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“Intimate Partner Violence in Lebanon: Overview of Screening and Follow-up Practices in Non-Specialized Social Work Settings”

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Abstract:

OBJECTIVE

IPV is widespread and affects many women in Lebanon, with harmful consequences for their physical and mental health, as well as their socio-economic well-being. However, few studies have examined screening practices in the country, particularly within non-specialized organizations. This article presents the first exploratory phase of Participatory Action Research (PAR) study conducted with social workers.

METHODS

A participatory Focus Group Discussion (FGD) was conducted with social workers practicing in non-specialized organizations to explore their current IPV screening and follow-up practices, perceptions of IPV screening and follow-up protocols, and training and support needs. The analysis was situated within a secondary prevention approach focused on the early identification of signs that may indicate IPV.

RESULTS

Social workers’ practices included non-systematic and unstructured approaches to IPV identification, including direct disclosure by women, indirect reporting by third parties, passive recognition, direct questioning, and indirect questioning. Challenges to IPV screening and follow-up included limited skills, lack of trust in services, and distrust toward women. Social workers highlighted the need for two distinct protocols for IPV identification and follow-up, including clear and structured procedures and tools. Knowledge of IPV definitions and signs, skills related to building trust, nonjudgmental attitudes, and clarity regarding their role in non-specialized social work settings were identified as key training needs. Timing, conditions, and institutional support were also identified as critical to strengthening social workers’ capacity to screen for IPV and support women exposed to it.

CONCLUSION

The findings highlight the need to strengthen the competencies and support provided to social workers to promote a proactive and consistent approach to IPV screening within non-specialized organizations. The development of a contextualized protocol could improve the identification and follow-up of women affected by IPV while strengthening the role of social workers in secondary prevention.

KEY WORDS: Intimate partner violence, screening, social work, secondary prevention, Lebanon.

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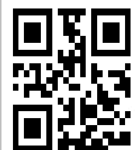

Introduction

Intimate Partner Violence (IPV) affects millions of women and has shattering long term effects on their health, mental health, socio economic wellbeing as well as their children's health. IPV affects around 840 million women, almost one in three women in the world between the ages of 15 to 49, have been subjected once to IPV or sexual violence (WHO, 2025). In Lebanon, there is no nationally representative data on IPV. Nevertheless, a study conducted in Lebanon in 2021, to evaluate the prevalence of violence against women (VAW) in the Lebanese population, found that the 37.1% of women were subjected to physical violence and that and 49.4% were subjected to non-physical violence (Rahme et al., 2021). In addition, a UNFPA study found that Lebanon ranks eight out of 10 countries with 35 per cent of women subjected to IPV including physical, and or sexual violence in the last 12 months (UNFPA, 2021). Results across studies highlight high levels of IPV in Lebanon and align with the global estimates.

In Lebanon, IPV screening studies have been limited and only conducted in health care settings and not in social work settings. These studies primarily focused on the prevalence of IPV (Awwad et al., 2014; Hammoury & Khawaja, 2008), on integrating IPV management in the Lebanese health care (Usta et al., 2012) as well as on the health practitioners' attitudes towards IPV and the perception of their role in identification of IPV (Usta et al., 2014). However, screening allows early identification of IPV and enables early intervention of women presenting some signs of IPV or having some risk factors of IPV (Phares et al., 2019).

Social workers have a unique position to screen for IPV, as they play a central role in identification of IPV and in the provision of follow up services to women experiencing IPV, even if their practice setting is not domestic violence (Crabtree-Nelson et al., 2016). However, despite their unique position and the importance of UPV screening, they still face many personal, and attitudinal obstacles (Lundberg & Bergmark, 2021), institutional obstacles (Pelkowitz et al., 2023) as well limited guidance and lack of information and training (Lundberg & Bergmark, 2021).

This article focuses on the first exploratory phase of a participatory action research, using a participatory focus group discussion with social workers from two non-specialized social work settings in Lebanon. It explored their IPV screening practices, challenges as well as their needs for implementing IPV screening and follow up, in the aim of developing an IPV screening and follow up protocols, adapted and relevant to the Lebanese context.

The article includes five sections: the problem, the theoretical framework, the methodology for data collection and analysis, the findings of the focus group and a conclusion outlining the main reflections, implications for practices and recommendations.

Problem

IPV is considered one of the most common forms of violence against women and it is widespread and affect millions of women worldwide (Sardinha et al., 2022). Intimate partner violence has shattering and long-term health consequences on women experiencing it (WHO, 2025). IPV has negative consequences on women experiencing it, and also affects children within the family, especially that 60% to 75% of families where women are experiencing IPV, have children who are exposed to abuse as well (Wathen & Macmillan, 2013).

