*Review Article*

# Domestic Violence: With Emphasis on International Cultural and Societal Variations

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**Abstract**

Domestic violence is serious health and social problem that constitute an obstacle to nation's development and welfare through preventing women from enjoying their fundamental right and hindrance of their development.

Domestic violence is classified into three categories, physical violence (anything from pulling to use of fire weapons), psychological abuse and controlling behaviours (both range from shouting to verbal abuse and social and economic restriction).

Two major factors are responsible of domestic violence, the subordinate position of women in the society, and the social acceptance of violence as a method to resolve family conflicts. Then factors at the individual level stem from these two factors (e.g. poverty, age, poor education, alcohol). At the long time, there are grave health and social consequences for domestic violence.

There are emergency care measures to victims. Initially, the health setting should deal with the abused women as a health problem; then they should be referred to the concerned parties for support.

Prevention of domestic violence need implementing of multi-disciplinary programmes with participations of non-governmental organizations, governmental departments, legal authorities, medical profession, academicians, media and religious men to deal with the problem at all levels, individual, family and society. Major lines of DV prevention include women empowerment, and adopting measures to combat societal and individual and combating sociocultural norms that encourage violence against women (changing perceptions). Some issues in DV prevention strategies are relevant to men and should be addressed (e.g. alcohol, their concepts on masculinity and men's social roles). Research on domestic violence should be promoted and to allocate part of research fund to this topic.

***Keywords:*** Domestic violence; Intimate partner violence; Dynamics of domestic violence

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**الملخص**: العنف المنزلي هو مشكلة اجتماعية ذات علاقة بالصحة وهو يشكل عقبة أمام رفاه المجتمع وتنميته من خلال منع النساء من التمتع بحقهن الأساسي وإعاقة تنميتهن. ويصنف العنف المنزلي إلى ثلاث فئات هي العنف الجسدي (أي شيء من السحب وحتى استخدام الأسلحة النارية)، والإيذاء النفسي والسلوكيات المسيطرة (وهما يبدآن من الصراخ وحتى الشتم والتقييد الاجتماعي والاقتصادي). اثنان من العوامل الرئيسية المسؤولة عن العنف المنزلي هما وضعية المرأة كتابعة في المجتمع، والقبول الاجتماعي للعنف كوسيلة لحل النزاعات العائلية؛ ثم العوامل المتجزرة على المستوى الفردي من هذين العاملين (مثل الفقر، والعمر، وضعف التعليم، والكحول). منذ وقت طويل، هناك مشاكل صحية خطيرة وعواقب اجتماعية ناتجة من العنف المنزلي.

هناك تدابير رعاية طارئة لضحايا العنف المنزلي. في البداية، يجب على القطاع الصحي التعامل مع العنف المنزلي كمشكلة صحية. ثم يجب إحالة الضحايا منن النساء إلى الجهات المعنية للحصول على الدعم اللازم. الوقاية من العنف المنزلي في حاجة لتنفيذ برامج متعددة التخصصات مع الحاجة لمساهمات المنظمات الطوعية والدوائر الحكومية والسلطات القانونية، و الطب، والأكاديميين، ووسائل الإعلام ورجال الدين للتعامل مع المشكلة على جميع المستويات المتمثلة في الفرد والأسرة والمجتمع. تشمل الخطوط الرئيسية للوقاية من العنف المنزلي تمكين المرأة، واتخاذ تدابير لمكافحة الأعراف الاجتماعية ومكافحة العادات الثقافية المجتمعية والفردية التي تشجع على العنف ضد المرأة (تغيير المفاهيم). بعض القضايا الاستراتيجية لمنع العنف المنزلي هي ذات الصلة بالرجل وينبغي معالجتها (مثل الكحول، والمفاهيمهم حول الذكورة والأدوار الاجتماعية للرجال). ينبغي تشجيع إجراء البحوث العلمية الخاصة بالعنف المنزلي وتخصيص جزء من التمويل للأبحاث المتعلقة بهذا الموضوع.

