ljm Libyan Journal of Medicine

COACTION PUBLISHING

SPECIAL ARTICLE

Addressing domestic violence in primary care: what the physician needs to know

Jinan Usta* and Rim Taleb

Family Medicine Department, American University of Beirut Medical Center, Beirut, Lebanon

Domestic violence (DV) is quite prevalent and negatively impacts the health and mental wellbeing of those affected. Victims of DV are frequent users of health service, yet they are infrequently recognized. Physicians tend to treat the presenting complaints without addressing the root cause of the problem. Lack of knowledge on adequately managing cases of DV and on appropriate ways to help survivors is commonly presented as a barrier. This article presents the magnitude of the problem of DV in the Arab world, highlights the role of the primary care physician in addressing this problem, and provides practical steps that can guide the clinician in the Arab world in giving a comprehensive and culturally sensitive service to the survivors of DV.

Keywords: *domestic violence*; *primary care*; *Arab world*; *managing survivors*; *physicians*; *mental health*

*Correspondence to: Jinan Usta, Family Medicine Department, American University of Beirut Medical Center, Beirut, Lebanon, Email: ju00@aub.edu.lb

Received: 8 December 2013; Accepted in revised form: 9 January 2014; Published: 14 March 2014

Family violence, defined as the intentional intimidation or abuse of children, adults, or elders by a family member, intimate partner, or caretaker to gain power and control over the victim (1), is a common and worrying social phenomenon. It is considered a public health issue of epidemic proportions (2), predominantly affecting women and children, while men are less frequently subjected to violence within the family (3, 4). Studies worldwide show that one out of seven women has experienced domestic violence (DV) and that 20–40% of women will be victimized at least once during their lifetime (3, 4). A World Health Organization (WHO) multi-country study has shown that the lifetime prevalence of DV ranges from 15 to 71% (5, 6). According to a European Women's Lobby survey report, every fourth or fifth woman in the European Union has experienced violence from her partner (7). In Jordan, the *2007 Population and Family Health Survey* reveals that one in three ever-married women aged 15–49 years reported being subjected to physical violence (8), while 21% of women surveyed in the *Family Health Survey* carried out in Iraq reported exposure to physical violence (9), and one fifth of women surveyed in Egypt reported exposure to physical violence in the year (10) preceding the survey.

Given the statistics presented, there is no doubt that all primary care physicians encounter victims of violence in their practice. Looking at the prevalence of DV in healthcare settings, 15 and 87% of women who attended a healthcare center in Syria and Jordan, respectively, disclosed abuse by their husbands (11, 12), while 35% of women users of primary care in Lebanon were found to be exposed to violence (13). A survey of ever-married women at primary health clinics in Medina, Saudi Arabia, found a prevalence rate of 25.7% of intimate partner violence (IPV) and a life time prevalence of 57.7% (14).

Violence is a medical problem, resulting not only in physical injury but also in emotional and psychological harm. It is a major cause of mental ill health globally (15). Individuals experiencing IPV often develop chronic mental health conditions, such as depression, posttraumatic stress disorder, anxiety disorders, substance abuse, suicidal behavior, somatizing disorders, eating disorders, and chronic pain (16–21). In adolescents, physical and sexual assault are associated with poor self-esteem, alcohol and drug abuse, eating disorders, obesity, risky sexual behaviors, teen pregnancy, depression, anxiety, and suicidality (22, 23). An experience of DV was also found to be significantly associated with high levels of symptoms of perinatal depression, anxiety, and PTSD (24). It also seems that the vast majority of people with severe mental illness, such as bipolar disorder and schizophrenia, have experienced either physical or sexual assault during their lifetime, and this is often associated with a history of childhood abuse and substance misuse (25, 26).