Barriers to IPV disclosure

Disclosing IPV is a challenging and complex step for women experiencing IPV as many cultural, personal, family, financial barriers silence them and affect their ability and willingness to disclose IPV and obstruct their help seeking behavior.

The cultural barriers include Cultural barriers to disclosing IPV, such gendered social norms that expect women to be family nurturers and protectors, often silence women (Pokharel et al., 2020). Cultural stigma and patriarchal gender beliefs such as notions that women provoke violence, deserve it, IPV is a private matter and that husbands have the right to be abusive hinder help-seeking (Spencer et al., 2014).

Barriers to disclosure also include personal factors related to the woman's fear of retaliation and escalation of violence, emotional attachment to the partner, hope for change, and concerns about losing their children (Barakati et al., 2026). Other personal barriers include self-reliance, women readiness to disclose, emotional attachment and the hope that the violence will end and their partners will change (Pokharel et al., 2020).

Family barriers involve lack of support and unwillingness to help the woman exposed to IPV (Vranda et al., 2018). Furthermore, financial dependency on the abusive partner and their controlling behaviors of women, force them to stay silent (Barakati et al., 2026).

The importance and Challenges of IPV Screening

Given the numerous barriers that affect women's ability and willingness to disclose IPV (Katiti et al., 2016), screening interventions that intentionally ask about IPV are needed to intentionally ask about IPV and to offer opportunities for women experiencing IPV to disclose abuse and receive proper care and support who otherwise may not be identified (J. M. Spangaro et al., 2010).

Screening for intimate partner violence is a process that involves various methods tools, including face-to-face interviews, written forms or a range of direct questions asked on one or more occasions, to identify women who are experiencing violence (O'Doherty et al., 2014). Screening allows identification of women experiencing IPV and enables early intervention by linking them to counseling and referrals, which improves health outcomes and mitigates the harm resultant from IPV (Miller et al., 2021).

Despite its benefits, screening till faces many barriers and challenges that hinder its implementation by social workers (Petersson et al., 2025). Common challenges include attitudinal and personal barriers, resources and institutional barriers and knowledge and trainings barriers.

Attitudes and beliefs of social workers include normalization of IPV, believing IPV is a private matter (Overstreet & Quinn, 2013, Petersson et al, 2025), and blaming attitudes towards women (Dannis, 2003). Many perceive asking about IPV is intrusive and fear that women will offend if asked (Connor et al., 2012). Others perceive women unwillingness to disclose IPV (Petersson et al, 2025) and fear for women's safety as personal challenges (Pelkowitz et al., 2023).

Institutional obstacles involve a lack of resources for referrals of women (Pelkowitz et al., 2023), insufficient time (Anguzu et al., 2022), the absence of protocols to guide social workers on how to screen and respond to IPV as well as the lack of institutional support for implementation (Pelkowitz et al., 2023).

Knowledge and training barriers include the lack of knowledge and familiarity with concepts of IPV (Pelkowitz et al., 2023). The absence of trainings on IPV screening to equip them with proper knowledge, skills, tools and how to ask about violence to be able to screen pose a major barrier (Pelkowitz et al., 2023) and lack of protocols to follow (Petersson, 2025). Social workers perceptions about their lack of self-efficacy to manage and refer women experiencing IPV to relevant services (Lundberg & Bergmark, 2021).

IPV screening realities in Lebanon

In Lebanon, there is no nationally representative data on IPV, and this gap persists even in the most recent WHO estimates (2025). This knowledge relies largely on fragmented and non-representative sources (Usta & Shatila, 2023). However, available data suggests a high prevalence: 35 % of women subjected to IPV including physical, and or sexual violence in the last 12 months, (UNFPA, 2021). Despite the high percentage of women experiencing IPV in Lebanon, help seeking behavior remains extremely limited (Usta & Shatila, 2023).

In Lebanon, barriers to disclosure are similar to those that have been identified in other contexts. Cultural and social norms constitute a significant barrier, by forcing women to conform to the social expectations and to their duty to obey their abusive partner and normalizing IPV within the family (Usta et al., 2012). Few screening experiences have been conducted in Lebanon and remain limited to health care settings focused on trying to estimate the prevalence of IPV (Usta et al., 2007; Hammoury & Khawaja, 2008; Awwad et al., 2014). Others focused on exploring the attitudes and opinions of women in relation to screening for IPV by health service providers and regarding including IPV management in the Lebanese health care system (Usta et al., 2012). In addition, another study explored health practitioners' attitudes towards IPV and their perception of their role in identification of IPV in health care settings in Lebanon (Usta et al., 2014). Studies exploring the practices and needs of Lebanese social workers in IPV screening are notably absent.

