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Review

Psychometric Test Review of the Abusive Behaviour Inventory (ABI)

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Abstract: This paper examines the Abusive Behaviour Inventory (ABI), which is regarded as an efficient self-report measure with demonstrated high reliability and validity. This examination aims to determine the tool's effectiveness when screening for victims of domestic violence and present recommendations for how the device may be improved. Within this critique, the ABI is analysed through a literature review and the exploration of the tool's development. A detailed overview of the ABI is included, and its reliability and validity are critically reviewed. Findings from the research base of this tool are presented and also discussed. While the ABI is regarded as an efficient self-report measure which has been demonstrated to have both high reliability and validity, after evaluation, implementing a structured professional judgement (SPJ) approach is recommended. This would expand the tool's utility to include risk and safety assessment. In addition, methods and considerations for including LGBTQ relationships are introduced. Finally, implications for the ABI's use in informing batterer intervention programs are highlighted. It is concluded that more research is warranted to continue increasing the ABI's applicability to different intimate relationship archetypes and populations.

Keywords: ABI; domestic violence; intimate partner violence; validity; reliability

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1. Introduction

Domestic violence is a significant public health issue that spans the globe and relationship paradigms. Both mental and physical health repercussions are associated with domestic violence, including depression, suicide, injuries, and death (WHO 2013). The lifetime prevalence rate of intimate partner violence (IPV) data for women shows that 641 to 753 million women have experienced IPV since the age of 15 (WHO 2021). Researchers in the area of domestic abuse have highlighted the importance of assessing domestic violence to better assist public health (Graham et al. 2019). More specifically, researchers have stated that information needs to be obtained about the content types, the genders of perpetrator and victim, and methods to evaluate underreporting and overreporting (Follingstad and Rogers 2013).

The ABI is a domestic violence screening measure used to detect the presence of intimate partner violence. There are questions concerning physical abuse, psychological abuse, and sexual abuse. This tool aims to alert healthcare professionals to victims of domestic violence so they can provide safety resources. Shepard and Campbell (1992) are the original creators of the ABI. Within their paper, they include an examination of the ABI's psychometric properties which provides data to suggest that the ABI is a respectable tool.

1.1. Evolution of the ABI

The ABI was initially developed by Melanie Shepard in 1984 and was devised to evaluate the Duluth domestic intervention program. The ABI's items were developed from the "power and control" wheel, originating from female victims' experiences of domestic violence. The instrument is based on a feminist perspective that conceptualizes that men maintain patriarchal power and control over women through coercive techniques, including physical, sexual, psychological, and economic abuse (Ali and Naylor 2013). The "power and control wheel" contains behaviours such as using male privilege, threats, coercion, emotional abuse, physical and sexual violence with the aim to maintain power over the victim. These conceptions are conveyed through the items in the ABI concerning intimidation, causing fear, physical and psychological violence that assume that the motivation of the perpetrator is power.

There is a revised version of the ABI, called the Abusive Behaviour Inventory—Revised by Postmus et al. (2016). The original ABI consists of items over physical, psychological, and sexual abuse; however, it only contains physical and psychological subscales. Questions concerning sexual coercion are included within the physical abuse subscale. After conducting a confirmatory factor analysis and explanatory factor analysis, Postmus et al. (2016) concluded that the creation of a third subscale for sexual abuse would be an improvement for the ABI. Implications from treating sexual abuse as its own method of IPV include better-informed risk assessment and more individualized treatment for victims (Postmus et al. 2016). The presence of sexual assault within domestic violence is a common occurrence and is associated with verbal threats and additional physical violence, such as nonfatal strangulation (Zilkens et al. 2016). So, to better understand the predicament of a specific victim and evaluate their risk of experiencing future violence, a sexual abuse subscale is a necessity. The ABI-R has been used and found effective in recent research for screening victims of relationship violence based on a clinical cut-off score of eight (Voth Schrag and Edmond 2018). However, there continues to be literature advocating for the expansion of types of IPV measured by the ABI. Item content pertaining to economic abuse was deemed too limited to support the inclusion of an economic abuse subscale (Postmus et al. 2016), but this type of abuse is frequently found within IPV and is uniquely correlated with depressive symptoms (Stylianou 2018).