Citation: Libyan J Med 2014, **9**: 23527 - http://dx.doi.org/10.3402/ljm.v9.23527

Conversely, mental illness seems to predispose to abuse. A systematic review and meta-analysis, including 41 studies relating mental problems to abuse, revealed that women with depressive disorders, anxiety disorders, and PTSD are at a higher risk of experiencing adult lifetime partner violence when compared to women without mental disorders. Individual studies reported increased odds for women and men for mental problems of all diagnostic categories, including psychoses, with a higher prevalence reported for women (27).

Women who are victims of DV often present to their physician with a wide range of complaints, including disturbed sleep pattern, headache, anxiety, and most commonly depression (28). Yet, in spite of its strong association to ill mental health, DV is often overlooked in clinical settings. A review of the recently published research on health outcomes associated with partner violence victimization showed that women who experience partner violence are likely to seek health services, have poor overall physical and mental health, but their health needs are not addressed sufficiently by current health and human service systems (15). Some of the reasons reported by mental health and primary care professionals (29) included feeling that women may not disclose abuse to them especially if they are males, thinking that addressing DV is not part of their role or that DV is irrelevant to healthcare, lack of knowledge and expertise in the area, lack of training, resources, and time, feeling powerless to offer a solution, fear of offending the woman and of opening up a 'Pandora's box, negative cultural social attitudes, and institutional constraints (30–32). DV could also be overlooked by physicians who may themselves be perpetrators of abuse or believe that religious laws allow men to control or sometimes beat their wives.

Studies revealed that women are ready to talk about abuse when asked (13), and, even in the Arab world, they welcome getting the healthcare involved in combating DV, considering it to be a socially accepted way to address the issue (33). Primary care physicians are well positioned to care for violence victims. While providing care for women and their children, they can use these therapeutic relationships to identify DV, make brief office interventions, offer continuity of care, and refer for further management or assistance. Helpful tips are given in this article in order to improve the knowledge of the primary care physicians and assist him/her in these services. The word 'survivor' will be used throughout the article, except when the original reference uses the word 'victim', to refer to females exposed to DV either from a past or current relation. The term 'survivor' has been a preferable term to 'victim' in recent literature and within organizations addressing violence against women. 'Victim' implies passivity while women are actually active in trying to defend themselves and their children and seeking ways to survive.

What healthcare providers can do

Identifying female survivors, providing them with adequate referral, and supporting them safely on a pathway to recovery could be a way to avoid the long-term impacts of violence (34) and prevent further incidents of abuse. The approach to survivors is usually a multidisciplinary one, involving physicians, social workers, psychologists as well as community resources. The clinician's role is to identify cases of abuse, assess the patient and her family level of safety, and provide ongoing medical care and non-judgmental support. This includes counseling about the nature and course of DV and assessing the level of readiness to undergo changes, educating the patient about the range of available support services and making the appropriate referral, documenting findings, and assuring follow-up. In order to fulfill this role adequately, the physicians need to be equipped with proper knowledge and communication skills and be aware of the resources available in the community. Training programs (workshops, symposia, online education) may be warranted to increase the awareness of the primary care providers (physicians and nurses) and to provide guidance about this urgent medical and public health issue. Moreover, having awareness leaflets or brochures related to DV with a list of community resources available in the patients' waiting room is advisable as it facilitates disclosure.

Identifying survivors

Controversy exists as to the best way to identify survivors: screening or case finding or targeted screening. Routine screening can be incorporated within the routine history taking, has the advantage of identifying women at risk, and gives an insight into the local prevalence of IPV. It is recommended by the Institute of Medicine as well as several professional organizations (35–38), but screening in some studies was not associated with improved physical and mental health in females (39). The U.S. preventive task force (USPTF) found that the evidence is insufficient to support a recommendation to screening (40) for IPV. As an update on the USPTF recommendation, a systematic review of articles published between 2002 and 2012 was conducted and concluded that the benefits of screening vary by population, while the potential adverse effects have minimal effect on most women (41). The adverse effects reported included feeling judged by the provider, increased anxiety about the unknown, disappointment in the provider's response, and a non-significant increase in the verbal abuse victimization rates among the screened population (41).