The critical role of social workers

Social workers are frequently contacted by women experiencing all forms of abuse and are uniquely positioned to provide safety and support services, provided they are adequately equipped (Messing & Thaller, 2015). Social workers have a unique position to screen for IPV, as they play a central role in identification of IPV and in the provision of follow up services to women experiencing IPV, even if their practice setting is not domestic violence (Crabtree-Nelson et al., 2016). Despite the critical role recognized for social work in addressing IPV, significant gaps persist in IPV screening guidance and follow-up in practice (Messing, 2019; Pelkowitz et al., 2023).

In this study, we explored the current practices of social workers working in non specializes social work settings in Lebanon, in relation to IPV screening and follow up. Equally, this study also examined their challenges, as well as their understanding

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and perception of IPV screening and follow-up protocols and identified the required qualifications including knowledge, skills, attitudes and support for their implementation.

Analytical framework

The adopted analytical framework places the screening and follow-up of intimate partner violence within a secondary prevention approach, which aims to intervene at the earliest warning signs of violence to prevent its recurrence and escalation (Flores et al., 2010; Kirk et al., 2017; Rinfret-Raynor & Turgeon, 1995). Secondary prevention of IPV focuses on the early identification of violence and the prevention of its recurrence and worsening (Kirk et al., 2017).

Screening is considered to be secondary prevention as it allows identification and support to women experiencing IPV and is different than primary prevention that addresses the risk and protective factors before violence takes place (Phares et al., 2019).

In the context of IPV screening, follow up refers to the act of following up on a positive screen of IPV to adequately address the woman's immediate needs (Dichter et al., 2015). An initial response or follow-up on screening outcomes is necessary, as IPV screening without appropriate follow-up can be harmful and may create safety concerns for women experiencing IPV (Flores et al., 2010). The follow up interventions comprise risk and danger assessment for the life of women experiencing IPV (Crabtree-Nelson et al., 2016; Messing & Thaller, 2015), provision of information related to IPV, development of a safety plan and referrals to other needed services and specifically case management (Messing & Thaller, 2015).

This framework guided the analysis of social workers' narratives to understand how they conducted the IPV screening and follow-up. It also made it possible to explore the barriers they encountered, including personal, professional, and institutional constraints.

Methods

The participatory action research doctoral thesis aims to develop a screening and follow-up protocol for intimate partner violence tailored to the Lebanese context, in close collaboration with social workers working in non-specialized organizations in Lebanon. The initial exploratory phase was conducted with the relevant social workers by means of a participatory focus group discussion.

The participatory focus group discussion had an objective to explore social workers' practices to IPV screening and follow up, their understanding and perception of IPV screening and follow-up protocols and identify the required qualifications including knowledge, skills, attitudes and support for implementation. The goal was to build on the experience of these social workers to develop the protocols to be implemented in non-specialized social work settings in Lebanon, while also exploring their implementation skills in order to strengthen them where needed.

An interview guide was developed in Arabic. Topics included were the 1) current practices of IPV Screening and follow-up, 2) challenges in IPV screening and follow-up, 3) perceptions of IPV Screening and follow-up protocols, 4) required knowledge, skills, and attitudes for effective Implementation and 5) required Support for implementation.

The participatory FGD was moderated by the researcher using a participatory approach to actively engage participants and encourage collective reflection in line with the FGD objectives (Elliott et al., 2006). The FGD was recorded and transcribed by the researcher. A thematic analysis was conducted using an inductive approach and a semi-structured coding framework based on predefined themes. The emerging findings were validated through a meeting with the social workers, during which they reviewed and provided feedback on the researcher's analysis to ensure that the findings accurately reflected their perspectives and views (Patton, 2002). The obtained quotes of the social workers were provided in Arabic and translated to English for the purpose of this article.

This study was approved by the ethics committee at University of Saint Joseph. The FGD was only conducted after obtaining approvals from the participating organizations and only after receiving the written consent from social workers willing to participate. No incentives were provided for the social workers participating in this research study.