1.2. Utility of the ABI

The ABI measures the frequency of physical and psychological abuse that females experience from their partners over a 6-month time frame. The tool can be used with both men and women and can distinguish between women who are abused and women who are not, as well as men who are abusers and men who are not. The ABI is a self-report scale; thus, when interpreting men's responses, it is important to be cautious. Research has shown that male perpetrators of domestic violence are likely to minimize or underreport their abusive behaviours, especially on self-report measures with no response-monitoring system (Strang and Peterson 2020). The authors of the ABI take this into consideration by recommending that, when males complete the tool, the researcher maintain caution in their interpretation as the responses may not be totally accurate. However, the ABI fails to recommend that the researcher should also be cautious when women complete the tool. Research has found that both men and women in relationships reported being a victim more than their partners reported being a perpetrator, revealing a reporting bias on behalf of both men and women (Renner et al. 2015). It is therefore important that the researcher is equally cautious when interpreting both women's and men's responses, as both genders have the potential to answer dishonestly. The ABI's self-report measure for both men and women is identical apart from the use of a different pronoun. For example, women are asked how often "did your partner kick you" and men are asked how often they had "kicked her".

1.3. Scoring of the ABI

The ABI consists of 29 items altogether. Initially, the instrument consisted of 30 items, but 1 item was removed due to low response rates. The instrument is estimated to take 15 min to complete, and it is divided into two subscales (psychological abuse and physical abuse). The psychological abuse subscale consists of 17 items drawn from the sub-categories of emotional abuse, isolation, intimidation, threats, use of male privilege, and economic abuse. The physical abuse subscale consists of 12 items involving physical acts (e.g., hitting and choking) and sexual abuse (e.g., forced or pressured to engage in unwanted sexual acts). Respondents are asked to rate on a 5-point Likert-type scale how often they have abused in the case of men or been abused in the case of women, from 1 (never) to 5 (very frequently). To obtain an overall score, the values of all answered items are summed together and divided by the total number of answered questions to yield a score from 1–5. To calculate individual subscale scores, the values of answered items in that subscale are summed together and divided by the number of answered items in that subscale, yielding a value from 1–5. Higher scores are indicative of a greater level of being abused or abusing. Scores produced are the overall level of abuse, psychological abuse, and physical abuse.

2. Criticisms of the ABI

The ABI is regarded as an efficient and effective domestic violence screening tool; however, it has been criticized for several reasons. Zink et al. (2007) criticized the tool for not providing clinical cut-off scores that would indicate a victim's level of being physically or psychologically abused. Zink et al. (2007) investigated this and suggested a cut-off score of 10 for the two subscales (psychological/physical). Zink et al. (2007) rationalized that cut-off scores were important as they helped healthcare professionals and other professionals in their decision making when screening for domestic abuse. More recent literature has continued to hold the same opinion regarding the usefulness of assessments in conjunction with clinical judgement (Whiting and Fazel 2019).

Another criticism of the ABI is that it only focuses on abuse perpetrated or received within the last 6-month period. This may lead to an incomplete picture of violence the victim is suffering because some forms of violence are progressive or episodic (Ali et al. 2016; Ornstein and Rickne 2013). Short assessments such as the ABI are not likely to capture the actual extent of abuse as they only ask for abuse occurring within the last 6 months; therefore, any abuse prior to this will not be identified by the tool.

The ABI also fails to consider individual differences or circumstances for victims or abusers. For example, not all victims or abusers will have children. Yet, one of the questions on the ABI (item 11) assumes that all victims will have children, asking whether the perpetrator has tried to use their children against the victim. For victims who have no children, they will respond never, causing them to have a lower score for psychological abuse. However, this does not mean that the victim is not being psychologically abused in other ways. Other examples of the item's lack of applicability to every victim include items that ask about work or school (item 22). Again, not all victims may go to work or school, and with the item (item 17) asking 'has your partner driven recklessly when you were in the car', it may be that their partner does not drive, but they may still be intimidating in other ways. Therefore, adaptations need to be made to the ABI's items, as the currently existing items are likely to not apply to every victim and fail to take into account individual differences in circumstances.

