Violence between intimate partners: working with the whole family

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Violence between intimate partners (one area of domestic violence) is a common violation of human rights, with long term consequences for the health of survivors and their children.[1 2] Health services have lagged behind other agencies in responding appropriately to this problem. Here we review the evidence on identification and management of intimate partner violence in families and summarise primary care guideline recommendations from an international consensus group that we led.[3]

Sources and selection criteria

We searched Medline, Embase, CINAHL, PsycINFO, DARE, and Cochrane for recent (1999-2005) clinical guidelines or recommendations about the management of survivors or perpetrators of intimate partner violence and their children, including guidance on care of the whole family. We referred to reviews in *Clinical Evidence* and systematically reviewed primary studies of advocacy and psychological interventions for survivors.[4] We are the key authors on the systematic reviews and consensus guidelines that this review draws on.

Defining intimate partner violence

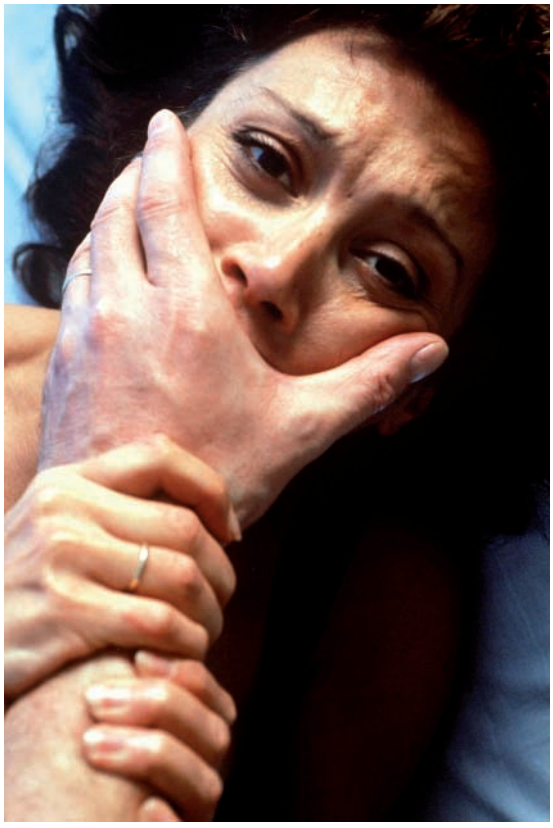
Intimate partner violence is defined as any behaviour within an intimate relationship that causes physical, psychological, or sexual harm. This includes:

- Physical aggression, such as hitting, kicking, and beating
- Psychological violence, such as intimidation, constant humiliation
- Forced intercourse and other sexual coercion
- Various controlling behaviours, such as isolation from family and friends, monitoring movements, financial control, and restricting access to services.[5]

Lifetime prevalence of isolated violent acts within relationships is comparable for men and women, but repeated coercive, sexual, or severe physical violence is perpetrated largely against women by men.[6] Although intimate partner violence also occurs in same sex relationships, research evidence on the health consequences of intimate partner violence and the management of survivors is largely confined to women in heterosexual relationships, and they are the focus of this review. We do not know to what extent our conclusions can be extrapolated to male patients and to women in same sex relationships, although it is likely that our main recommendations will be relevant to these groups.

Why is intimate partner violence a major public health problem?

Intimate partner violence damages the social and economic fabric of communities, as well as the mental and physical health of individual women, men,



ACTION PRESS/REX FEATURES

Box 1 Potential presentations of intimate partner violence[26]

Psychological

Insomnia; depression; suicidal ideation; anxiety symptoms and panic disorder; somatoform disorder; post-traumatic stress disorder; eating disorders; drug and alcohol misuse

Physical

Obvious injuries, especially to the head and neck or multiple areas; bruises in various stages of healing; injuries from sexual assault; sexually transmitted diseases; chronic pelvic pain; chronic abdominal pain; chronic headaches; chronic back pain; numbness and tingling from injuries; lethargy

General indicators

Delay in seeking treatment of injuries; multiple presentations to general practice; recent separation or divorce; history of child abuse; age less than 40; abuse of a child in the family

