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"An Effect That is Deeper Than Beating" Family Violence in Jordanian Women

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Abstract

This study informs healthcare approaches to gender-based family violence through focus groups with Jordanian women. The authors conducted a thematic qualitative analysis of 12 focus groups among 70 married, divorced, or widowed women about their experiences and beliefs regarding family violence. Five themes relevant to healthcare providers were identified. Three of the themes addressed participant-perceived causes of gender-based family violence: 1) unmet gender role expectations, 2) stigma and social norms, and 3) extended family roles. The fourth theme reflects effects on victims. The fifth theme reflects protective qualities and help seeking behaviors. The themes identified in the analysis reveal multiple ways that gender-based family violence can contribute to health problems and that it can be kept secret by Jordanian women as patients. Potential clues are described for the violence which may not be typically explored in a medical encounter. Additional ways that Jordanian families may seek help from other family or clergy instead of police and family violence agencies are described. Implications of these results for healthcare providers who care both for Jordanians and Arab immigrants in Western cultures are discussed.

Keywords

Intimate partner violence; family violence; women; Jordan

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INTRODUCTION

Gender based family violence is a major source of morbidity and mortality and affects on average 30–60% of women in multiple regions worldwide. Such violence includes beatings, rape, and other forms of abuse (Garcia-Moreno & Watts, 2005; UNIFEM Headquarters, 2003). For Arab women from the Middle East, experiences, attitudes, and beliefs of abused women (Boy, 2008; Btoush & Haj-Yahia, 2008; Douki, Nacef, Belhadj, Bouasker, & Ghachem, 2003; Haj-Yahia, 2000) and consequent recommended healthcare approaches are not well understood. This study attempts to add to that knowledge. Putting the problem in perspective, a women's lifetime prevalence of intimate partner violence (IPV) in Jordan, where this study was based, averages 32–43% (Government of Jordan & ORC Macro, 2008; Khawaja & Barazi, 2005). Prevalence of violence in the Middle East from non-intimate partner family members is 26% and associated with a fourfold increased risk of IPV (Boy, 2008; Clark, Bloom, Hill, & Silverman, 2009). Family violence clearly represents a significant health burden in this region.

Family violence victims in the Middle East rarely seek systemic help (Douki et al., 2003; Garcia-Moreno & Watts, 2005; Haj-Yahia, 2000). Those who do more often first seek family help or change their behaviors to try and decrease violence (Boy, 2008; Btoush & Haj-Yahia, 2008; Oweis, 2009). Only 7% of Jordanian women suffering severe sexual or physical family violence seek police help and less than 1% from social service agencies, while over 55% seek help from parents or siblings (Government of Jordan & ORC Macro, 2008).

We report experiences of Jordanian women which may assist healthcare providers in the identification and management of family violence (Abu-Ras, 2007; Kulwicki & Miller, 1999). We will discuss how these experiences may inform care of both Jordanian women and Arab immigrants to the West. Because violence by extended family is frequently described regarding this population, we define "family violence" as gender-based violence against women perpetrated by any family member, including an intimate partner (Clark et al., 2009; Douki et al., 2003; Hyder, Noor, & Tsui, 2007; Kulwicki & Miller, 1999).

METHODS

Recruitment

The Institutional Review Board (IRB) at Harvard School of Public Health and the scientific committee of the University of Jordan School of Nursing approved the research protocol. This protocol followed the World Health Organization's ethical and safety guidelines for conducting research on IPV against women (Hyder et al., 2004; World Health Organization, 2001). Details of the recruitment, consent, translation, and focus group facilitation processes are presented elsewhere and will be summarized (Clark et al., 2009; Clark, Silverman, Shahrouri, Everson-Rose, & Groce, 2010). However, this new thematic analysis was driven by different questions regarding the overlap between Jordanian women's experiences of violence and health. This analysis focuses on additional findings that aim to deepen understanding of Jordanian women's beliefs and perceptions about violence, focusing on aspects that would be of particular relevance to diverse healthcare providers. Seventeen focus groups were conducted in Amman, Jordan, August through October, 2003. All written and verbal materials and discussions were in Arabic. Women were recruited through varied community organizations, obtaining a diverse age and socioeconomic participant mix. The invitation described a group discussion on women's health and family relations. Family violence was not specifically mentioned, so that women could investigate attending without potentially compromising their safety, however, the family violence content of the discussion was revealed during the consent process. Groups of approximately 6 women were

formed according to marital status (never married, currently married, divorced, or widowed), resulting in participants similar enough to each other in age and life experiences to be at ease and allow a respectful, rich interaction (Brown, 1990). Four of the groups (2 currently married groups and 2 divorced groups) were specifically formed to bring together women that had reported family violence exposure. Of the 17 focus groups, we excluded the first focus group from analysis because it was used to fine tune focus group procedures. From the remaining 16 focus groups, we focused this analysis by including only groups of women who had ever been married, leaving 12 focus groups, totaling 70 women. Recruited participants provided socio-demographic information regarding marital status, age, number of children, and years of education (Table 1).