Other criticisms of the ABI are that it is based on traditional feminist theory, which may limit the applicability of the measure. Traditional feminist theory builds on power, specifically patriarchal ideals of power which subordinate women. These ideals constitute the "Power and Control Wheel" (Cannon et al. 2015). The feminist theory of domestic violence is greatly responsible for IPV becoming a mainstream topic and inspiring policy changes. However, it is severely limited in its applicability and empirical support (Cannon et al. 2015). Thus, the ABI fails to provide a foundational understanding for LGBTQ and male victims of domestic violence. Walker et al. (2020) researched men's experiences with

IPV and their reporting behaviours. Their investigation revealed that up to 55.4% of men had experienced abuse from their female partners, and terms such as "boundary crossings" were used instead of domestic violence. The change in language served to reconcile the lack of identification men have with words such as "abuser" and "victim" that have gendered connotations. Men also noted barriers to reporting IPV, including fear of emasculation, police and care provider stereotyping, and not recognizing behaviours as abusive (Walker et al. 2020).

The ABI also fails to take into consideration situational motivations for abuse. Research indicates that abuse risk increases when partners become separated, and this violence can occur without previous abuse in the relationship (Ali et al. 2016). Further to this, violence upon separation is observed in both men and women and can increase with allegations of abuse (Ali et al. 2016). Therefore, the ABI is highly criticized for failing to consider the whole context, for example, the current state of the relationship and different motivations for violence.

The ABI is further criticized for not asking about both partners' possible use of violence and abuse. Research has found that domestic violence can be mutual and in the form of resistance, such that violent resistance can increase abusive actions taken by the other partner (Ali et al. 2016). In addition, there is some evidence of the progression of IPV, and what may begin as predominantly male or female perpetration can evolve into mutual aggression (Leonard et al. 2014). Research concerning female perpetration seems to indicate that some forms may be retaliatory from being victimized, but this would only be one form of female-perpetuated abuse, as research has demonstrated that women can be both the instigators and equally aggressive as their partners (Ali et al. 2016).

For a very long time, the Conflict Tactics Scale (CTS) created by Murray Straus in 1979 was one of the most widely used scales to measure family violence (Straus 1979). However, this scale received extensive criticism, resulting in a second version being devised, the Conflict Tactics Scale Version 2. The CTS original version was criticized for many reasons, one of which was the combination of violent and non-violent acts of abuse within the same measure (Jones et al. 2017). The scale was further criticized for not focusing on the context of the situation, motives, and severity (Jones et al. 2017). Other criticism derived from the fact that this scale did not measure intimate partner violence specifically, but rather, was based on the conflict theory, which measured conflict in general. Therefore, it misrepresented domestic violence and failed to account for other elements such as controlling behaviours (Jones et al. 2017). The CTS-2, its second version, has received similar criticisms. The CTS-2 remains limited in its assessment of content types of IPV and situational contexts, still not accounting for perpetrator motivations (Jones et al. 2017). Such problems with the CTS and CTS-2 resulted in the development of the ABI. Shepard and Campbell (1992) devised this instrument to address the flaws that were identified in earlier questionnaires such as the CTS. Firstly, these measures differ in their theoretical underpinning. The CTS-2 has a conflict theory foundation, while the ABI is based on a coercive control model, including various abusive behaviours (Postmus et al. 2016). While the CTS-2 assumes a present conflict and acts of violence to be isolated incidents, the ABI includes behaviours that are intended to hurt and control partners (Postmus et al. 2016). This is a limitation of the CTS-2, as respondents are not given the opportunity to report abuse that is related to control or abuse not arising out of a known cause such as a conflict situation. For this reason, the ABI appears to be a better measure than the CTS and the CTS-2, as this tool does not assert that a conflict must occur for abuse to occur. Inclusion of more behaviours that take place within the context of domestic violence is an advantage because this increases the measure's sensitivity, making it less likely to produce false negatives, and increases its applicability to more types of IPV.

Other questionnaires continue to be criticized due to their lack of assessment of multiple types of abuse and excluding psychological abuse. In a review of 10 IPV measures, only three tools assessed psychological abuse (Arkins et al. 2016). Those which screen for psychological abuse are the Abuse Assessment Screen (AAS), Humiliated Afraid Kicked

and Raped (HARK), and Hurt Insulted Threatened or Screamed at Questionnaire (HITS), but HITS does not assess sexual assault (Arkins et al. 2016). Thus, Shepard and Campbell's (1992) ABI instrument is supported not only for its ability to measure intimate partner violence, but also for specifically examining psychological abuse as this has not always been investigated by researchers. Another measure called the Composite Abuse Scale (CAS) covers items concerning physical, sexual, and psychological abuse (Ford-Gilboe et al. 2016). However, this measure aims to capture a woman-oriented experience of abuse (Ford-Gilboe et al. 2016). Therefore, it is not applicable to males and victims who do not identify as female. In addition, all of the measures mentioned are in need of additional research to further determine their validity and use with diverse populations (Arkins et al. 2016; Ford-Gilboe et al. 2016).