Several screening tools are available and presented in Table 1. When strategies of screening for DV in primary

Citation: Libyan J Med 2014, **9**: 23527 - http://dx.doi.org/10.3402/ljm.v9.23527

Table 1. Commonly used screening tools for intimate partner violence (IPV)

Screening tool	Description
HITS (42)	It is a 4-item tool in which the patient is asked if her/his partner hurts, insults, threatens her/him, or screams at her/him. Each item is scored, according to the frequency of occurrence, from 1 (never occurring) to 5 (frequently occurring). A score of 10 or more indicates partner violence. This screening tool was also used in Arabic (33).
WAST and WAST–SF (Woman Abuse Screening Tool and WAST-Short Form) (42)	It is a more detailed screening tool made of 8 items. The woman is asked to describe the relationship with her partner, how the arguments are worked out and if they result in getting hit, kicked, or pushed, or in feeling frightened or down; the tool also asks if the partner ever abuses her emotionally, physically, or sexually or frightens her, the items use a likert scale but there is no cutoff point for considering the tool as positive. It is more a clinical evaluation.
Partner Violence Screen (43)	A short 3-item tool. The questions relate to being hit by the partner and whether the patient is feeling unsafe in a current or previous relationship. A positive response to any question is considered to denote abuse.
The relationship chart (44)	It is an easy tool to administer, formed of a table with illustrations. It is mainly administered to females, made of 4 items (insulting/swearing, yelling, threatening, hitting/pushing). It asks about the frequency of physical and emotional domestic violence experienced during the past 4 weeks. The items are scored from 1 to 5 depending on the frequency of abuse.
Computer-based IPV questionnaire (45)	This self administered tool is formed of 4 parts, with several questions on exposure to physical and emotional abuse, in addition to safety assessment. The test is considered reflecting abuse if the victim answers "YES" on questions about being abused either physically or emotionally by a current partner. It is thought to supplement screening efforts and allows providers to focus on assessment, counseling, and referral for those at risk.

care settings were compared (questionnaires, screening via healthcare providers and computer-assisted-self-interviews), the computer-assisted self-interviews were shown to be the best at eliciting a high rate of DV disclosure (46).

Case finding or targeted screening requires the physician to be aware of and vigilant to the presence of the signs and symptoms associated with abuse (Table 2).

Regardless of which strategy is being used, probing about DV has to include both current and past relations, and it has to be done in private and in a confidential manner. It is advisable not to discuss DV with children or when the partner is present. Introductory statements can be used like 'violence is so common around here, that we started asking everyone about it'. A funneling technique, that is moving from the broad less-threatening questions (example: 'married couples may disagree; how do you resolve conflicts at home') to asking about specific behaviors (example 'are you being hit') is recommended. Questions are to be asked in a non-judgmental way (for example, avoid asking 'what have you done for him to hit you') while avoiding use of emotionally charged words like 'violence' or 'abuse'. Maintaining good eye contact is advisable when culturally appropriate. Observing the patient's non-verbal cues when answering questions can be insightful.

Responding

Inappropriate responses to patients' replies to inquiries about violence may result in harm. It is important for health providers to reassure patients that they do believe their physical symptoms in order to gain their trust and to develop a better therapeutic relationship (47). If violence was denied, the physician should respect the patient's decision not to disclose violence even when there is clinical suspicion of its presence. It is better to acknowledge the relation of the complaints to violence, 'sometimes patients having symptoms like yours turn out to be abused', and express readiness to discuss DV in future visits whenever the patient wishes. Providing education about the impact of violence on the health of survivors and children witnessing it and a list of resources and organizations offering support to abused women can be additionally helpful in raising awareness. A close follow-up visit is warranted.