## What is domestic violence?

Violence, literally, is defined as behaviour toward another person which is outside the norms of conduct, and entailing a substantial risk of causing physical or emotional harm.[1] Common types of violence include war and war crimes such as rape and ethnic cleansing, state violence, politically rooted turmoil, street violence and violence against women (VAW). Violence against women (usually rooted on sex inequality), includes domestic violence, rape, harassment, forced prostitution, genital mutilations, early (child) marriage, sex selective abortion, wife inheritance, abuse of elder women, honour killing, acid throwing, economic restriction, forbidding employment, and state perpetrated violence (including laws that criminalize some women's dresses or their relations with men). The list of perpetrators in VAW is too long including, for example, spouses, parents, teachers, employers, religious men and policemen.

Domestic violence is the most common type of violence against women, as the victim is nearby to the abuser all the time. Synonyms of DV include domestic abuse, wife abuse, family violence, spousal abuse, intimate partner violence (IPV) and battering. The term 'IPV' should better be reserved for areas where men-women intimate relationships are allowed outside formal marriage, in 'unions 'such as cohabitation and intimate partnerships. Some researchers used this term 'IPV' to describe unions that include sexual abuse in both formal marriages and other relationships.[2]

Domestic violence (DV) is a violence exerted toward the woman by a family member (most commonly the husband or the

intimate male partner).[3] The WHO defined DV as acts of physical, sexual and emotional abuse by a current or former partner whether living together or not. [4] The American Medical Association defines DV as a pattern of physical, sexual and/or psychological abuse by a person with whom the victim has had an intimate relationship.[5] Some researchers favour using a broad definition for DV (by including omissions beside offending acts) to enable entry of wider social parties in the programmes against it, although this may lose it its very descriptive nature.[6] Some researchers, for the purpose of their works, use an operational definition of DV as that any act that is perceived as violent by the respondents. [7] For the purposes of this article, the Authors use only the term 'DV' to avoid using the term 'IPV' that imply presence of an intimate partner other than the 'husband', which is not accepted in many cultures throughout the world, whereas the term 'DV' is a neutral term and is not connected to type of man-woman union.

Rarely the husband can be the victim, or both partner (mutual violence).[8] In some cultures with extended families, the source of violence may be the father, brothers or even other first degree relatives (in-laws). But, nevertheless, the husband is the more likely the abuser rather than other parties.

## Domestic violence: global magnitude

The international attention to DV had started since the first report about battered women appeared in early 1970s.[9] Domestic violence occurs in all ages, cultures, races, socioeconomic classes, religions and crosses all geographical boundaries.

The prevalence of DV varies between 40% in American and British studies, and 45% in African and Asian studies.[6,10,11] There is an impression that one third of women attending general practices had experienced violence.[12] In Egypt, Palestinian lands, Israel and Tunisia one in three women are abused by their husbands. [7] In rural Vietnam, the prevalence of lifetime DV reaches 31%.[13] In Iran, a study indicated that the prevalence of physical violence is 15%, whereas that of psychological abuse had reached 82%.[14]

In general, according to the WHO multi-country study, the prevalence of physical domestic violence in most countries is 23-49%. [15] The lowest rates of DV were reported from Japan, whereas the highest were reported from Bangladesh, Peru and Ethiopia.[15] Prevalence rates in developed versus developing countries varies between 28% and 67%.[16]

We observe that DV is not considered a major public health problem in the Third World, receiving only a small public and formal attention (although the studies revealed a lifetime prevalence that exceeded 40%).[1,16]

## Patterns of DV

The patterns (forms) of DV are classified into three major categories, physical violence, psychological abuses and controlling behaviours (Table 1).

The physical abuses include wide ranges

of assaults ranging from pushing or pulling the victim, to use of weapons. Anything from a mild pain to death may result from physical injuries (e.g. wounds, haematomas, abrasions, fractures, burns and scalds, dental injuries, jaw injuries, oral soft tissues injuries, homicide). [1] Physical abuses include sexual abuses such as forcing wife to sexual intercourse, coercing (forcing) sexual acts and marital rape; it results in unintended pregnancies, abortions, adverse pregnancy outcomes (such as low birth weight or perinatal death, maternal morbidity or even mortality) and sexually transmitted diseases.[1]

Psychological abuses include verbal abuses, criticizing wife at public in a humiliating way and threatening behaviors (throwing things, threatening with a fist, threatening to injure the children, threatening with a weapon, threatening with divorce or remarriage).

The controlling behaviors include shouting or yelling at her, criticizing her in public, restricting her social life, checking her movements (being stalked) and keeping her short of money.