Results

Five key findings emerged from the analysis of the focus group discussion. The first finding captured the current identification and follow up of IPV by social workers in non-specialized social work settings. The second finding related to the challenges associated with IPV screening and follow-up. The third finding concerned the social workers' perceptions and expectations regarding IPV screening and follow-up protocols. The fourth finding involved the qualifications required for the application of the research, particularly in relation to IPV screening and follow-up protocols. The final finding focused on the support needed to facilitate the implementation of IPV screening and follow-up protocols within the research study.

The current practices of social Workers

The current practices of social workers in relation to identification of IPV in non-specialized social work settings, were often unstructured. This was followed by limited follow-up on IPV, largely restricted to referrals.

Identification of IPV by social workers: unstructured practices

According to the findings, the current practices of social workers (SW) for identification of women exposed to IPV were nonsystematic and non-structured. They revealed five fragmented ways of identification, one related to the direct disclosure of IPV by women, one related to indirect reporting by third party, and three related to social workers practices that include passive recognition, indirect questioning as well as direct questioning which was the least used.

Direct disclosure is when the woman reports IPV and shares that she is being abused or exposed to IPV. Social workers reported a direct disclosure by the woman after building trust over time, as one of the main ways to know if a woman is experiencing IPV.

> "The easiest way is when she mentions it." (SW)

> "We know it after following up with her for a few months, she discloses it." (SW)

Indirect reporting was mentioned by one social worker. This refers to situations in which information about abuse is shared by a third person who has witnessed the violence. This third party is usually a child or a neighbor who reports to social workers that a woman is experiencing IPV.

> "Sometimes the neighbors tell us, someone comes and tells us that the woman is being subjected to violence." (SW)

Passive recognition refers to situations in which social workers unintentionally observe signs that may indicate IPV, without taking action to explore these indicators further or to initiate follow-up. The social workers who shared experiences that reflect passive recognition mentioned several signs indicating the presence of IPV. They noticed a few psychological signs such as crying, agitation, or distress of the woman, in addition to fearful behaviors exhibited by women, in case their partner knew that they were coming to social work settings. Moreover, social workers noted some signs related to the couple's relationship and interactions, such as controlling or dismissive behaviors of the partner, including shutting down or interrupting the woman during conversations.

> "She could be crying or expressing herself in a way […] a certain psychological state, which shows that something is not right." (SW)

> "During our intervention, the woman insists to exclude her partner. And when we ask her about the reasons, […] the fear of what his reaction would be if we talked to him." (SW)

> "The dynamic between them, for example, when she speaks, he silences her." (SW)

Indirect questioning entails asking open questions about the individual's feelings and relationships that may indicate potential abuse, without directly asking whether the woman is being exposed to violence. During the assessment phase of child protection case management, some social workers used indirect questioning to explore the woman's relationship with her husband, how they met, and whether she was forced into the marriage. These questions were rather asked informally and without an objective related to responding to women's experiences of violence.

> "There's a question I ask: 'How is your relationship with your husband? even if the violence is directed at the child …I think it gives us an idea about the situation of violence." (SW)

> "During the assessment, we ask how long she has been married and how the couple met. This can reveal, for example, that although they are married, she did not marry out of love or was forced into the marriage." (SW)

Lastly, direct questioning was the least commonly used for identification of IPV, as one social worker only, shared that she might ask directly about violence. Direct questioning involves a social worker asking directly about abuse. Overall, asking directly about IPV was generally avoided. Direct questioning was not aimed at a purposeful response but rather informal practices that are avoided, partly due to discomfort around the topic of IPV.

> "While talking about violence towards the child, I might ask if she is also experiencing it." (SW)

Limited follow-up on IPV restricted to referrals

The practices revealed very limited follow-up, which, when present, was primarily focused on two types of referrals. After recognizing IPV, social workers' main actions consisted of referring women to two services, case management services and, to a lesser extent, to legal support. Referrals to legal service providers were occasionally made based on the woman's preference. In addition, one social worker mentioned verifying whether the woman was already receiving case management, with the aim of referring her to gender-based violence case management services outside their organization. These actions were limited as they missed supporting the woman with handling disclosure, risk assessment, safety planning and education about IPV.

> "I ask about what she wants, if she wants to continue with the legal procedure." (SW)

> If she received case management services or not." (SW)

> "If she has already taken steps regarding the matter, and if not, I tell her, 'You know you have the option, that this exists in Lebanon, etc… I see whether she wants to take steps, I mean referral." (SW)

Some social workers described making follow up, through assessment of the level of danger or exploring the woman's support systems. One social worker explained that she would assess the severity and frequency of violence to guide her next steps, including decisions around referrals. Another social worker mentioned asking about the woman's support system, such as family or external services. These questions were asked sporadically, without a clear plan for follow-up or for using the information to guide subsequent interventions.