The guidelines issued by the WHO (48) for responding to DV and sexual abuse stress the importance of woman-centered care as first-line support. This entails respecting confidentiality when possible, assuring privacy, non-judgmental support, validation, and not pressuring the woman to leave the relationship. Although the guidelines incorporate recommendations for mandatory reporting, most Arab states do not have a law that

Table 2. Signs and symptoms suggestive of abuse

- Injuries that point to a defensive position over the face (bruises and marks on the inside of the arms, back)
- Injuries to the chest and stomach, reproductive organs, and anus
- The illness or injuries do not match the cause given
- Delay in requesting medical care
- Injuries and bruises of various colors, indicating injuries occurring regularly over a period of time
- Repeat injuries, someone who is 'accident prone'
- Injuries during pregnancy
- Repeated reproductive health problems: repeat miscarriage, early delivery, sexually transmitted diseases
- Psychological or behavioral problems
- Suicide attempts or signs of depression
- Repeat and chronic medical complaints, pelvic problems and pains, psychological diseases
- Behavioral signs: multiple visits, lack of commitment to appointments, not displaying emotion or crying easily, inability to undertake daily interactions, negligence, defensive positions, stilted speech, avoiding eye contact and animosity in body language

Partner's behavior

- Extreme and irrational jealousy or possessiveness
- Attempts to control time spent with the healthcare providers
- Speaking on behalf of the patient
- Insisting on staying close to the patient, who hesitates to speak before the partner

criminalizes family violence, making mandatory reporting inapplicable.

When the patient discloses abuse, the initial response of the physician is to *show empathy* 'I am sorry this is happening to you', acknowledge the difficulty to share the information 'this must be hard on you to talk about it', express validation while alleviating guilt 'no one deserves to be hit or treated badly, it is not your fault', and offer help and assurance of continuous assistance in the future 'you are not alone in this, we can help you take care of your health and support you while going through this problem'. When the patient narrates a violent incident, it is better to obtain a behavioral description of what has happened rather than why it happened. Asking about the 'why' has the subtle implication that violence can be justified in certain situations. Further interventions are summarized in Table 3 and described in details below. They can be easily remembered using the mnemonic SOS Doc: Support, Safety, Options, Strengths, Document, Continuity (49, 50).

Although most survivors encountered are not in imminent danger, the physician should ask open-ended questions to *assess the safety* of the patients. A danger assessment tool (51) is available to assist in predicting increasing danger or lethality in the future. Indicators of danger include history of threats of murder or suicide, attempts of suicide or homicide, increased severity or frequency of the perpetrator's fits of anger, use of weapons or tools in the assault or an attempted strangulation, alcohol or substance abuse, or if the survivor acknowledges a fear for life. Violence tends also to escalate during life changes like pregnancy, separation, divorce or unemployment.

If any of the danger indicators are present, the physician should discuss a safety plan with the survivor, even when survivors deny danger. Unfortunately, calling the police is not considered an option in many Arab countries as DV is considered a private issue and not a crime. Therefore, a safety plan can include hiding money, extra car keys, or a bag with extra clothes; having important documents (IDs, passports, certificates, bank account numbers, driving license, insurance policy, marriage license.) in a place outside the home in the event of an urgent escape; agreeing on a safe place to escape to (shelters' hotlines to be provided when available); and a signal to alert neighbors requesting their help. Survivors are also advised, when the perpetrator is around, to stay away from rooms with weapons, such as the kitchen, or with hard surfaces, such as a bathroom, to decrease the risk of injury in times of escalating conflicts. The safety plan is to be revisited on later visits and modified according to situation.

Disclosing violence does not necessarily imply that a major change is going to happen. Assessing the survivor's readiness to change is necessary, as physicians can be instrumental in helping the survivor move from one stage to the other towards action. The stages of change are:

1. Pre-contemplation – The survivor is not aware of the situation or is still justifying abuse. There is no concern about the situation.
2. Contemplation – The survivor is considering change but is not ready to take action yet.
3. Determination – A decision has been made by the survivor to make changes.
4. Action – The survivor is actively taking steps to address the DV.