There is an overlap of the different types of DV especially psychological abuse and controlling behaviors (both are considered as an attempt to control the abused partner).[17] But we think it is better to be taken in separate, as the degree of severity of psychological abuse is much more than controlling behaviors. Anyhow, the psychological abuse and controlling behaviors are considered the commonest.[13]

## Theoretical basis of domestic violence

Although the DV is linked to certain demographic and socioeconomic correlates, but no family is exempted from the possibility of its occurrence. It can occur even in a normal appearing life of spouses with significant professional success. In fact DV can occur in all religions, social classes, races, economic backgrounds and geographical boundaries.

Theoretically, DV is a product of the interaction of factors at four levels, individual, family, society and community levels.[18,19] At the individual level, DV is determined by husband's abuse as a child, witnessing violence at home, having an absent or rejecting father, poverty and frequent use of alcohol or drugs. Factors at the family level include marital conflicts and dominant male control of wealth and family issues. In certain societies (especially in the Third World), marriage is a whole family affair, and its interests to family should be considered prior to the individual options (family may have a veto on the future wife). The societal factors include lack of support and isolation of family and women. At the community level, DV is determined by linkage of the concept of masculinity to male honour or dominance, acceptance of violence as a way to resolve conflicts, social tolerance of physical punishment of women and prevalence of some religious concepts that favours male supremacy and confers on men the right to correct their 'erring' wives.

In many societies, the above mentioned factors result in the current subordinate position of women and the unfair 'family order'. Thus, men are families' masters, and women should 'serve' them and to

show obedience. Violence, then, occurs on breaching these roles.[1,20-21]

Abusers, usually, tend (or pretend) to be 'perfectionist' and also demand 'perfection' from their surroundings. This area of their personality may serve them to justify their violence toward their wives. Abusers, commonly exert controlling behaviours, are usually jealousy and tend to accuse their partners of flirting or extramarital sexual acts. This may be due to their poor self-esteem; on the other hand, he 'learned' that emotional abuse and physical violence get him what he wants.

## Causes and risk factors of domestic violence

In Table 2, we list the possible causes and risk factors for occurrence of DV. In DV studies, there is an overlap between concepts of cause and risk factor, but in this article they are taken with the same significance.

In the presence of the risk factors or susceptibility to DV, very minor or 'absurd' things can trigger an immediate violent episode, e.g. talking back, not having food ready on time, refusal of sex or suspicious behaviors (Table 3). We notice that there is an overlap between some triggering and risk factors.

Age is a known risk factor for DV, with young women are more susceptible to assaults. In a study by the first author (AMA), the high gap in wife-husband age was found more significant than absolute wife's age as a determinant of violence.[1]

Poverty is an important risk factor for DV. It is more frequent and severe among poor families. But affluent families are not exempted. The link between poverty and violence is, usually, through stress generation.[1, 2] In some situations there is income inequality between husband and wife within the family net poverty, e.g. when the wife is working and the husband is unemployed, or when her income is higher; this factor is thought to be a source of violence.

Alcohol (especially problem drinking) is linked to DV. Alcohol reduces both inhibitions and ability of judgment. A relevant source of violence is argument about alcohol drinking, especially when affects family's budget or professional performance of the husband.[2] Some abusers knows that the society may accept the excuse that alcohol or drug by lowering the inhibitions may 'urge' them to be violent.

The in-laws can be a source of wife battering due to factors such as dislike of wife, miscommunications, husband's favouring of wife over parents, arguments, infertility, not having a male kid (a wrong belief that the mother is responsible of the child's sex).[7] The presence of inlaws, or even the large number of kids resulting in crowded homes provide a suitable environment tensions and conflicts and then violence.[2] The crowded homes may lead to overburdening the domestic work on the wife, as some of the inlaws may expect that their son's wife to be their servant. The competition between the wife and the in-laws on the attention of the husband may

generate violence. A similar situation occurs in polygamous families living in one home, where jealousy, suspicions and seeking preference of the husband lead also to violence.[22, 23] Even more, the large number of children is closely associated with DV even in nuclear families.[2]

Lack of social support and isolation of the wife leave her more susceptible to battering. Social support, e.g. from families, non-governmental organizations (NGO), governmental parties such as legal and welfare authorities is protective against DV. An early step in wife battering is tendency of abusive husbands to isolate wives and restrict their movements and contacts with the others. This is not only generating violence but increases its frequency and severity. These abusive husbands usually fear revealing and discussing their wives assaults with the 'strangers', so this further justified the usefulness of social support. Social support may be more useful through empowerment of women, through improving her education, income, community role and other forms of social support.[22,23]