Pregnancy related indicators

Miscarriages; unwanted pregnancy; antepartum haemorrhage; lack of prenatal care; low birth weight of infant

adolescents, and children. The total cost of such violence to the United Kingdom is estimated to be £5.7bn (€7.2bn; $11.4bn) a year.[7]

Intimate partner violence is a major public health problem with a prevalence similar to chronic diseases such as diabetes and asthma.[1] The World Health Organization's multinational study estimated that 15-71% of women had been physically or sexually assaulted at some time by a partner.[8] Prevalence in clinical populations is higher, with general practice studies finding lifetime physical abuse rates ranging from 23% to 41% of women[9-11] and 12 month rates from 5%[12] to 17%.[11] In Australia intimate partner violence is the leading contributor to death, disability, and illness for women aged 15-44 years.[13]

Health consequences of intimate partner violence for women

Intimate partner violence can have short and long term negative health consequences for survivors, even after the abuse has ended.[2] Most presentations in clinical settings are hidden and not an obvious injury (box 1), Women with a current or past experience of intimate partner violence use primary care and specialist outpatient services more frequently, are issued with more prescriptions, and admitted to hospital more often than non-abused women.[2] Psychiatric disorders are the most persistent and disabling conditions resulting from intimate partner violence, particularly depression, post-traumatic stress disorders, chronic anxiety, and substance misuse.[14]

Up to 60% of children directly experience the abuse of their mother[15] (including witnessing her abuse and being used in threats or as a spy) or its aftermath, including removal to a refuge. Children exposed to intimate partner violence have a higher risk of physical, emotional, behavioural, and educational problems that persist into adulthood.[16] Clinical indicators in children and adolescents include aggressive behaviour, anxiety, bedwetting, depression, drug and alcohol misuse, self harming, and suicidal ideation.

Identification of women

Systematic reviews have concluded that there is insufficient evidence for a policy of screening in clinical settings.[17-19] However, expert consensus opinion recommends a low threshold for asking about intimate partner violence, particularly when the clinician suspects underlying psychosocial problems.[3] Surveys and interview studies show that clinicians often do not inquire about such violence because of a perceived lack of training and insufficient time; rates of inquiry vary from 13% to 20%.[9-11] Furthermore, they often fail to document physical violence in the medical records.[10] Most women do not disclose abuse to clinicians, with lifetime disclosure rates from 18% to 37%, with women in interview studies reporting many barriers to disclosure.[20]

To facilitate disclosure in the consultation clinicians should use a "funnelling" technique when asking questions about intimate partner violence—that is, start with indirect questions then move to direct questions (box 2).[3] Several short clinical tools are available, which have had limited validation in clinical settings. The abuse assessment screen developed for an antenatal setting was adapted and validated in a United Kingdom primary care population.[21]

Initial response of clinicians

A meta-analysis of 25 qualitative studies of women's expectations and experiences (847 informants)[22] reported consistent messages about how clinicians can respond appropriately to disclosure (box 3).

Focus groups of "physicians committed to providing quality health care" to survivors of intimate partner violence concluded that clinicians, before any other response, should validate the experience of abuse (box 4), affirm that violence is unacceptable behaviour, and express support.[23] Even if a woman does not choose to pursue other interventions, a clinician's support is an act that may in the long run contribute to the woman being able to change her situation. In addition, the clinician needs to make an initial

Box 2 Possible questions to ask if you suspect intimate partner violence[21]

- Sometimes partners use physical force. Is this happening to you?
- Have you felt humiliated or emotionally abused by your partner (ex-partner)?
- Are you now or have you been afraid of your partner (ex-partner)?
- Has your partner ever physically threatened or hurt you? Or have you been kicked, hit, slapped, or otherwise physically hurt by your partner (ex-partner)?
- In the past year have you been forced to have any kind of sexual activity by your partner (ex-partner)?

assessment of her safety (box 5), checking with the woman if it is safe for her (and her children) to return home. A more detailed risk assessment will include questions about escalation of abuse and the content of threats as a US case-control study found that threats of deadly violence and access to a weapon are predictors of domestic homicide.[24]

Referral to external agencies

Beyond their initial response, most generalists have neither the expertise nor the capacity to meet the needs of women experiencing partner violence, which include legal, financial, housing, and safety needs. A key step, particularly in the context of current or recent violence, is an offer of referral to specialist support, such as domestic violence advocacy.