Citation: Libyan J Med 2014, **9**: 23527 - http://dx.doi.org/10.3402/ljm.v9.23527

Table 3. Essentials of intervening with DV survivors

Assess: The degree of danger, presence of danger indicators, the mental status of the survivor
Safety: Does the survivor feel safe at home? Discuss a safety plan and revisit it with the survivor at each encounter
Support: Talk in private; make eye contact; assure confidentiality while stating its limitation (possible self harm or harm to others); use encouraging statements 'violence is not your fault'; 'you deserve to be safe and respected'; show empathy 'I'm sorry this has happened'
Options: Discuss options 'If you decided to leave, where you could go?', "what would be your children's reactions if you requested divorce?". Provide information about legal tools and community resources (e.g. women's shelters, support groups, legal advocacy)
Strengths: Recognize the survivor's strengths. "It is usually difficult for people to talk about violence. you did it"
Documentation: Record the patient's words, describe the observed behavior and injuries when present (can use drawings, body map or even photographs after obtaining patient's approval). Include also in documentation the assessment of the mental status, danger severity and follow up plans
Continuity: Show willingness to continue taking care of the survivor "you are not alone in this"; offer a follow-up appointment. Check for barriers to access and discuss solutions

While supporting the patients going through their life, physicians need to recognize that change is a long process, sometimes non-linear, with frequent setbacks. Survivors are not to be pushed but rather supported to go through changes at their own pace of readiness. By insisting on making changes or on progressing through stages of change, the doctor recreates power and control dynamics, which is not advisable. When setbacks occur, and they are to be expected, physicians need to assure the patients that they will not be abandoned and that they will have their continuous support.

Counseling improves the patient's self-esteem and self-worth and assists the decision-making process. Providers are not supposed to encourage survivors to leave the relationship (52). Many survivors may believe that the abuse will stop one day or that they deserve it. Others may not be ready to leave their abusers for fear of losing contact with children, financial dependence, lack of an alternative place to go to, or because of the social pressure. In the Middle East, there is widespread tolerance of DV by both men and women that 'most victims are unable or unwilling to seek help from legal authorities or from health care providers' (53). When the decision to leave the relationship is being discussed, the risk of danger escalating is to be considered and safety plans should be revisited.

Throughout the counseling process, the physician must ensure trust and continuity, maintain boundaries, and encourage patients to make autonomous decisions even in matters related to health. Counseling of couples is to be avoided when active violence, intimidation, fear, or control is present in the relationship; physicians should also resist the repeated demands from the survivor to confront the perpetrator as this may endanger the patient and the physician.

Addressing the impact of abuse on the *mental wellbeing* of survivors, that may persist for years after the abuse ends (54), is an integral part of the healthcare provider's role. Cognitive behavioral therapy (CBT) and other psychological interventions were shown to be effective in decreasing PTSD and symptoms of depression and hence decrease the probability for future partner violence (54, 55). Referral to mental health clinicians for CBT or dialectic behavioral therapy may be warranted. The survivor needs to be notified of the services and/or facilities offered by various agencies and may sometimes need assistance in accessing them. Caution should be taken when providing written material as the safety of the survivor may be jeopardized if the perpetrator finds them. Frequent scheduled follow-ups are needed to continue offering moral support and assistance.

Proper *documentation* is important as it may be of value if the patient decides to seek legal support. When documenting, words such as denies, claims, or alleged perpetrator are to be avoided as they imply the physician does not believe the patient. The following should be recorded in the patient's file:

1. The occurrence, nature, and time of abuse and the perpetrator identity when possible. Using patient's quotes is recommended.
2. Findings from the physical examination with an accurate recording of injuries: nature, shape, and color. If possible, photographs of any physical injuries may be obtained if the patient permits. The photographs must include the patient's face or identifying features with the injury to be useful as evidence. If a camera is not available, the physician should make a sketch of the injuries or use body maps to record injuries.
3. The laboratory or radiological studies ordered, the medications prescribed, and the referral when done.
4. Comments on comorbidities; pregnancy, if present; and degree of disability.

