. UE)	−0.414	0.323	0.200	473
	IJS (vs. UE)	−0.133	0.326	0.683	473
	FF/YRBS (vs. UE)	−0.544	0.217	0.012	575
	CADRI (vs. UE)	−0.484	0.211	0.022	575
Do you know your options for keeping yourself safe?	UVPS/WEB (vs. UE)	−0.262	0.556	0.638	475
	IJS (vs. UE)	0.589	0.657	0.370	475
	FF/YRBS (vs. UE)	−1.227	0.436	0.005*	583
	CADRI (vs. UE)	−1.515	0.414	0.000*	583
Number of resources participants know how to access	UVPS/WEB (vs. UE)	−0.042	0.073	0.565	477
	IJS (vs. UE)	−0.029	0.070	0.679	477
	FF/YRBS (vs. UE)	−0.692	0.205	0.001*	523
	CADRI (vs. UE)	−0.410	0.198	0.039	523
Agency and mutual respect with staff	UVPS/WEB (vs. UE)	0.042	0.387	0.914	477
	IJS (vs. UE)	−0.083	0.367	0.820	477
	FF/YRBS (vs. UE)	−0.755	0.204	0.000*	592
	CADRI (vs. UE)	−0.790	0.198	0.000*	592

*$p < .007$, the critical alpha for these analyses based on Bonferroni corrections for multiple comparisons

IPV/TDV screening, universal education and follow-up into their existing work with participants, perceiving that addressing abuse and promoting healthy relationships were not two disparate activities competing for their time, but mutually reinforcing and complementary objectives. Indeed, some staff observed that the IPV/TDV-related interactions with participants, in part because they were so personal, helped to build rapport and a sense of personal care and trust between staff and participants: "It just opens the door to have that difficult conversation…It really added more value to the program." Particularly in adult-serving HMRE programs, the individual relationships and understandings of participants' lives that staff built through the process of IPV/TDV-related interactions became an asset that allowed staff to deliver their relationship education curricula more effectively.

In several communities, HMRE and domestic violence program staff were inspired by their joint work to collaborate on developing other local resources and community-wide education and awareness-raising activities designed to benefit their shared target populations. In one community, the local domestic violence program had not previously offered dedicated services for TDV survivors. As a result of their joint work with the HMRE program, domestic violence program staff reported that they were expanding their youth programs and cultivating new approaches and options for meeting TDV-related needs. One advocate noted that addressing this gap was a natural extension of the core philosophy underlying their work: "Everyone has to have a willingness to serve all victims."

Influences on Outcomes of Brief IPV/TDV Intervention (Research Question Two)

Inductive analysis of participant and staff perspectives identified two major factors that seemed to shape collateral responses to brief IPV/TDV interventions: the service delivery

context in which the tools were administered, the rapport between staff and participants, and staff demeanor when administering the tools.

Service Delivery Context Participants saw the HMRE program as offering a safe environment for learning and sharing about relationships, including IPV/TDV issues. Youth and adult participants and staff suggested that the general focus on relationships helped to normalize conversations about abuse, while safety protocols and confidentiality protections helped to set participants at ease. An adult participant who was in an actively abusive relationship during the time she was participating in the HMRE program explained:

> I felt safe there.… He wasn't there. He was at work when I went there. It's in a safe spot. They keep the doors locked. You know, all the people that are involved in that program are very familiar with domestic violence—and other things, you know. That happened to be my particular issue. Other people had other issues. But I felt very safe, and I felt that confidentiality was maintained. (HMRE program participant)

Participants also explained how group dynamics in the healthy relationship classes encouraged them to consider and share about difficult personal relationship experiences and issues. One participant described it as a "family" atmosphere. Another explained, "They created an environment where everyone just felt comfortable with each other and non-defensive." Some noted that it was peer-to-peer exchanges—particularly the opportunity to get feedback or to benefit others in the class who might face similar situations—that motivated them to reflect and share about their own experiences.

> I would share, like, when we had our group's discussions. You know, I was actually in a really good group of girls…. We were all really supportive of each other, and, like, I didn't feel ashamed or embarrassed or whatever to share anything. (HMRE program participant)

Being part of a class with people of similar cultural backgrounds or who had other major life experiences (such as recovery from addiction) in common set participants at ease and further invited this kind of sharing. This atmosphere supported some participants in recognizing past or current experiences with IPV/TDV and prompted others to think about what they might do if they ever encountered abuse in a relationship.

Among youth, this kind of reflection was supported less by peer-to-peer dynamics and more by an interactive, conversational style of curriculum facilitation that included discussions and other reflective activities (such as journaling). These approaches encouraged youth to personalize the concepts being taught. Youth and staff emphasized that an interactive style of relationship education supported positive outcomes of the brief IPV/TDV interventions.

> They didn't judge nobody. They didn't single nobody out and stuff. They made sure everybody participated. It felt safe. (Youth participant)

Offering a personal perspective while delivering curriculum content and taking a non-judgmental tone when teaching about youth relationship issues (e.g., sex before marriage or the decision to end a relationship) set the stage for youth to reflect openly on experiences with abuse.