Educated women enjoy more autonomy, and usually are economically independent to a greater extent. In general, high educational attainment is associated with lower rates of DV. Educated women have a greater range of choice in partners. Also educated women are in a better position to control her income and the family's wealth. On the other hand less educated women are more likely to accept the traditional gender role that favour males' supremacy. [24] But a point to be considered is that in many conservative societies that favour male dominance, the relatively liberal ideas of educated women may leave them at a greater risk of violence. [2] Then, education can be a protective and a risk factor for DV in certain conditions.

Witnessing of violence within abusers and victims' parental families is an important determinant of DV. It leads to its normalization as a way of conflict resolution. Then, this concept passes from generation to generation.[25]

There is a debate on the effect of urban/rural residence on prevalence of DV. The WHO multi-country study indicated higher rates of violence occur in rural areas.[15] But some studies indicated higher rates in urban areas.[25] This may underlie some failure in coping with values and stresses of urban life. As well, the conservative rural societies may lead to under-reporting cases of violence due to their acceptance and tolerance of marital assaults.

Some health conditions and problems have some relevance to DV. Women with chronic diseases such as diabetes mellitus and hypertension are vulnerable to violence due to diverting part of the family's budget to their care, and by inadequate home care due to their diseases.[26] Association of pregnancy to DV was mentioned elsewhere in this article.

## Responses of victims

Domestic violence is, nevertheless, a crime and constitutes a violation of human rights,

and should never a part of normal marital relationships.

Usually the women are 'sustained' victims of DV because they are physically weak, their dependent status, the social tolerance of women abuse and the private domain that violence occurs in. Domestic violence is pervasive; involving several life aspects of abused women and evolves slowly over a long period of time. Once it is established, it becomes a chronic phenomenon and part of the life regular events of the abused women. The abusers, usually, tend to limit avenues of escape for their victims.

The response of the victim to assaults varies according to different individual and socioeconomic factors. A large number of the victims, especially in developing countries, opt to remain silent, and then stay in the abusive relationship. This is usually due to lack of autonomy (resulting from poverty, lack of professional skills or poor education), fear of social stigma, fear of violence escalation, feeling that disclosure of violence is unhelpful, adoption of societal norms of the husband's right to beat his wife, feeling shame or embarrassment that they are battered, feeling that her children need a father however bad. Abused women tend to develop conflict avoiding personality in a trial to avoid anger and problems with the side of her partner. The conflict avoiding behaviour may extend outside the family to friends and coworkers. The net resultant is tightening of the social isolation (which is in itself a risk factor for violence initiation or escalation).

Other responses include seeking medical help, approaching a family member, seeking help from NGO or police or considering leaving this 'bad' relationship (divorce). But what is frustrating is that divorce may generate more violence by stalking or even murder. [2] In North America, there is a high prevalence of severe violence among divorced women, more than other communities. [2]

What is worse than DV is the acceptance of women at some cultures of it as a method for punishment or discipline for married women. Some abused wives saw so much violence in their lives before marriage, and she might think that this is normal. In African studies, percentages of women's justification for their battering by husbands range from 66% in Nigeria to 90% in rural Uganda.[27,28] The situation in Middle East and Asia is similar.[11]Even more, the abused wives, at times, are blamed as being 'disobedient' or failing to satisfy her husband as a 'good' wife. Some studies indicated that factors associated with women's acceptance of violence include disempowerment, fear of divorce, younger age at marriage and rural residence.[16]

Some wives who realize the criminality of wife abuse fear the punitive actions of husbands or their families if they decide to go to the police, or ask for divorce, as they may lose their children. A large proportion of them are unable to lead an independent life to their limited resources.