This review of the ABI is necessary because other domestic violence measures, such as the CTS-2 and the CAS-R, continue to be updated. Bringing the ABI up to date and increasing its applicability can aid in identifying victims of IPV. Use of the ABI and ABI-R remains prevalent within the literature (Postmus et al. 2016; Stylianou 2018; Voth Schrag and Edmond 2018; Garrison et al. 2019; Wong and Bouchard 2021; Johnson et al. 2022; Postmus and Stylianou 2023), signalling its relevance. Within this review are recommendations for improvement that expand the utility of this measure. It is possible that the ABI may be used for risk assessment, risk management, and informing treatment plans for both victims and perpetrators. Therefore, this screener can be crafted into a tool to combat public health concerns from multiple vantage points.

3. Psychometric Properties

According to the American Psychological Association's (2017) Ethical Principles of Psychologists and Code of Conduct, the appropriate use of a psychometric assessment relies on its reliability, validity, and the population used to calibrate the test. Koocher and Keith-Spiegel, in their book *Ethics in Psychology and the Mental Health Professions* (Koocher and Keith-Spiegel 2016), assert that it is good practice for psychologists to examine psychometric properties of assessments to understand their strengths and limitations. The authors of the ABI did indeed examine the tool's psychometric properties and provided data to show that the instrument does have good reliability and validity, and this is further discussed below.

3.1. Reliability

3.1.1. Internal Consistency

Shepard and Campbell (1992) reported the ABI to have good internal consistency following a study that they conducted in which they surveyed 100 men and 78 women. Males were selected from a chemical dependency treatment program; the females who participated were these males' partners. They were each classified into one of four groups: females were either abused/not abused and males were either an abuser/not abuser. Relationship abuse was assessed during an interview with the males, and the females later completed an ABI questionnaire. Internal consistency was calculated using the alpha coefficient (Cronbach 1951). This manner of calculating internal consistency is the most common since the creation of the Cronbach alpha coefficient (Souza et al. 2017). Shepard and Campbell (1992) reported alpha coefficients for the four groups (abused/not abused; abuser/not abuser) ranging from 0.70 to 0.92. Therefore, the ABI was deemed to be very reliable, as the value for adequate to ideal internal consistency ranges from 0.6 to 0.7 or greater (Souza et al. 2017).

3.1.2. The Standard Error of Measurement

The standard error of measurement shows how much variability should be expected with repeated testing of the same person based simply on methods of measurement. Therefore, this is essential for the interpretation of scores from individuals (Polit 2015). Shepard and Campbell (1992) reported that the SEM scores for the four groups ranged from 0.04 to 0.12 in their study (See Table 1 below for alpha coefficients and SEM scores for

the two subscales). Having a low standard error of measurement is crucial for domestic violence, as it informs risk assessment and risk management plans of individual patients.

Table 1. Alpha coefficients and standard error of measurements for the two subscales (no abuse/abuse).

	No Abuse		Abuse	
Men	Alpha	SEM	Alpha	SEM
ABI-psychological	0.79	0.06	0.88	0.08
ABI-physical	0.82	0.03	0.82	0.07
Women				
ABI-psychological	0.92	0.11	0.88	0.12
ABI-physical	0.88	0.07	0.70	0.08

3.1.3. Test Re-Test Reliability

The authors did not report test re-test reliability for the ABI. This is a weakness because the ABI only covers abuse within a 6-month period, and victims need to be continually assessed to monitor progress. Lacking information on this type of reliability is a gap in the literature.

3.2. Validity

3.2.1. Face Validity

Regarding the ABI, it can be concluded that this instrument does measure whether an individual has perpetrated or been a victim of physical/psychological abuse within a 6-month period. Therefore, it can be considered to have face validity. However, face validity is subjective and lacks scientific support; hence, the other areas of validity must also be considered.

3.2.2. Criterion Validity

Shepard and Campbell (1992) reported that the ABI has good criterion (concurrent) validity in their study. The established difference upon which they evaluated the criterion validity was the grouping of abused and non-abused participants. They found that mean scores for psychological and physical abuse in the abuser/abused group were 25% higher than in the non-abuse groups. For males, the difference in group means was 0.55 (psychological abuse subscale) and 0.42 (physical abuse subscale) and the differences for the females' group means was 0.80 (psychological abuse subscale) and 0.55 (physical abuse subscale). Therefore, the ABI did show good criterion validity in both cases and significant differences were observed at the 0.001 level.