Participant-Staff Rapport The nature of the healthy relationship courses that HMRE programs delivered, which were typically completed over the course of 10–12 weeks, required staff to develop trust and rapport with participants over a short time. Given the sensitive and stigmatized nature of abuse, this rapport building was particularly essential as a foundation for positive participant experiences during the brief IPV/TDV intervention. Staff found that conveying empathy, non-judgment, and sensitivity in all interactions contributed to this foundational work.

> You are just connecting, you're making them comfortable…making [participant] laugh, and it's just creating a bond and her feeling comfortable…. I think that's what's important. Truly just being yourself and just creating a bond. (HMRE program staff member)

Staff largely succeeded in this effort; participants reported very positive first impressions of HMRE program staff, whom they saw as warm and approachable. A typical participant described her staff contact at the HMRE program as "very warm, welcoming, and understanding about my situation." Many commented that they felt most at ease when staff cultivated a sincere, person-to-person connection, rather than having strictly functional or scripted interactions. Participants and staff often noted that shared culture or other shared life experiences made it much easier for them to relate authentically.

> She's a Native woman like me, from our culture. We look for connections, how we connect tribally. We got into that conversation, and so we go from there and start going over the forms, what brought you in today…and she told her story. (HMRE program staff member)

Participants observed that staff warmth and relatability made them feel like the HMRE program was an environment where they could ask for help with IPV/TDV if they needed it.

Staff Demeanor while Administering Tools Youth and adult participants were keenly attuned to staff affect and the manner in which they delivered the IPV/TDV tools. Youth noted that an overly formal staff manner could set an uncomfortable tone for the interaction. One youth participant exhorted staff to avoid creating an officious atmosphere around thse interactions:

> Don't make it awkward… Don't just come in, stack your papers, and start reading those. Have a conversation with them. Make them feel like you're there to talk to them, not just marking checkmarks on the survey. (Youth participant)

Time pressure represented another contextual issue that appeared to shape participants' responses to screening and universal education. Although participants and staff all saw the IPV/TDV tools as very short, staff acknowledged that the process of administering the tools—particularly during the initial program intake meeting or on the first day of class—could be challenging to balance with other initial paperwork (such as intake forms and program evaluation paperwork). In sites where staff found the balance a struggle, participants picked up on it, noting that staff had seemed rushed or time pressured in these interactions.

Adult and youth participants observed that staff who approached the IPV/TDV-related interactions in a relaxed way and sought to connect on a personal level helped them feel more comfortable sharing about their lives. One HMRE staff member stressed that it was important when asking questions about abuse that "whoever's listening is actually listening, you know—giving them that respect, and then not interrupting them…responding in a respectful, kind way." Staff emphasized that a caring tone and genuine interest prevented an "impersonal vibe" and helped to turn the screening and universal education sessions into an opportunity for getting to know a participant as an individual. This approach, in turn, fueled staff members' ability to facilitate meaningful and engaging interactions during the group-based relationship education activities.

> It's a sensitive subject, so it can't be approached without any feeling or thought. It has to be something that you're sensitive to....but you have to be comfortable talking with them about it, being empathetic and non-judgmental….the success really falls on how the staff will give the [tool]. (HMRE program staff member)

A meaningful, personal connection was particularly helpful for the universal education conversation, which one adult-serving staff member noted could feel "like false intimacy" without solid rapport. Youth participants and staff in youth-serving programs agreed that authenticity was critical for realizing the potential positive outcomes of universal education.

> [HMRE staff member] was really great. She really knew how to do an interview and she said that she had [children] and you just felt like you knew who she was and you could talk to her. That really helped. (Youth participant)

Youth felt that staff who shared about themselves, expressed non-judgmental attitudes about youth relationships, and interacted with youth in a warm (and not overly formal) manner were better able to set a relatable, approachable tone during these interactions.

Discussion

Contributions and Implications for Policy and Practice

The pervasiveness of IPV and TDV and the profound difficulties survivors face in accessing specialized victim services has prompted researchers and practitioners to explore brief IPV/TDV intervention strategies that make proactive contact with survivors rather than waiting for them to seek services. This prior work has focused heavily on the use of questionnaire-style tools to elicit IPV disclosures from adults in health care settings—with less focus on youth (or TDV), non-questionnaire-style tools, or community settings other than health care. Perhaps most importantly, prior work has rarely examined whether other processes and outcomes, such as trauma-informed and survivor-centered practice (Goodman et al., 2016b; Kulkarni, 2018) and safety-related empowerment (Goodman et al., 2015), might be realized in brief IPV/TDV interventions outside of a victim services setting. The current study began to address these gaps, leveraging several methodological strengths: a randomized design, the inclusion of both adult and youth study populations (with tools appropriate to each study population and adequate sample for each), and an integrated analysis of qualitative and quantitative data from the same settings and populations.