A systematic review of nine controlled studies (including four randomised controlled trials) found that domestic violence advocacy, particularly for women who have actively sought help from professional services or are in a refuge setting, may reduce abuse, increase social support and quality of life, and lead to increased use of safety behaviours and accessing of community resources. We do not know how effective advocacy is for women identified in healthcare settings because of the small number of studies and their relatively poor design.[4]

Although not the focus of this review, domestic violence advocacy for male survivors is now offered by some agencies in North America and the United Kingdom, as is advocacy for survivors of intimate partner violence in same sex relationships.

Box 3 What abused women say they want from clinicians[23]

Before disclosure or questioning

- Understand the problem, including knowing about the community services and appropriate referral systems
- Ensure that the clinical environment is supportive, welcoming, and non-threatening
- Place brochures and posters in the clinical setting
- Try to ensure continuity of care
- Assure abused women about matters of privacy, safety, and confidentiality
- Be alert to the signs of abuse and raise the matter
- Use verbal and non-verbal communication skills to develop trust
- Be compassionate, supportive, and respectful towards abused women

When the topic of domestic violence is raised

- Be non-judgmental, compassionate, and caring when questioning about abuse
- Be confident and comfortable asking about domestic violence
- Do not pressure women to disclose abuse as simply raising the topic can help women
- Ask about abuse several times because a woman may disclose abuse at a later date
- Ensure that the environment is private and confidential, and provide time

Immediate response to disclosure

- Be non-judgmental, with compassion, support, belief of experiences
- Acknowledge the complexity of the problem, and respect the woman's unique concerns and decisions
- Put the needs identified by the woman first, and help to ensure that social and psychological needs are met
- Take time to listen, provide information, and offer referrals to specialist help
- Validate her experiences, challenge assumptions, and provide encouragement
- Respond to any concerns about safety

Response in later interactions

- Be patient and supportive, and allow her to progress at her own therapeutic pace
- Understand the chronicity of the problem and provide follow-up and continued support
- Respect the woman's wishes and do not pressure her into making any decisions
- Be non-judgmental if a woman does not follow up referrals immediately
- Give abused women an opportunity to disclose abuse at a later date

Box 4 Possible validation statements if a woman discloses intimate partner violence[25]

- Everybody deserves to feel safe at home
- You don't deserve to be hit or hurt. It is not your fault
- I am concerned about your safety and wellbeing
- You are not alone. I will be with you through this, whatever you decide. Help is available.
- You are not to blame. Abuse is common and happens in all kinds of relationships. It tends to continue
- Abuse can affect your health and that of your children in many ways

Stages of change and safety planning

Qualitative studies show that women in abusive relationships are at various points in a cycle of change (precontemplation, contemplation, decision, or action) with regard to the abuse.[26] Some women who are at the precontemplation stage need brief messages suggesting a possible connection between symptoms and their experience of abuse. Those who are at the contemplation stage need encouragement to explore possibilities of change with the clinician's help. At the decision stage, resources and support need to be explored further; and at the action stage, some women need their injuries documented or referral to an advocate or counsellor. A systematic review of qualitative studies found that, whatever the stage, women experiencing intimate partner violence want recognition and continuing support from clinicians, without pressure for a particular course of action.[22]

Limited evidence exists of effectiveness of interventions involving advice on safe behaviour and safety planning from three controlled trials.[27,28] However, clinicians need to inform women that the risk of violence increases at the time they are leaving or after they have left the abusive partner.[24]

Psychological interventions

A systematic review of 11 controlled studies found that psychological treatments largely based on the principles of cognitive behavioural therapy may benefit women survivors of abuse.[4] In most of these studies the interventions were delivered by therapists with additional training in intimate partner violence and may not be appropriate or even safe while a

woman is still experiencing the violence. These psychological treatments have the greatest potential for improving long term mental health outcomes, although most studies have just measured short term benefit.[4]

Managing other members of the family

General practitioners are often the only clinicians who see not only the woman who is experiencing the abuse but also the perpetrator and the woman's children. The central principles for management of the family, drawn from an expert consensus panel, are the safety and confidentiality—within legal limits—of the victims, the children, and the perpetrators, who may self harm as well as harming others in the family.[3]

Children

Intimate partner abuse and child abuse are closely associated.[16] If a woman has disclosed intimate partner violence, clinicians should, if a safe opportunity arises, do the following:

- Assess either parent's perception of the impact of the abuse on the children
- Ask the older children independently about their safety and level of support
- Let the children know that the abuse is not their fault and offer confidential support and referral where possible
- If child abuse is clearly present and the non-offending parent has been unable to improve her own or her children's safety, clinicians are obliged to report the matter to child protection services.