## Sequelae of DV

Apart from the immediate results of DV such

as physical injuries or acute psychological reactions, there are long term sequelae.[29] Physical disabilities due to severe assaults, such as weakness or blindness may occur. Psychiatric conditions such as anxiety, depression and suicidal thoughts and attempts are commonly encountered.[2] Unexplained chronic health problems, e.g. fatigue, abdominal pain, post-traumatic stress disorders may occur and warrant screening for occult DV in appropriate cases.[30]

Not only physical or mental health that deteriorates with DV, but other life aspects are affected. Some victims may suffer lack in confidence, poor self-esteem and distorted self-image. Victims capitulate to the abusers' demands through isolation, fear, shame and insufficient financial resources. Marital conflicts amounting to divorce may escalate with continuity of abuse. Hindrance of women's participation in the social and economic well-being of the society occurs due to poor social skills and failure to create and maintain normal social relations. Even children of abuse families are not immune of sequelae of DV, such as dis-regulated aggressions from early age, disturbed sleeping, nightmares, constant waking, enuresis and fear of the dark.[31]

## Domestic violence in medical practice

Domestic violence is a real public health problem. [32-34] The clinician may be the first professional contact for DV victims. [35] And at times may be the only contact. All body systems and both physical and mental heaths are affected by DV, in a wide spectrum, from pain to severe burns and even physical disabilities. Both short and long term health consequences are expected to occur; at times can be a life threatening event. Some studies indicate that 1 in 10 up to 1 in 5 women attending emergency departments have problems related to DV.[36] Some unexplained medical problems such as chronic headache, fatigue or abdominal pain are linked to DV.[30] Other medical problems associated with DV include sleeping disorders, malnutrition, eating disorders, panic attacks, self-neglect and sexual dysfunctions. Pregnancy is reported to increase the risk and pattern of assaults to women due to associated hormonal and psychological changes that may depress her mood and activity. Then violent actions can be initiated by even minor events. In conclusion, the similarity of DV relation to health is as the similarity smoking relation to ischaemic heart disease. In conclusion, due to inter-relationship of DV with other medical problems, care for abused women should be integrated into existing health services rather than as a stand-alone service.[35]

In clinical practice, the commonest cause of missing a case of DV is, merely, not to ask about battering, or even not be put it as a possibility. Simply, this is due to that health personnel are not taught or trained to identify, support or refer DV victims; so it is important to take a good medical history as it is an important tool to discover cases.[37]

There are several factors in the clinic setting that may suggest presence of abuse and should

be noted by the examining doctor. Usually, there is a delay between time of injury and time of presentation to medical care (patient is unable or unaffordable to leave home by public transportations). There is a tendency to self-treatment of injuries. The victim is, usually, young, with an increased age gap compared to husband; appears depressed, with poor eye contact, withdrawn or fearful of visitors and caregivers. The husband often accompanies victim, refuses to leave the patient alone and may insist to answer questions for the patient. [38] There is a history of multiple visits to emergency departments, with repetitive complaints inconsistent with organic disease and prevalence of psychosomatic symptoms secondarily to depression or anxiety. Physical injuries are usually bilateral at multiple sites and with fingernail markings scattered on the body.

There are several barriers of efficient case taking of abused patients. Patients are non-compliant to appointments. Some doctors tend to blame the victims (may be themselves adopt the common social norms that tolerate DV). The patients may be questioned in an inappropriate manner. An important barrier is the low index of suspicion of DV by many doctors, and then DV is not considered in differential diagnosis of suspected cases, leading to failure or delay of the diagnosis. The DV as a differential diagnosis is usually not considered by doctors because the abusive husbands appear concerned and attentive when accompany victims to medical care

Considering DV as a health problem carries several advantages. Health settings are the first place, and may be the only one that DV victims attend. The private nature of the medical encounter encourages victims to reveal their problems. The public health approach usually adopts epidemiological methods that investigate victims and abusers' characteristics, and circumstances and reasons of violence.

Thus, the public health approach provides a good basis to implement prevention programmes.

Unfortunately, there are several shortcomings that prevent the medical profession from significant contribution in handling the problem of DV. The medical professionals are unaware of nature and extent of DV even as social problem.[39] Some even do not recognize DV as a health problem. Medical professionals are unaware of their role to help the victims of DV, thinking that their role is limited to treatment of the bodily manifestations.[3] Even the doctors who realize occurrence of DV may fear involvement in prolonged court proceedings. Some doctors may share the society misconceptions that DV is rare, or a private matter, then fear offending women if ask them about husband's abuse. Even some doctors may erroneously label victims as hypochondriatic or hysterical.[39] Doctors' unawareness of social and psychological dimensions of violence leads to its escalation. There is a lack of teaching and training on DV in medical schools. The unprepared or uninterested doctors are harmful by minimizing abuse and then

increase victim sensation of entrapment and helplessness.[39]

## Management of domestic violence

Domestic violence is not a simple health problem like chest infection that needs a short medical encounter and prescribing a drug to be treated for good.[40] It is a complicated health problem with socioeconomic and cultural dimensions that should be properly addressed, beside, of course, to organic and mental associated problems. For this reason, we better adopt the concept of 'management' rather than 'treatment' to include these aspects in its handling.