3.2.3. Construct Validity

In their study, Shepard and Campbell (1992) reported the ABI to have good construct validity, possessing both convergent and discriminant validity. They found variables that are highly related to abuse in relationships (such as clinical assessment of abuse, client assessment of abuse, and previous arrest for domestic violence) to be significantly correlated with the subscales for both men and women. In addition to this, they found variables believed not to correlate as highly with domestic abuse; for example, household status and age did not correlate as highly with the subscales for men and women as did the other variables. This study, therefore, provided sufficient evidence to suggest that the ABI does have construct validity.

Additional research conducted by Zink et al. (2007) compared the ABI to the CTS-2. The correlations of the ABI and CTS-2 total scores were 0.76 with significant differences at the 0.001 level (Zink et al. 2007). The correlations of the physical abuse subscale of the ABI with the verbal physical aggression, injury, and sexual coercion subscales of the CTS-2 were 0.71 with significant differences at the 0.001 level (Zink et al. 2007). Similarly,

correlations between the psychological abuse subscale of the ABI with the verbal aggression scale of the CTS-2 were 0.74 with significant differences at the 0.001 level (Zink et al. 2007). This illustrates that the ABI has adequate criterion validity and is comparable to a well-established measure such as the CTS-2.

3.2.4. Factor Validity

Shepard and Campbell (1992) examined the factorial validity of the ABI by computing the correlations between each item. They found that although many items were highly correlated with related variables, some were correlated with unrelated variables, behaviour, or being violent towards objects. Therefore, it made sense that these items correlated with both the psychological and physical subscale. Other modifications to the test involved the omission of item 21 (being spanked), as a result of this item having negative connotations and receiving a low response rate. For example, 93% of participants in their study stated that they had never been spanked or spanked someone else. Due to these modifications, it may be argued that the ABI does have factorial validity as the authors examined the factorial validity of the test and updated the test accordingly.

3.3. Appropriate Norms/Populations

In order to gain an accurate interpretation of a psychometric measure, appropriate norms are required. Shepard and Campbell (1992) provide norms for the ABI; however, these norms are based on a US based sample and therefore they may not be generalizable to cultures outside the US. As it stands, there is no evidence to suggest that the ABI has been culturally validated and so this is problematic when using the tool with individuals from non-Western countries. Domestic violence researchers have stressed the importance of multicultural considerations in progressing the area, as culture can influence risk assessment and safety predictions (Mallory et al. 2016).

Further to this, Shepard and Campbell (1992) also based the norms on an in-patient chemical dependency program, hence again, the norms are limited as they may not apply to normal populations. Research shows that substance and alcohol use have an influence on both the perpetration and victimization of IPV (Cafferky et al. 2018). Additionally, substance and alcohol use have different effects depending on gender, such that male users are more likely to perpetrate violence and female users are more likely to be victimized (Cafferky et al. 2018). Therefore, as the relationship is complex between drug and alcohol use, IPV perpetration, victimization, and gender, the ABI should be standardized on a sample that is not in a chemical dependency program.

In the study conducted by Zink et al. (2007), they analysed the false negative rate of the ABI. They discovered that those who were not identified as a victim of abuse were younger African-American women. This is crucial to note as mental health providers must be aware of a measure's tendency to under report in certain populations.

3.4. Distorted Responses

Self-reporting bias, social desirability bias, and recall bias have been reported to be confounding factors in self-report tools (Althubaiti 2016). Although the ABI relies on self-report, a validity scale was not included by the authors. However, the authors did advise that male respondents' (potential perpetrators') scores should be interpreted with caution as they may respond defensively. Research illustrates that perpetrators of domestic violence often minimize and deny their abusive behaviours, more specifically underreporting, further highlighting the importance of accurately assessing domestic violence potential's role to better assist public health (Graham et al. 2019). In Strang and Peterson's (2020) study, when men were led to believe the honesty of their responses would be evaluated, they admitted up to 6.5 times more sexual assault behaviours. This suggests that the presence or perceived presence of validity scales can produce more candour in respondents. Conversely, the ABI tool may be advantageous in that it may be able to assess for defensive responses if both the victim and the perpetrator complete the tool. This may allow for their results

to be compared and any inconsistencies in the victim's/perpetrator's responding may be explored. This could also be used in the context of treatment, allowing clinicians to see if there is a lack of insight/denial of abuse on the part of the victim/perpetrator.