A systematic review found that parenting interventions with women survivors and their children improve behavioural and emotional outcomes for women and children.[29] Other than for children, research evidence is limited on intervening with couples and perpetrators.

Couples

A cross sectional study[30] found that clinicians often base management decisions more on their relationship with the couple than on the severity of violence. Clinicians should never try to raise the problem of intimate partner violence with the perpetrator without first seeking the victim's permission. Even if it is a safe and appropriate option, generalists usually do not have the training to conduct couple counselling. Joint counselling for a couple where one partner is abusive should be conducted (if at all) by a specialist agency with expertise in domestic violence.

Perpetrator

Evidence is limited about the proportion of men in clinical populations who use violence in their relationships. They are at increased risk of depression and substance misuse and were more likely to have experienced abuse in childhood.[31] They are unlikely to disclose their violence spontaneously to a clinician but may present with mental health problems or difficulties controlling their anger, or at times of acute crisis in their relationship. Perpetrators are a heterogeneous population and clinicians' responses may vary with a perpetrator's willingness or ability to change his behaviour. Our consensus expert panel made the following recommendations to clinicians:

- Move from general questions to possible perpetrators ("how are things at home?") to specific questions ("how does your wife/partner/children respond when you shout/hit/threaten?")

Box 5 Assessing safety of women experiencing intimate partner violence[24]

- What does she need in order to feel safe?
- Have the frequency and severity of the abuse increased?
- Is her partner obsessive about her?
- How safe does she feel?
- Has she been threatened with a weapon?
- Does he have a weapon in the house?
- Has the violence been escalating?

A PATIENT'S PERSPECTIVE

When I was 19 I began a relationship with a man that was characterised by what I now know is intimate partner violence. He would have regular outbursts during which he would behave very aggressively towards me and his two children from his first marriage. In addition, he isolated me from family and friends and kept me desperately short of money. I lived for eight years in a state of fear, trying to placate him in any way I could to stave off the next attack on me and the children. I told no one about the abuse because I found it incredibly shameful and I could not believe it was really happening to me.

I left him after my son was born because I began to see how damaging his behaviour was to me and my baby. Shortly after, I managed to move to another state in an effort to keep my baby and me safe. Within weeks of the move I began to develop chronic insomnia, flashbacks to abusive incidents, nightmares accompanied by cold sweats, intrusive thoughts about the abuse, and an avoidance of anything associated with my ex-partner. A family friend helped me to connect with a general practitioner who had expertise in the field of intimate partner violence, and together we began the slow process of recovery.

My general practitioner referred me to various supportive organisations, as well as to a psychiatrist and a solicitor (by this time I was facing family court proceedings). She prescribed the medications I needed at the time (antidepressants and sedatives), wrote letters to the family court, and provided weekly or fortnightly supportive sessions, which she bulk-billed. At this time I was greatly dependent on the medical profession for the management of the after effects of the abuse.

After about three years I began to be more self sufficient in managing these after effects. For example, I began to exercise as a way of managing anxiety and was able to stop taking the antidepressants. I also became very engaged with my psychotherapy and began to "process" the abuse and its effect on me and my son. Now, five years after leaving my ex-partner, I have formed a relationship with a wonderful man who is very loving and protective towards me and my son—this relationship has been very healing and I no longer take any medication.

I know that the abuse and its after effects will never go away, particularly in the light of the ongoing contact that my son has with my ex-partner as a result of a court order. However, I also know that I have found ways to make what was once unbearable bearable, and I could not have reached this point without the support of my dedicated general practitioner and psychotherapist.