Study results regarding the implementation of questionnaire-style tools and universal education in community settings are both promising and provocative. The tools elicit a variety of positive reactions from participants other than disclosure: they appear to support some aspects of safety-related empowerment and also to serve as a prompt for personal reflection on relationship experiences and an opening for dialogue with staff. Regression results underscore the importance of universal education approaches (compared to traditional, questionnaire-style screening) in promoting positive outcomes other than disclosure. Qualitative findings highlight that the way these protocols are delivered by staff—

whether relaxed or hurried, warm or officious—appears to matter at least as much for purposes of such outcomes as do the protocols themselves. Further, whether an interaction includes a disclosure also matters: findings suggest that interactions in which disclosure occurred were less comfortable, suggesting a potential tradeoff between the goal of eliciting disclosure and other goals that such interactions might achieve. Indeed, this issue might have confounded the observed association between universal education and adults' greater self-rated comfort, which contradicted the qualitative results; comfort was inversely correlated with disclosure, and disclosure was much less likely as part of the didactic universal education protocol.

Results of this study lend empirical weight to an emerging call to attend to other potential outcomes of IPV/TDV screening (and other forms of brief intervention) beyond disclosure. Some studies have documented occasional adverse effects of such interventions, including distress, discomfort, or loss of privacy (see Nelson et al.'s, 2012 review). The current study suggests that they might also carry collateral benefits for participants, such as safety-related empowerment. The process of implementing brief IPV/TDV interventions may also catalyze positive organizational-level changes for HMRE programs and local victim service providers.

Findings point to promising possibilities for broader implementation of such interventions in HMRE programs and in other health and human services settings as well. They also indicate that replication in other community contexts will require care and discernment. Some prior research suggests that simply providing a resource list (on its own or as accompaniment to a questionnaire-style tool) in a likely hurried medical setting does not support later quality of life among participants (Klevens et al., 2012). However, other research finds that offering TDV-related information and resources to adolescents in pediatric and school health settings can be effective (Miller et al., 2015; Miller & McCaw, 2019). Alongside these prior findings, results from the current study point to the importance of *how* brief IPV/TDV interventions are delivered and to the underlying need for strong alignment between the provider, program, or agency mission and the goals of brief IPV/TDV intervention. Many providers face unavoidable time pressure and must manage multiple priorities during their interactions with clients and patients. The results of this study suggest a critical role for organizational leadership in giving clinicians and frontline service providers the time and tools they need to forge a sincere human connection with those they serve (see Miller & Levenson, 2013 for further guidance) and communicating clearly that addressing IPV/TDV enhances providers' other goals.

Limitations and Implications for Future Research

Several methodological limitations should be borne in mind when interpreting the results of this study. First, selection bias could have affected responses to qualitative interviews. Although prospective participants were randomly selected and independently recruited by study staff (regardless of their ongoing participation in the program), it is possible that those who were still engaged in the HMRE program or who had positive experiences in the program or with the brief IPV/TDV interventions might have been more likely to respond. In addition, due to the modest sample size for the qualitative interviews, we were not able to systematically assess differences in qualitative themes by race/ethnicity, gender, or other sociodemographic variables. Although no statistically significant racial/ethnic differences were evident in quantitative analysis (results not shown), cultural and community connections among participants and between staff and participants emerged as highly salient in the qualitative analysis. This suggests that future research to better elucidate how sociodemographic differences shape participants' qualitative experiences of IPV/TDV screening and universal education would be fruitful.

Second, caution should be exercised in generalizing these results to other settings. The HMRE programs included in this study were purposefully selected based on their strong service delivery strategies and commitment to safe and healthy relationships; they do not represent all HMRE programs nationwide. The study sites' ability to implement brief IPV/TDV interventions in a manner that promoted reflection and increased resource awareness among participants might not be generalizable to all such programs. However, qualitative data across all sites converged strongly on the idea of a natural accord between HMRE program goals and work to address IPV/TDV, which suggests that such programs do represent a promising setting for reaching large adult and youth populations with brief IPV/TDV intervention. Future research is needed to explore whether such alignment exists in other clinical and non-clinical settings and to what extent the results obtained in the current study are sensitive to its presence or absence.

Third, the cross-sectional design of this study does not support causal inference. The potential benefits of the tools were measured at a single time point, immediately after the final brief IPV/TDV intervention session (and captured the outcomes associated with whichever of the three tools a participant had been randomly assigned to received during that session). Future studies should apply longitudinal and experimental designs to further examine outcomes other than disclosure, including safety-related empowerment and self-efficacy.

Finally, due to the dearth of validated measures for understanding potential non-disclosure outcomes of brief IPV/TDV interventions, this study used adapted measures that have not been formally validated. The development of validated measures of these constructs that can be used for assessing outcomes of brief, general-population-focused IPV/TDV

interventions in community settings (that is, settings other than specialized victim services) is an important future direction for the field of research. Such measures, if they are brief enough to be incorporated into IPV/TDV-related interactions without adding substantial burden, would support not only further research but also real-time feedback from participants to practitioners.

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Declarations

Conflict of Interest The authors declare that they have no conflict of interest.

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