> "What is the frequency of the violence, its severity, and how often it is occurring. Based on this, I think I might act." (SW)

> "I might ask her […] if she ever turned to someone for help, or whether she has a source of support, perhaps within the family or outside of it." (SW)

Social workers challenges of IPV screening and follow up

The focus group discussion revealed several key challenges in screening and following up on IPV, categorized into four main areas: three related to social workers and one related to women.

Challenges in identification and response to IPV

Social workers shared that it's very difficult for them to identify and follow up with women who are experiencing IPV. They shared a perceived lack of self-efficacy in their ability to identify women experiencing IPV, as IPV is complex and requires a lot of knowledge and skills to be to be effectively identified. Similarly, they indicated a perceived lack of self-efficacy in following up with women exposed to IPV, including uncertainty on how to intervene and feeling fearful of causing harm. Social workers expressed uncertainty about how to intervene when women did not recognize the violence as problematic, which made it more difficult to engage them in conversations about IPV or offer support. In addition, they shared that they fear harming the woman, particularly in cases of severe violence, due to feeling unequipped to provide proper follow up and lacking guidance on how to proceed. This indicated a lack of skills and specific knowledge as well as confusion and uncertainty about the appropriate actions to take in relation to IPV identification at the first level and follow-up on the second level.

> "As professionals, maybe we can provide support, accompany her, help […] support her and it might stop there. But in cases where it's truly a matter of life or death, we don't have anything, we're afraid to take it further." (SW)

> "In both [screening and follow up] I have the same fear, I'm afraid she won't admit it, that she won't accept it […] In many cases, she justifies it. If she's justifying it, I can't help her the way I should be helping." (SW)

Distrust in the services for follow up

Social workers affirm to be hesitant to make referrals due to a lack of trust in the services and their limited availability. This mistrust was a key barrier to follow-up, stemmed from the fear of social workers that referrals might not lead to a safe environment for the women, potentially exposing them to greater risk referrals, raising false hope and ultimately letting them down. In addition, many social workers felt that even when they made referrals, there were few accessible options for women to turn to, if those services didn't work out. This perception of scarce and costly support, combined with poor geographical coverage, left women without adequate assistance and placed a heavy ethical burden on social workers.

"In cases of referrals, […] my intention is to bring her to a safe place. And if she doesn't find that safe place, I feel like I gave her hope, and she ended up nowhere." (SW)

"You need support and psychological care and those are also very expensive, and in many places they're not even available." (SW)

Distrust towards women

While social workers emphasized the importance of maintaining professional boundaries, they expressed feeling manipulated and described challenges in navigating situations in which women attempt to manipulate them to obtain desired outcomes, particularly given they are women too. They explained that the language used by women, suggested a degree of a distrustful attitude implying manipulation. This reveals a key challenge social workers think they need to work on: balancing critical distance with empathy, while remaining aware of how biases or assumptions about women's intentions can shape their responses in IPV situations.

In addition, they also shared that they wouldn't consider a woman being exposed to IPV if she resists or defends herself. They tend to view women experiencing IPV as passive or weak victims who do not defend themselves. This stereotype poses a challenge to social workers, as it overlooks the common responses to abuse often include fight, flight, or freeze reactions, and that women may actively resist or defend themselves in these situations. Addressing these challenges is essential for social workers to be able to implement IPV screening and follow up protocols.

"One woman once told me very honestly, 'He's hitting me and the children, you need to find a way to make sure they stay with me and that he doesn't take them because you are a woman too.' […] They are able to manipulate us." (SW)

"We were working with a family where the father used to hit the mother regularly. However, we never really saw her a women exposed to IPV, or even suggested referring her to GBV services, because although he hit her, she fights back, she defends herself […] she's not the profile of an abused woman." (SW)

Women challenges: declining referrals

Declining the referral was identified as the main challenge regarding the women, for following up on IPV. Several complex factors contribute to this refusal. This includes fear, normalization of IPV, a lack of support from their family, a lack of support from their society and lack of trust in the legal system in Lebanon.