QUESTIONS FOR FUTURE RESEARCH

- Do system-level interventions in healthcare settings improve the response of health services to survivors of partner violence or improve health outcomes for women?
- Do psychological and advocacy interventions after disclosure of partner violence in healthcare settings—whether this is the result of screening, routine inquiry, or selective inquiry—reduce violence and improve quality of life and mental health?
- What do women want from health care or healthcare related interventions after disclosure of partner violence?
- What is the natural course of partner violence?
- What is the long term prognosis for survivors of partner violence after identification in healthcare settings?

- If a man discloses his violence, acknowledge his courage and the unacceptability of violent behaviour and offer ongoing support if he is willing to change
- If you feel hostile towards or are in a compromised relationship with the perpetrator, consider referring him to another practitioner
- Assess the patient's suicide risk and his family's safety and offer only limited confidentiality
- Refer him to an accredited behaviour change programme.

Although the evidence for effective interventions for perpetrators is not strong and is based mostly on mandatory programmes, evidence from their partners in a longitudinal study suggests that for those men who do remain in programmes, their partners' quality of life improves.[25]

System change

A systematic review of nine controlled studies of system based interventions that were centred on staff training with additional quality assurance (including audit, posters in waiting areas, and clinician prompts) and referral measures found a short term increase in the identification of women experiencing intimate partner violence and in referrals to specialist domestic violence services.[4]

Conclusion

Responding appropriately to intimate partner violence in healthcare settings should become part of good clinical practice. A synthesis of interview studies[23] found that women want clinicians to have a low threshold for asking about abuse in relationships and to be confident about validating the experience of the survivor, checking their immediate safety and that of their children, and referring to the appropriate expert service if that is what the woman wants. For general practitioners and others who can provide continuity of care, follow-up and non-judgmental long term support are crucial for all family members when intimate partner violence is present.

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ADDITIONAL EDUCATIONAL RESOURCES

For healthcare professionals

- Roberts G, Hegarty K, Feder G. *Intimate partner abuse and health professionals: new approaches to domestic violence*. London: Churchill Livingstone Elsevier, 2006. (Recent overview of intimate partner violence and health care, including history, health impact, education of healthcare professionals, interventions, and cultural diversity)
- Taft A, Hegarty K, Feder G, on behalf of the Guidelines Development Group. *Management of the whole family when intimate partner violence is present: guidelines for the primary care physicians*. Melbourne, VIC: Victorian Government Department of Justice, 2006. www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/Familywomenviolence/Intimatepartnerabuse/20060507intimatepartnerviolence.pdf (International consensus guidelines, on which much of this clinical review is based)
- Department of Health. *Responding to domestic abuse: a handbook for health professionals*. London: DoH, 2005. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4126161 (Guidance on responding to survivors of intimate partner violence and their children)

For patients and the public

- Family Violence Prevention Fund (http://endabuse.org/programs/healthcare/)—US based organisation campaigning against family violence with one of the best generalist websites on intimate partner violence and health
- Women's Aid (www.womensaid.org.uk/)—The most comprehensive and practical website for survivors of intimate partner violence in the UK
- Australian Domestic and Family Violence Clearinghouse (www.austdvclearinghouse.unsw.edu.au/)—Provides high quality information about domestic and family violence matters and practice in Australia

SUMMARY POINTS

If you suspect intimate partner violence, ask all family members directly about any abuse they may be experiencing or perpetrating