Self-care

Dealing with survivors of abuse or mistreatment represents an undeniable challenge, and it usually brings

out various reactions in the care provider. When dealing with a person whose physical and emotional safety is continuously undermined, it is natural that these encounters stir feelings (love and hate, concern, anger, frustration, etc.) within the care provider that vary according to past experiences. It is important to differentiate between the feelings raised by the recipient and those resulting from recalling personal experiences or cases. Refraining from feeling angry at the patient for not taking action or for going back on decisions made; this should not be interpreted as failure as many factors could have prevented patients from doing so.

At the end of every medical encounter with the survivor, the physician is advised to stop for a moment and self-acknowledge what was achieved, that is, that they helped a person who was in need. Although the involvement of the provider is often limited to listening, disclosure of abuse was found to decrease somatic complaints and improve wellbeing (56). Considering the limited control that the physician has on the life, decisions, and special circumstances of the survivor, the provider needs to keep in mind that assisting abused patients does not mean saving the patient but assisting them in carrying out the changes themselves.

Conclusion

DV is frequently encountered in primary care and needs to be addressed properly. Expressing empathy, acknowledgement, and continuous support are the most important elements of immediate care provided to patients who disclosed abuse; safety is to be assessed and if risk of abuse escalation is present, safety planning is to be devised. Counseling can strengthen the survivor's sense of self-worth and feeling of continuous support and assistance. Referral for psychological assistance and organizations working with abused women may be needed.

Conflict of interest and funding

The authors have not received any funding or benefits from industry or elsewhere to conduct this study.

References

1. Knapp JF, Dowd MD. Family violence: implications for the pediatrician. Pediatr Rev. 1998; 19: 316–21.
2. U.S. Preventive Services Task Force. Guide to clinical preventive services: report of the U.S. Preventive Services Task Force. 2nd ed. Baltimore, MD: Williams & Wilkins; 1996.
3. Ronan GF, Dreer LE, Dollard KM, Ronan DW. Violent couples: coping and communication skills. J Fam Violence. 2004; 19: 131–7.
4. Yount KM, Li L. Women's "justification" of domestic violence in Egypt. J Marriage Fam. 2009; 71: 1125–41.
5. Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. Lancet. 2006; 368: 1260–9.
6. Stöckl H, Devries K, Rotstein A, Abrahams N, Campbell J, Watts C, et al. The global prevalence of intimate partner homicide: a systematic review. Lancet. 2013.
7. European Women's Lobby Study. Unveiling the hidden data on domestic violence in the European Union. Final report. Brussels, Belgium: European Women's Lobby; 1999.
8. Jordan Population and Family Health Survey. 2008. Available from: http://www.dos.gov.jo/sdb_pop/sdb_pop_e/pop_2009.pdf [cited 5 October 2013].
9. Republic of Iraq: Iraq Family Health Survey. 2008. Available from: http://www.who.int/mediacentre/news/releases/2008/pr02/2008_iraq_family_health_survey_report.pdf [cited 5 October 2013].
10. Egypt Demographic and Health Survey. 2005. Available from: http://www.measuredhs.com/pubs/pdf/FR176/FR176.pdf [cited 5 October 2013].
11. Al-Nsour M, Khawaja M, Al-Kayyali G. Domestic violence against women in Jordan: evidence from health clinics. J Fam Viol. 2009; 24: 569–75.
12. Maziak W, Asfar T. Physical abuse in low-income women in Aleppo, Syria. Health Care Women Int. 2003; 24: 313–26.
13. Usta J, Farver JA, Pashayan N. Domestic violence: the Lebanese experience. Public Health. 2007; 121: 208–19.
14. Tashkandi A, Rasheed F. Wife abuse: a hidden problem. A study among Saudi women attending PHC centers. East Mediterr Health J. 2009; 15: 1242–53.
15. Macy RJ, Ferron J, Crosby C. Partner violence and survivors' chronic health problems: informing social work practice. Soc Work. 2009; 54: 29–43.
16. Eisenstat SA, Bancroft L. Domestic violence. N Engl J Med. 1999; 341: 886–92.
17. Campbell JC. Health consequences of intimate partner violence. Lancet. 2002; 359: 1331–6.
18. Golding JM. Intimate partner violence as a risk factor for mental disorders: a meta-analysis. J Fam Violence. 1999; 14: 99–132.
19. Campbell JC, Lewandowski LA. Mental and physical health effects of intimate partner violence on women and children. Psychiatr Clin North Am. 1997; 20: 353–74.
20. Lehmann P. Posttraumatic stress disorder (PTSD) and child witnesses to mother-assault: a summary and review. Child Youth Serv Rev. 2000; 22: 275–306.
21. Silverman ME, Loudon H. Antenatal reports of pre-pregnancy abuse is associated with symptoms of depression in the post-partum period. Arch Womens Ment Health. 2010; 13: 411–5.
22. Trickett P, Putnam F, Noll J. Longitudinal study on childhood sexual abuse – summary. Cincinnati, OH: Cincinnati Children's Hospital; 2005.
23. Sickel AE, Noll JG, Moore PJ, Putnam FW, Trickett PK. The long-term physical health and healthcare utilization of women who were sexually abused as children. J Health Psychol. 2002; 7: 583–97.
24. Howard LM, Oram S, Galley H, Trevillion K, Feder G. Domestic violence and perinatal mental disorders: a systematic review and meta-analysis. PLoS Med. 2013; 10: e1001452. doi: 10.1371/journal.pmed.1001452.
25. Goodman LA, Salyers MP, Mueser KT, Rosenberg SD, Swartz M, Essock SM, et al. Recent victimization in women and men with severe mental illness: prevalence and correlates. J Trauma Stress. 2001; 14: 615–32.
26. Howard LM, Trevillion K, Khalifeh H, Woodall A, Agnew-Davies R, Feder G. Domestic violence and severe psychiatric disorders: prevalence and interventions. Psychol Med. 2009; 40: 1–13.