"Refusal of the referral also comes from fear, not from an unwillingness to give consent." (SW)

"Many times, mothers don't accept the referral […] The refusal because she sees IPV as normal, or because she doesn't trust the laws in Lebanon, or because society doesn't support her, or her family doesn't support her." (SW)

Social workers' perceptions and expectations for IPV screening and follow-up protocols

Due to the lack of existing or formalized protocol, social workers shared their expectations for what such protocols would offer to support their practice. Their input highlighted a need for two distinct protocols, one for IPV identification and one for follow up, including clear and structured procedures and tools.

Two distinct, evidence-based screening and follow-up protocols

Social workers identified the need for two distinct protocols, one for screening of women experiencing IPV and one for following up on a positive screen. They expected both to be grounded in evidence and to promote objectivity. They also expected these protocols to be an active part of the regular child protection case management they provide, to support gathering of the information related to IPV. Furthermore, the social workers expected both protocols to provide them with clear and ethically reassuring frameworks that would enhance their confidence, reassure them that they have fulfilled their responsibilities, using concrete step-by-step processes.

"Identifying is something and responding is something else, these are two. One for identification and one for follow up." (SW)

"I see it as a framework for practice, meaning how I can identify and respond in a right way […] This framework defines how we as social workers work and how we handle these cases." (SW)

Protocols promoting consistency and objectivity in IPV identification and follow up

Social workers viewed both the IPV screening and follow-up protocols as providing them with a unified process and approach as providing a unified process and approach to guide their practice. They viewed both protocols as promoting objectivity, ensuring uniformity in practice, and helping social workers feel confident that they are implementing them correctly, without confusion or personal bias.

> "We would work in the same way, at the same pace, on certain issues that don't allow for a yes or no. Meaning you're not doing interpretation." (SW)

> "In general, a protocol helps me remove my own subjectivity. It allows me to be more objective in the questions I ask and, in a sense, more scientific, rather than relying on my personal interpretation." (SW)

Structured IPV screening protocol

More specifically to the IPV screening protocol, social workers expected it to equip them with steps to follow that allow them to have a better overview of the situation of the woman. Social workers viewed the IPV screening protocol as a clear structured set of questions to be asked that allows them to obtain clear answers about violence and avoid shocking the woman. They also expected it to inform their practice and to enable them to appropriately respond and follow up on a positive screen.

> "The protocol is clear and very precise questions that I can answer with a yes or no. I feel like it's something very clear and very organized, question and answer […] and it can give you the steps for what to do in the next stage." (SW)

> "What questions do I ask and how, especially to avoid causing a shock to the woman?" (SW)

> "The questions will be targeted and chronological, and if I follow them in order, they will give me a clear picture." (SW)

Structured follow up protocol

As for the follow-up protocol, social workers envisioned it as providing clear guidance and defined steps to take after screening a woman experiencing IPV. They highlighted that the protocol would help them understand what actions to take next, what steps are essential, and how to respond appropriately to each situation. In this way, the protocol ensures a structured and intentional approach to their work.

> "It also helps me know what I need to do next […] What I need to do at least, what actions I can do to respond to the situation." (SW)

> "It also helps me know what I need to do […] I know what to do next." (SW)

In addition, social workers expected the follow-up protocol to support risk and danger assessment by guiding questions that measure the severity and frequency of abuse and determine whether the woman's life is in danger. The protocol was also seen as helping to evaluate the woman's capacity for self-protection, including the resources she has available and the steps that need to be taken to ensure her safety, following the assessment of danger.

> "For me, it will allow me to measure the severity and frequency of the abuse … and whether there's a danger to her life." (SW)

> "On the other hand, how able she is to protect herself, meaning, does she have resources […] and what steps need to be taken." (SW)

Lastly, social workers expected the protocol to support the assessment of a woman's readiness to leave an abusive relationship. They highlighted that it could help them evaluate if her intentions to leave the abusive relationship reflect a decision, uncertainty, or impulsiveness. By providing structured guidance in this assessment, the protocol was seen as assisting social workers in making informed decisions about the need for intervention and determining the most appropriate next steps.

> "Maybe this protocol can help us know whether the action she wants to take is impulsive or if it's truly realistic and she really wants to act and leave the house." (SW)

> "Perhaps this protocol can help us take a step back and better determine whether she really wants to leave the house or not." (SW)

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Required competencies for implementing the IPV screening and follow up protocols

According to the findings, social workers highlighted the importance of possessing adequate knowledge, skills, and attitudes to feel equipped to implement IPV screening and follow-up protocols effectively.