Check adult and children's safety and make a safety plan if appropriate

Respond non-judgmentally and offer ongoing support

Do not offer couple counselling

Refer women and children to advocacy and therapeutic programmes

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1 Watts C, Zimmerman C. Violence against women: global scope and magnitude. *Lancet* 2002;359:1232-7.
2 Campbell JC. Health consequences of intimate partner violence. *Lancet* 2002;359:1331-6.
3 Taft A, Hegarty K, Feder G, on behalf of the Guidelines Development Group. *Management of the whole family when intimate partner violence is present: guidelines for the primary care physicians*. Melbourne, VIC: Victorian Government Department of Justice, 2006. www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/Familywomenviolence/Intimatepartnerabuse/20060507intimatepartnerviolence.pdf
4 Ramsay J, Feder G, Rivas C. *Interventions to reduce violence and promote the physical and psychosocial well-being of women who experience partner abuse: a systematic review of controlled evaluations*. London: Department of Health, 2005. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4126266.
5 Krug E, Dahlberg L, Mercy J, Zwi A, Lozano R. *World report on violence and health*. Geneva: World Health Organization, 2002.
6 Tjaden P, Thoennes N. *Extent, nature, and consequences of intimate partner violence*. Washington, DC: US Department of Justice, 2000:1-62.
7 Walby S. The cost of domestic violence. London: Department of Trade and Industry, 2004.
8 World Health Organization. *Multi-country study on women's health and domestic violence against women*. Geneva: WHO, 2005.
9 Hegarty K, Bush R. Prevalence of partner abuse in women attending Australian general practice: a cross-sectional survey. *Aust NZ J Public Health* 2002;26:437-42.
10 Richardson J, Coid J, Petruckevitch A, Wai Shan C, Moorey S, Feder G. Identifying domestic violence: cross sectional study in primary care. *BMJ* 2002;324:274-7.
11 Bradley F, Smith M, Long J, O'Dowd T. Reported frequency of domestic violence: cross sectional survey of women attending general practice. *BMJ* 2002;324:271-4.
12 McCauley J, Kern DE, Kolodner K, Smith J. The "battering syndrome": prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. *Ann Intern Med* 1995;123:737-46.
13 VicHealth. *The health costs of violence. Measuring the burden of diseases caused by intimate partner violence*. Melbourne: Victorian Health Promotion Foundation, 2005.
14 Golding J. Intimate partner violence as a risk factor for mental disorders: a meta-analysis. *J Family Violence* 1999;14(2):99-132.
15 Pinheiro PS. *World report on violence against children*. Geneva: United Nations, 2006.
16 Bair-Merritt MH, Blackstone M, Feudtner C. Physical health outcomes of childhood exposure to intimate partner violence: a systematic review. *Pediatrics* 2006;117:278-90.
17 Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? Systematic review. *BMJ* 2002;325:314-8.
18 Wathen N, MacMillan HL. Interventions for violence against women: scientific review. *JAMA* 2003;289:589-600.
19 Nelson HD, Nguyen P, McInerney Y, Klein J. Screening women and elderly adults for family and intimate partner violence: a review of the evidence for the US Preventive Services Task Force. *Ann Intern Med* 2004;140:382-6.
20 Gerbert B, Johnston K, Caspers N, Bleecker T, Woods A, Rosenbaum A. Experiences of battered women in health care settings: a qualitative study. *Women & Health* 1996;24(3):1-14.
21 Sohal H, Eldridge S, Feder G. The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice. *BMC Fam Pract* 2007;8(1):49-52.
22 Feder G, Hutson M, Ramsay J, Taket A. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Arch Intern Med* 2006;166:22-37.
23 Gerbert B, Caspers N, Milliken N, Berlin M, Bronstone A, Moe J. Interventions that help victims of domestic violence. *J Fam Pract* 2000;49:889-95.
24 Campbell JC, Webster D, Koziol-McLain J, Block C, Campbell D, Curry MA, et al. Risk factors for femicide in abusive relationships: results from a multisite case control study. *Am J Public Health* 2003;93:1089-97.
25 Gondolf E. Reassault at 30-months after batterer program intake. *Int J Offender Ther Comp Criminol* 2000;44:111-28
26 Zink T, Elder N, Jacobson J, Klostermann B. Medical management of intimate partner violence considering the stages of change: precontemplation and contemplation. *Ann Fam Med* 2004;2:231-9.
27 McFarlane J, Groff J, O'Brien J, Watson K. Secondary prevention of intimate partner violence: a randomized controlled trial. *Nurs Res* 2006;55(1):52-61.
28 Tiwari A, Leung W, Leung TY, Humphreys J, Parker B, Ho P. A randomised controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *BJOG* 2005;112:1249-56.
29 Feder G, Hester M, Williamson E, Dunne D. Reducing intimate partner violence. In: Trafton JA, William GP, eds. *Best Practices in the behavioural management of health from pre-conception to adolescence*. Los Altos, CA: Institute of Disease Management, 2008.
30 Ferris L, Norton P, Dunn EV, Gort EH. Clinical factors affecting physicians' management decisions in cases of female partner abuse. *Fam Med* 1999;31:415-25.
31 Oriel MF. Screening men for partner violence in a primary care setting. A new strategy for detecting domestic violence. *J Fam Pract* 1998;46:493-8.