First, due to the special nature of cases of DV, there are some prerequisites to be fulfilled for an efficient management of DV victims. A private and save environment should be secured for the encounter, as the victim is reluctant to speak or disagree in the presence of his partner. The examiner should ask simple questions in a neutral manner that does not justify the abuse. The patient should be respected, cared of and listened to, in a safe environment and ensuring him that she is not at fault. The clinician should avoid certain behaviors such as judging, pitying, blaming and trivializing.[41]

Emergency medical care for DV victims is a top priority, e.g. emergency, surgical and medical treatment of physical injuries, involvement of all medical departments when needed, e.g. obstetrics, orthopaedics, physiotherapy, dental departments. A psychiatric consultation is needed in some cases for mental status assessment, and screening for suicidal thoughts and attempts.

Next step in management of DV is to help the victims to access social support, or referring them to colleagues with better knowledge on such areas. For this reason part of the medical encounter should be devoted for asking about (and observing) the risk factors for abuse, as their knowledge may help further supporting the patient, e.g. poor educational level, poverty, unemployment, alcohol and drug abuse by the perpetrators

## Prevention of domestic violence

The DV preventive strategies need implementing of a multidisciplinary programme with participations of medical profession, governmental departments, NGOs, legal authorities, academicians and religious men. The preventive programme should raise the governmental and public awareness to the occurrence of DV in the community and to provide medical, moral, legal and social support to victims. Raising awareness of the society to DV as a crime is important as, still, there are some social sectors that considering wife battering as a social norm or a personal issue (then others should not 'interfere').

Changes in the health system should be encouraged for better services to battered ladies, through training of all personnel, and issuing a multidisciplinary guideline to help in identification, treatment, counseling and prevention of DV.

In particular to train health personnel to have a high index of suspicion to suspect

and screen for cases of DV victims. Health service settings, by providing a private and confidential environment and easy accessibility for battered woman is an ideal place to establish preventive activities. Services of DV cases need not to be separated from the general clinics, but to be incorporated with them, as this may serve to label DV as a health problem and encourage abused women to attend.

A dual approach in preventive strategies is necessary, through women's empowerment to improve their status in the society, and through combating sociocultural norms that encourage violence against women (changing perceptions). [16] Empowerment of women can be initiated through education, participation in domestic decision making and to have a control over her income. Not only basic education to be available to all girls, but to include concept of gender equality and to remove any material that degrade women in its curriculae. University curriculae need revisions to include DV as a teaching and training topic for both under- and postgraduate students, especially in medical and social and human sciences schools. Modern banking assistance programs such as microfinance loans can be utilized to empower women from poor backgrounds.

Media (including social media sites in the Internet) can initiate debates to criminalize DV, and support campaigns against DV, and can encourage women empowerment in their societies. The media can get use of modern and elegant presentations such as soap opera, educational drama, community theatre and talk show programs. The media can support DV prevention by reducing portrayal of violence against women in its programs.

Steps to protect victims are needed, such as providing shelters, support of children, criminalization of DV and tightening of legal measures against abusers.

Strategies to prevent DV should address both wife and husband. For example, addressing education or income empowerment in women only, may result in a gap between the spouses that will be a source of more violence. Some issues in DV prevention strategies are relevant to men, and should be addressed and to including them (e.g. alcohol problem drinking, cultural roots of their controlling behaviors). This will explore men's behaviors, and discovers motivations necessary to secure success of preventive programs.

The preventive programs should be tailored according to situational societal and cultural concepts on women's roles and rights, and to type of DV, as there are significant differences between them, in reference to risk factors and characteristics of abusers and victims. Always difficulties are expected in such programs that address a longstanding multi-factorial problem. For example, women's acceptance, and even justification, for wife battering in some cultures is a great obstacle to prevent DV.