Knowledge: IPV definition and signs

Social workers highlighted a key knowledge gap and the need for targeted training on the broader issue of IPV. This included the definition of Intimate Partner Violence (IPV) and its various forms. The respondents emphasized the need to understand the different definitions of IPV, highlighting that it encompasses more than just physical abuse and includes psychological, economic, and other forms of violence. In addition, social workers wanted to have the information on the signs to look for, to assess the presence of IPV.

> "I feel like I need to have a clear definition; what is economic violence? I'm supposed to have these definitions; that's the first thing." (SW)

> "The signs that I can pay attention to during the assessment I'm doing." (SW)

Moreover, social workers emphasized the need for clear information about case management service providers operating in their geographical areas. They highlighted that a clear understanding of the organizations available and the services they provide are essential for effective referrals and coordination. Access to this information was seen as necessary to ensure that women could be connected to appropriate resources and that social workers could navigate the referrals with confidence.

> "I need to have clear information about who's working on the ground in these areas." (SW)

> "Who are the organizations […]and what they do, so I feel it's necessary for me to have that information." (SW)

Skills: building a trusting relationship with women

Social workers mainly focused on the importance of acquiring skills that allow them to build a trusting relationship with women as a pre-requirement before screening for IPV. These skills included how to reassure women, maintaining confidentiality and professional boundaries. They also recognized the need for communication skills to address a woman's resistance to disclosure and to applying the protocol.

> "How can I build a trusting relationship with her, how can she feel safe with me, not afraid all the time." (SW)

> "The skills that we need in every interview […] confidentiality and professional distance." (SW)

> "A technique to use when there is resistance regardless of what the reason might be. What techniques can we use to address or overcome that." (SW)

Attitudes

Social workers identified two main needed attitudes to feel equipped to implement IPV screening and follow up in a balanced, professional and non-reactive way: professional neutrality and nonjudgement. They emphasized the potential for bias, noting that as women, they might feel compelled to protect those experiencing violence, highlighting the need for neutrality. They also emphasized the importance of non-judgmental approach in relation to the gender roles and stereotypes in IPV cases.

> "Especially because she's a woman like us, I feel like I want to defend her rights, […] It's about learning how to regulate ourselves and not let our emotions take over." (SW)

> "Neutrality is the most important thing, not having prejudgments, like assuming the man is aggressive and violent, and the woman is always the victim. We see that a lot." (SW)

Clarifying roles and professional boundaries

Social workers also expressed their need for clarity about their role and professional boundaries in non-specialized settings, emphasizing the need to recognize the limits of their role when dealing with IPV. Social workers expressed the need to understand how to approach screening and following up on IPV with women in a non-specialized setting, to make sure they are not causing them any harm. They also needed more clarity on the limits of their professional role in a child protection social work setting and the need to know how to prioritize support for the woman, while balancing it with the obligation to protect the child as their main function and mandate.

"I think about my limits and where I draw the line, especially as a social worker […] because sometimes when a mother is talking about her story, and I can see that it is linked to the current abuse […] How far should I go?" (SW)

"Where is my limit? I mean, we can't forget that even if I identified that the woman is exposed to GBV, my work with her is actually because of the abuse toward the child. So how much space should I give to discussing the GBV situation? […] Where does my role end?" (SW)

Support needed for implementing the IPV screening and follow up protocols

Social workers identified key areas of knowledge including the timing and conditions for applying the protocols as well as institutional support.

Timing and conditions for application of the research

Timing and conditions in the application of IPV screening and follow-up protocols were emphasized as the stage at which they engage with a woman can significantly influence the trust relationship, which is essential for effective assessment and intervention. One social worker noted that being involved with a woman from the very beginning allows for a stronger rapport, which can impact the outcomes of their work. Additionally, social workers stressed the importance of understanding the specific circumstances of each situation to determine how and when to apply the protocol appropriately.

"There is the duration […] and I see as very important. It makes a big difference whether I am with the family from the very beginning, […] or the trust relationship we build with the family is very important, so the timing of when this happens really matters a lot." (SW)

"In which cases. I mean, for every case that comes to me, do I follow this protocol?" (SW)

Researcher and institutional support needs

Social workers identified the need for regular weekly check-ins with the researcher, particularly at the beginning of implementation, to address questions and ensure they were applying the IPV screening and follow-up protocols correctly. In addition, social workers requested a paper-based version of the protocol to facilitate their work, explaining that filling out information immediately on paper is easier and more practical for them.