Furthermore, research has shown that female victims are not always able to recognize their partners' subtly controlling behaviours as abuse, and medical professionals lack awareness on the subject as well as training on how to approach the issue (Bradbury-Jones et al. 2014). This suggests that female victims' responses may not be fully accurate as they may respond with low scores on the psychological abuse subscale because of their inability to recognize this as abuse. Therefore, it is advised that when using the ABI, if professionals perceive that an individual is responding in a biased manner, they should perhaps use additional tests to assess for distorted responding. Not doing so could expose the victim to further abuse (Bradbury-Jones et al. 2014), and according to the American Psychological Association's (2017) Ethical Principles of Psychologists and Code of Conduct, a mental health professional should always consider these factors during interpretation of an assessment.

3.5. Structural Analysis

The creators of the ABI-R conducted a confirmatory factor analysis over the items of the ABI to determine if the two-subscale model was sufficient. They found that the conceptualization of IPV into physical and psychological abuse proved to be an inadequate structure for the ABI (Postmus et al. 2016). In conducting their CFA, they used a cut-off for a satisfactory model fit of CFI = 0.90 (Postmus et al. 2016; Byrne 2001). However, the statistical analysis revealed a value of CFI = 0.775., indicating that a two-factor model was not a bad fit for the measure. These results supported the creation of a third subscale of sexual abuse in the ABI-R (Postmus et al. 2016).

4. Discussion

4.1. Accounting for LGBTQ Relationships

Defining IPV only in terms of female victimization within heterosexual relationships cannot account for abuse in same sex or LGBTQ relationships. Cannon et al. (2015) used an example of a lesbian relationship, with a female abuser and a female victim, and explained how taking a heteronormative approach to domestic violence is not applicable because the female abuser is not asserting control through the patriarchy. So, despite similar violent behaviours, the motivations must differ. Cannon et al. (2015) called attention to how gender and IPV should be examined at the individual, interactional, and structural levels. Examining the risk of reoffending with domestic violence in same-sex relationships, Gerstenberger et al. (2019) found that the differences in perceived power within a relationship is a better predictor of future violence than sexual orientation. This speaks to the concept Cannon et al. (2015) expressed in "doing gender" referring to masculine and feminine ideals of power. Women offenders with a female partner were at the same risk of reoffending as male offenders with a female victim (Gerstenberger et al. 2019). This suggests that these women abusers had internalized more masculine ideas of power over their partners.

As domestic violence is a public health issue, the neglect of other relationship archetypes in which domestic violence occurs is something the profession of psychology needs to address. Bisexual women report 2.6 times more IPV than heterosexual women, 26.9% of gay men report having experienced IPV, and studies researching IPV in transgender people found rates from 31.1% to 50% (Walters et al. 2013; Goldberg and Meyer 2013; Brown and Herman 2015). LGBTQ people experience additional barriers to reporting and receiving support regarding domestic violence as opposed to cisgender heterosexual victims, including the fear of "outing" themselves, homophobia by healthcare providers, and a lack of LGBTQ-friendly resources (Brown and Herman 2015). With respect to the quality of services, many LGBTQ people have low confidence in healthcare providers' competence within this area and view law enforcement as ineffective (Brown and Herman 2015). Calton et al. (2016) dove deeper into the implications of three main additional

barriers faced by LGBTQ: empirical constraints, homophobia, and discrimination at a systemic level. In fact, taking advantage of discriminatory attitudes held towards LGBTQ people is a method that can be used by abusers, such as claiming that law enforcement and the courts do not take IPV in LGBTQ relationships seriously (Calton et al. 2016). Additionally, conceptualizing research on LGBTQ relationships has proved difficult because of a lack of understanding of terminology. Researchers confuse the connection between sexual orientation and gender identity within screening questions, resulting in inconsistent prevalence rates (Calton et al. 2016).