Citation: Libyan J Med 2014, **9**: 23527 - http://dx.doi.org/10.3402/ljm.v9.23527

27. Trevillion K, Oram S, Feder G, Howard LM. Experiences of domestic violence and mental disorders: a systematic review and meta-analysis PLoS ONE. 2012; 7: e51740. doi: 10.1371/journal.pone.0051740.
28. Joyner K, Mash R. Recognizing intimate partner violence in primary care: Western Cape, South Africa. PLoS ONE. 2012; 7: e29540.
29. Rose D, Trevillion K, Woodall A, Morgan C, Feder G, Howard L. Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. Br J Psychiatry. 2011; 198: 189–94.
30. Ambuel B, Butler D, Hamberger LK, Lawrence S, Guse C. Female and male medical students' exposure to violence; Impact on well being and perceived capacity to help battered women. J Comp Fam Stud. 2003; 34: 113–33.
31. Elliott L, Nerney M, Jones T, Friedmann PD. Barriers to screening for domestic violence. J Gen Intern Med. 2002; 17: 112–6.
32. Population reports. Ending violence against women. 2009. Available from: http://www.infoforhealth.org/pr/l11edsum.shtml [serial online].
33. Usta J, Antoun J, Ambuel B, Khawaja M. Involving the health care system in domestic violence: what women want. Ann Fam Med. 2012; 10: 213–20.
34. Hegarty K, O'Doherty L. Intimate partner violence – identification and response in general practice. Aust Fam Physician. 2011; 40: 852–6.
35. National Research Council. Clinical preventive services for women: closing the gaps. Washington, DC: National Academies Press; 2011.
36. Physicians' obligations in preventing, identifying, and treating violence and abuse. American Medical Association; Available from: http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion202 [cited 5 October 2013].
37. American Congress of Obstetricians and Gynecologists. Screening tools – domestic violence. *American Congress of Obstetricians and Gynecologists*; Available from: http://www.acog.org/About_ACOG/ACOG_Departments/Violence_Against_Women/Screening_Tools__Domestic_Violence [cited 5 October 2013].
38. Thackeray JD, Hibbard R Dowd MD; Committee on Child Abuse and Neglect. Intimate partner violence: the role of the pediatrician. Pediatrics. 2010; 125: 1094–100.
39. Klevens J, Kee R, Trick W, Garcia D, Angulo FR, Jones R, et al. Effect of screening for partner violence on women's quality of life: a randomized controlled trial. JAMA. 2012; 308: 681–9.
40. U.S. Preventive Services Task Force. Screening for family and intimate partner violence: recommendation statement. *Rockville, MD: U.S. Preventive Services Task Force*; 2004. Available from: http://www.uspreventiveservicestaskforce.org/3rduspstf/famviolence/famviolrs.htm [cited 30 August 2013].
41. Nelson H, Bougastos C, Blazina I. Screening women for intimate partner violence: a systematic review to update the U.S. Preventive Services Task Force recommendation. Ann Intern Med. 2012; 156: 796–808.