"Supervision, definitely […] at least once a week at the beginning, because we really need it." (SW)

"We definitely need to receive answers to everything that has just been discussed, answers to the questions […] that have come up and need to be addressed." (SW)

"Usually, if we want to fill out information, we prefer to do it right away rather than taking notes and then filling it later, so doing it on paper is easier." (SW)

In addition, social workers emphasized the need for support from their organization's management. They highlighted the importance of seniors understanding the effort required to implement the IPV screening and follow-up protocols, noting that this work demands time, sustained engagement, and practical commitment at the field level. Such organizational support was viewed as essential to enable effective implementation and to acknowledge the additional workload involved.

"But we also need support in our workplace, not just from you." (SW)

"We need the seniors to understand us, because we are making this effort and it will practically take time on the ground." (SW)

These findings informed and were the basis for the design and development of the training manual content as well as the implementation manual.

Discussion and conclusion

This exploratory phase of the research, which is part of a broader project aimed at developing an IPV screening and follow-up protocol, sought to understand the current screening and follow-up practices of social workers in non-specialized organizations in Lebanon, identify the challenges encountered, determine the competencies perceived as necessary for the implementation of the protocols, and explore the type of support required to facilitate their implementation. The findings provide an overview of the current screening and follow-up practices within non-specialized social work settings in Lebanon.

The findings highlight the use of often unstructured strategies for the identification of IPV and follow-up practices that are mainly limited to referrals to case management services.

The challenges faced by social workers in their daily practice were mainly professional challenges related to a lack of confidence in their ability to screen for and follow up on IPV. These findings are consistent with previous studies showing that social workers often encounter difficulties in identifying and following up on IPV situations (Danis, 2003; Petersson & Larsson, 2025). Lack of trust in specialized follow-up services was also identified as a barrier, as confirmed by other studies (Pelkowitz et al., 2023).

Other professional challenges were also identified. These are related to the lack of clarity regarding the role of social workers practicing in non-specialized organizations. Our findings confirm the conclusions of previous studies (Portnoy et al., 2020), according to which social workers did not always consider IPV screening and follow-up to fall within their scope of practice and perceived that they did not have a role in screening. In non-specialized social work settings, social workers are required to cover a broad range of tasks across the full spectrum of social services, which limits their ability to develop or maintain in-depth expertise in IPV (Petersson & Larsson, 2025). The blurred boundaries between generalist social work tasks and specialized roles in responding to IPV place social workers in situations where they are not always certain when or how their role should shift from that of a generalist social worker to that of a professional responsible for identifying and managing IPV risk (Petersson & Larsson, 2025). This ambiguity in their role is further reinforced by a lack of knowledge and confidence required to address IPV in a sensitive and appropriate manner, even when well-designed tools are available (Petersson & Larsson, 2025). Finally, the absence of clear protocols or referral pathways further reinforces these difficulties and makes IPV screening and follow-up even more complex (Petersson & Larsson, 2025).

Similarly, our findings revealed the absence of screening and follow-up protocols. This is consistent with the study by Messing (2019), which found that very few social work practices provide guidelines intended to support professionals wishing to integrate screening and risk assessment into their practice (Messing, 2019). Even when assessment tools and guidelines are available, many social workers tend to rely on their own judgment rather than on structured methods (Petersson & Larsson, 2025). These findings highlight the need to strengthen the competencies and professional support of social workers in order to facilitate the implementation of IPV screening and follow-up protocols in non-specialized organizations. Training appears to be an essential lever for developing the knowledge, skills, and attitudes required for systematic and informed IPV screening. These findings are consistent with several studies confirming the importance of training that includes information on IPV as well as on available services (Petersson & Larsson, 2025; Pelkowitz et al., 2023).

Finally, our findings highlight the importance of institutional support, which reflects the organization's commitment to prioritizing the implementation of IPV screening and follow-up, as also demonstrated by Olsson and his collaborators (2024).

The findings highlight the need to strengthen the competencies and support provided to social workers in order to promote a proactive and consistent approach to IPV screening within non-specialized organizations. The findings of the participatory FGD informed and constituted the foundation for the design and development of the training manual, the IPV screening and follow-up protocols, as well as the implementation manual. The development of a contextualized protocol could improve the identification and follow-up of women affected by IPV, while strengthening the role of social workers in secondary prevention.

This study nevertheless presents certain limitations, particularly those related to the sample size and the use of a single participatory focus group discussion, which do not allow for the generalization of the findings. Readers are instead invited to consider their transferability to other similar contexts.

Nevertheless, the conclusions of this exploratory phase constitute a starting point for future research aimed at deepening the understanding of IPV screening and follow-up practices within non-specialized organizations and designing interventions adapted to these contexts.

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