In recommending methods for LGBTQ inclusion, training for healthcare providers and mental health professionals is crucial, as well as the development of tools that measure abuse and assess risk in LGBTQ relationships (Subirana-Malaret et al. 2019). The lack of support this community feels is reinforced by the field of psychology continuing to produce assessments for domestic violence that cannot adequately account for LGBTQ victims and perpetrators. Reconstructing the ABI into a gender-neutral form will allow it to account for LGBTQ people and people who do not identify within the gender binary. Questions need to be included that can assess abusive behaviours within heterosexual and LGBTQ relationships. These actions will avoid confusing sexual orientation and gender identity, or assuming a heterosexual or LGBTQ partner.

4.2. Recommendations to Increase the Utility of the ABI

As previously mentioned, the ABI covers abuse perpetrated within a 6-month period. This is a weakness because it fails to take an adequate history of abuse. A possible method to ameliorate this issue is to have the ABI completed at regular intervals to better predict future risk of abuse. However, the authors have not reported test re-test reliability for the ABI, so further research is required to ensure that the ABI can be used at different time intervals. This will be essential in maintaining risk assessment and risk management plans for victims of abuse.

The creators of the ABI-R concluded that a two-factor model for screening the presence of IPV was insufficient, and added a third subscale for sexual abuse (Postmus et al. 2016). The ABI should continue to be expanded and include more items about sexual assault as this is an established concern because it signals a risk of an increase in physically violent behaviour (Zilkens et al. 2016). Additionally, the items explicitly asking about sex assume penetrative sex as the only form, discounting various sexual behaviours that may be considered coercive and abusive. Accompanying this is the assumption of heterosexuality, which decreases the measure's sensitivity to same-sex and LGBTQ relationships. These conceptions of sexual assault are added barriers for LGBTQ people when they come forward with their experience of abuse. It can lead to confusion about where their experience fits into the dominant discourse of male-perpetrated sexual abuse to a female (Mortimer et al. 2019).

The creation of an online format may increase forthcomingness in victims of abuse. Heron and Eisma (2021) conducted research pertaining to barriers to reporting and possible ways of encouraging disclosure. Victims may hesitate to reveal domestic violence due to distress over possible consequences, negative reactions from healthcare professionals, fear of their abuser, and feelings such as embarrassment and helplessness (Heron and Eisma 2021). One of the possible facilitators for encouraging victims to come forward with their experience of abuse was feelings of confidentiality and safety (Heron and Eisma 2021). Online formats may increase how forthcoming victims are in revealing abuse because they increase feelings of anonymity (Brock et al. 2015). This may combat the feelings of guilt and embarrassment victims experience in face-to-face situations with a healthcare professional (Heron and Eisma 2021).

In continuing efforts to reduce barriers to reporting domestic violence, research has begun to investigate delivering support for victims via online tools. Tarzia et al. (2015) proposed I-DECIDE, in which the goals are to increase the victim's awareness, self-efficacy, and perceived support. If victims feel safe to disclose online, it can increase their feelings of efficacy, and they may be more likely to reveal their experience of abuse to clinicians and

reach out for more resources and support. The ABI can become an implemented assessment within these online applications to measure the level of abuse at intervals during treatment.

The original authors of the ABI recommended administering the ABI with a cover sheet in order to obtain additional contextual information, including past hospital visits, interactions with police, and outcomes of the abuse. This should continue to be a crucial part of the assessment for several reasons. First, the ABI should only be one component of a comprehensive patient intake evaluation. Clinical decisions must be supported by multiple data sources, and the more information a clinician can gain from a client, the more informed the decisions. Second, these past experiences of a victim can provide insight into their history of responding. Previous interactions with healthcare professionals and the legal system will colour victims' perceptions of how domestic violence victims are treated. Because mutual and resistive violence is common, victims of IPV are excluded from an innocent victim stereotype (Meyer 2016). Victims also face blaming and stigmatization from healthcare professionals, so they may feel unworthy of support (Meyer 2016). This highlights the need for training on domestic violence screening and how to respond to disclosure. Clinicians need to be aware of these past experiences and use that in interpreting responses, as this can influence how forthcoming victims may respond.

Although the ABI has been found to be effective when screening for domestic violence in patient populations, another improvement that could be made to this tool is for the ABI to incorporate a structured professional judgement (SPJ) approach. This may allow a victim's risk of abuse to be predicted in a similar way to that of the Historical Clinical Risk Management-20 Version 3 (HCR-20-V3; Douglas et al. 2014), for example, predicting future violence rather than just focusing on historical violence. This may be helpful when communicating with other professionals about the victim's risk, as the final risk judgement could help with a risk management plan and could result in the victim being moved to a place of safety. In addition to informing risk assessment, an SPJ approach can be used to create safety plans. For example, based on the number and relevance of risk factors, professionals could recommend plans of action such as packing a "go bag" or calling a friend for support. The HCR-20-V3 has been demonstrated to have both adequate dynamic predictive validity and overall predictive validity (Douglas and Shaffer-McCuish 2020). As risk factors and their relevance change, such as the HCR-20, should the ABI adopt a Structured Professional Judgement (SPJ) approach, it is recommended that the tool be completed regularly so that any changes in the victim's risk or circumstances can be highlighted and monitored.