## Scientific research and domestic violence

Scientific research on DV is an important step for preventive programs. A great difficulty

of research in DV is its sensitivity, as a topic, in many cultures. In some societies, DV is not considered an appropriate topic to be discussed with 'strangers'.[24] Due to sensitivity of the DV in many cultures, the responses obtained may not reflect the true situation. Sensitivity of the DV issue may lead to prevalence underestimation in research studies. For this sensitivity, facilities such as health settings secure a confidential place for respondents. Most of studies on DV are designed as facility-based and not community-based studies. This will generate a shortcoming that it is difficult to generalize their results for the whole community as only a small portion of the targeted population attends facilities at one time. Community-based studies are, also, useful in providing reliable data on prevalence, frequency, patterns of DV.

The wide variations in obtained prevalence rates of DV may reflect major methodological shortcomings in tackling this problem. [42] Studies on men are useful to assess causes of DV and the impact of intervention programmes.[43] The private and intimate context where DV occurs poses further difficulties to study it.

Although the psychological abuse is the commonest of the DV patterns, but receives less attention from researchers.[44] This may be because physical violence is easier to define and measure, unlike psychological abuse and controlling behaviors. Even more, verbal abuses such as humiliations may not be perceived as an abuse by some women.[6]

Some steps in research should be carefully managed for more observance of respondents' safety and confidentiality.[43] For example, it is better to interview respondents in private rooms, with no other persons present, or can see or hear. In Interviewers, in some culture are better to be female, especially nurses, midwives or social workers to ensure respondents' trust and confidence. A verbal consent is preferred to a written one, as the latter may lead to identification of the respondent and may threaten her safety. For purpose of surveys, each country should issue a questionnaire tailored to the local societal and cultural norms. In particular, operational definitions are needed for more validation of questionnaires and other tools of data collection.

Points of strengths of research on DV include the community-based design, large size population, random sampling techniques, training of data collectors on interviewing techniques, choosing data collectors from sectors that are trusted by women such as midwives and nurses (this secure high response rates), use of validated questionnaires tailored according to local norms and cultural concepts on family and DV. The context of the interview, and the researcher's interviewing techniques should be considered as both may affect the validity of gathered data.

## Key issues 1
## Patterns of domestic violence

### I. Physical abuses

Hitting, shoving, slapping, pushing, pulling, shaking, punching, choking, kicking her on the floor, holding, binding, arm twisting, pulling hair, tripping, biting, burning, use of a weapon, forcing wife for sexual, intercourse (marital rape), coercion of certain sexual acts unaccustomed or unacceptable to the wife

### II. Psychological abuses

Threatening of physical harm, anger, yelling, false accusation, blaming wife when bad things occur to husband or family, intimidation, humiliation, degradation (make her feel bad of herself), economic restrictions (keeping partner short of money, prevent her from work, prevent her from controlling her earnings or dowry, property damage)

### III. Controlling behaviors

Not taking wife's opinion on family issues, husband gets angry on wife when speaking to another man, husband insists to know her movements and whereabouts, restriction of wife contact with her family or friends, suspicions of wife' unfaithfulness

## Key issues 2
## Causes of Domestic violence

### A. Wife's Demographic factors

Low educational level

Young age at marriage

No or low educational level

Having educational level higher than the husband

Low socioeconomic status (poverty)

Rural/urban residency

### B. Sociocultural norms degrading women's status

- Societal tolerance of women's beating
- Societal tolerance of physical punishment of women
- Societal Acceptance of violence as a way to resolve conflicts
- Wife acceptance of battering as a punishment method

### C. Adverse family environment

Crowded family (living with in-laws, large number of children)

Conflicts with in-laws

Overburdening domestic works

### D. Wife denied of power

Control of wife's income or dowry

Denying wife's decision of family issues

### E. Personal factors

Pregnancy

Witnessing violence at childhood

Use of alcohol

Infertility

Refusal of sex

Wife's isolation (lack of family and social support)

### F. Husband's factors

Wife's wide age gap

Poverty
No or low educational level
Unemployment (or its instability)
Use of alcohol or illegal drugs
Polygamy
Conflicts on family planning
Preference of sons
Sexual problems

## Key issues 3
## Immediate (triggering) factors for violent events

- Argument with husbands (e.g. talking back)
- Negligence of home
- Quarrel with children
- Negligence of children
- Not having food ready on time
- Refusal of sex
- Suspicious wife's behaviors
- Wife's going out without permission

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