42. Basile KC, Hertz MF, Back SE. Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2007.
43. Feldhaus KM, Koziol-McLain J, Amsbury HL, Norton IM, Lowenstein SR, Abbot JT. Accuracy of 3 brief screening questions for detecting partner violence in the emergency department. Journal of the American Medical Association. 1997; 277: 1357–61.
44. Wasson JH, Jette AM, Anderson J, Johnson DJ, Nelson EC, Kilo CM. Routine, single-item screening to identify abusive relationships in women. The Journal of Family Practice. 2000; 49: 1017–22.
45. Rhodes KV, Lauderdale DS, He T, Howes DS, Levinson W. "Between me and the computer": Increased detection of intimate partner violence using a computer questionnaire. Annals of Emergency Medicine. 2002; 40: 476–84.
46. Klevens J, Sadowski L, Kee R, Trick W, Garcia D. Comparison of screening and referral strategies for exposure to partner violence. Womens Health Issues. 2012; 22: e45–52.
47. Nicolaidis C, Gregg J, Galian H, McFarland B, Curry M, Gerrity M. "You always end up feeling like you're some hypochondriac": intimate partner violence survivors' experiences addressing depression and pain. J Gen Intern Med. 2008; 23: 1157–63. doi: 10.1007/s11606-008-0606-0.
48. Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guidelines; 2013. Available from: http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/ [cited 3 September 2013].
49. Cronholm P, Fogarthy C, Ambuel B, Harrison SL. Intimate partner violence. Am Fam Physician. 2011; 83: 1165–72.
50. Ambuel B, Hamberger LK, Lahti J. The family peace project: a model for training health care professionals to identify, treat and prevent partner violence. J Aggress Maltreat Trauma. 1998; 1: 72–3.
51. Campbell JC, Webster DW, Glass N. The danger assessment: validation of a lethality risk assessment instrument for intimate partner femicide. J Interpers Violence. 2009; 24: 653.
52. Nicolaidis C, Curry MA, Ulrich Y, Sharps P, McFarlane J, Campbell D, et al. Could we have known? A qualitative analysis of data from women who survived an attempted homicide by an intimate partner. J Gen Intern Med. 2003; 18: 788.
53. Boy A, Kulczycki A. What we know about intimate partner violence in the Middle East and North Africa. Violence Against Women. 2008; 14: 53–70.
54. Iverson KM, Gradus JL, Resick PA, Suvak MK, Smith KF, Monson CM. Cognitive-behavioral therapy for PTSD and depression symptoms reduces risk for future intimate partner violence among interpersonal trauma survivors. J Consult Clin Psychol. 2011; 79: 193–202.
55. Johnson DM, Zlotnick C, Perez S. Cognitive behavioral treatment of PTSD in residents of battered women's shelters: results of a randomized clinical trial. J Consult Clin Psychol. 2011; 79: 542–51.
56. Ryden J, Blumenthal PD, Charney P (Eds.). Intimate partner violence in practical gynecology: a guide for the primary care physician. 2nd ed. ACP press: American College of Physicians; 2009.