In addition, Reisenhofer and Taft (2013) recommend implementing the Transtheoretical Model of Change (Grimley et al. 1994) into interventions for victims of domestic violence. There are three main goals for IPV victims and healthcare providers: reducing risk and harm, promoting safety and ending abuse, and leaving abusive relationships (Reisenhofer and Taft 2013). Depending on the main goal, and assessment of the stage of change of the victim, a clinician can tailor more effective plans (Reisenhofer and Taft 2013). For example, in terms of safety promotion, a woman in the preparation stage may benefit from learning resources such as self-defence classes and reaching out for legal assistance (Reisenhofer and Taft 2013). Determining the state of change in which a client appears to be can be informed by completing the cover sheet with the client. In combination with an SPJ approach to formulating risk assessment and safety management plans, a mental health provider can use all of this information to hypothesize how susceptible the client will be to interventions.

Finally, it is recommended that there continue to be forms of the ABI for both the victim and perpetrator to complete, and that the recommended changes be implemented in both forms. Not only will this add additional context to better assess risk and safety for victims, but it can also inform treatment plans for offenders. As domestic violence is a public health concern, the issue can be combated from both sides of victimization and perpetration. Currently, batterer intervention programs (BIPs) in the U.S. have positive effects, but research is mixed on the significance of the effects (Babcock et al. 2016). This

may be due to the "one size fits all" approach to intervention, which does not consider individual factors (Babcock et al. 2016).

Regarding the assessment of offenders for intake into a specific intervention program, assessments should be able to measure progress toward a reduction in abusive behaviours and a readiness to change (Babcock et al. 2016). If the ABI adopts a Structured Professional Judgement (SPJ) approach and is used in accordance with an assessment of an offender's readiness for change, it may function as an important piece of information for a comprehensive assessment when it comes to intake for BIPs. In their comprehensive review, Babcock et al. (2016) recommended that in order to increase the effectiveness of BIPs, they need to be more suited to certain individuals and specific circumstances. Creating a form of the ABI for perpetrators of domestic violence to complete is a step in this direction.

5. Conclusions

The purpose of this critique was to provide an evaluation of the ABI. To summarize, the ABI is a short, easy-to-administer-and-score self-report measure. The authors of this instrument have demonstrated that it has both good reliability and validity. The ABI is currently used to assess abuse in clinical settings, program evaluation, and for research purposes. For these reasons and all the other reasons discussed above, it is concluded that the ABI is an appropriate tool to use for measuring physical and psychological abuse in victims.

Compared to other tools such as the CTS, the ABI is advantageous because it measures intimate partner violence; it is concerned with abuse rather than just conflict. However, the limitations that were identified in this review need to be taken into consideration. For example, the theoretical underpinning of the tool limits its applicability to male and LGTBQ victims of domestic violence. The mental health profession must stop continuing the creation of measures that cannot account for diverse victims of abuse. The ABI is susceptible to response distortion as it does not assess mutual violence. With established research showing that reciprocal violence is more common than not in relationships, this needs to change. The construction of psychological measures must be based on evidence to advance the field of psychology. Contemporary domestic violence screeners should aim to be sensitive to different types of motivations for domestic violence on both sides of the relationship (Ali et al. 2016). Additionally, the questions concerning sexual abuse are limited, and the creation of more items is needed to better inform the sexual abuse subscale and risk assessment.

Within this critique are recommendations for improvement that would increase the applicability and clinical utility of the ABI. Considerations for the inclusion of LGBTQ relationships and different abuse motivations are discussed. Furthermore, this critique highlighted the usefulness of incorporating a Structured Professional Judgement (SPJ) approach in conjunction with information on victims' past experiences to better inform risk and safety management. Finally, the potential use of the ABI as an assessment for Batterer Intervention Programs (BIPs) is emphasized, as this can help combat domestic violence from both sides of victimization and perpetration.

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