Focus group process

Focus group discussions were led by a professional moderator fluent in Arabic and English. Topics included participant understanding of domestic violence, its causes and consequences, and available victim assistance (Appendix 1) While the moderator followed the discussion guide, she was attentive to group responses and allowed a spontaneous exchange of ideas (Brown, 1990; Morgan, 1997; Stewart, Shamdasani, & Rook, 1997). Due to IRB concerns, instead of being taped, each focus group discussion was transcribed by a college graduate fluent in Arabic and English.

Data analysis

Identifying information was removed from the transcripts and each participant was assigned a number. Transcripts were translated from Arabic to English by the scribe. Each focus group discussion transcript was reviewed by the focus group facilitator and a co-author fluent in Arabic and English in order to confirm the interpretation and clarify issues of wording and meaning. In some cases community members were consulted for clarification. The authors are all women family violence experts and interdisciplinary healthcare professionals from the Middle East and the US. We utilized Atlas.ti to assist in a thematic analysis to derive and code emergent key concepts (Allan, 2003; Creswell & Maietta, 2001). Coded transcripts were entered into Atlas.ti by trained undergraduate research assistants.

We conducted a qualitative thematic analysis of the translated focus group transcripts. Because this was a new thematic analysis, the 3 (of the 4) investigators who did not participate in the prior analysis were blinded to all components of the previous work. Key words and phrases emerged to define the nature of the groups, discussed by the team in coding meetings. Consensus coding development continued iteratively until saturation was achieved, that is, no new codes emerged from examining additional transcripts (Creswell, 1998). Each transcript was coded to achieve consensus by three or four co-authors. Because the final coding document was derived iteratively, those transcripts not coded with this final coding document were recoded, again achieving consensus by three or four co-authors (Creswell, 1998). Utterances were coded according to explicit statements of attribution by focus group participants, not investigator inference. Because one goal was to better understand cultural issues for Jordanian women, particular attention was paid to perceptions of the Arab co-investigator and staff, and in this way triangulation was embedded in the coding and analysis (Gilchrist, 1999). We focused our analysis on the codes, categories, and subcategories of adult married or previously married women which would overlap with medical conditions or information healthcare providers would likely encounter. Codes were developed into overarching themes, using level 1, 2, and 3 coding and supercoding (Creswell & Maietta, 2001).

RESULTS

Three themes emerged containing narratives about participant-perceived causes of gender-based family violence that were relevant to healthcare providers: 1) unmet gender role expectations, 2) stigma and social norms, and 3) extended family. A fourth theme reflects effects on victims and a fifth theme contained narratives about gender-based family violence protective qualities and help seeking behaviors. Each theme contained 3–7 categories, which we describe in the text. Table 2 indicates the numbers and percentages of women who made statements relating to each theme and subtheme.

Unmet gender role expectations

Gender role issues contributing to violence were commonly reported. Many were classified into the theme of unmet gender role expectations for both sexes. One example is of husbands not meeting traditional male expectations due to unemployment or economic difficulties. These men could use violence as an outlet for associated stress, as one woman described below[1]:

> My son has two children, he goes…looking for a job, but…he can't find a job… and has no money. He takes it…out on his wife and children; he screams at them and beats them. FG 9, P9

Wives who defied gender roles by having more education or better jobs than husbands were described as making husbands lose pride with violence resulting:

> When [my] husband [was] not working…we were suffering from poverty, we didn't have money to pay the rent of our house, electricity…we had nothing…he kept blaming me and calling me names because I am educated....FG 6, P2

A traditional upbringing with male entitlement reportedly gave male family members a sanctioned duty to control or physically abuse women or girls who did not act according to expected gender norms in dress or behavior with men:

> The father gave the son the right to control…he keeps telling his son: 'You are the man of the family when I am not at home, you should watch your sisters.'…The boy starts to dominate his sisters first, and when he gets married controls his wife and daughters. FG 5, P1

> The brother…can do everything he wants, he is the man…he is the eldest one, even if he is only 10 years old. He could have the right to beat his 20 year old sister if she went out with boys…his father will be proud of his son, because [he] has become a man now. How will this boy act when he grows up if he is beating his older sister with the blessing of his father? FG 10, P2

Another way women did not meet traditional gender expectations was through infertility or birth of only daughters, which reportedly incited family violence. A husband's parents unhappy with lack of male grandchildren reportedly incited or perpetrated such violence, mostly physical, but could include threats of desertion or polygamy.

> When I married him and I started giving birth to my daughters, his family nagged him to remarry, and whenever they tell him that, he gets angry and starts beating me, FG 4, P2

Unfulfilled household duties were a form of unmet gender expectations for women, however some women justified or expected abuse in that situation, and stigmatized those victims.

[1]FG#=Focus group number; P#=Participant number

> …sometimes the wife is the one who forces the husband to commit violence. If he comes home from work tired, and finds no food, the house is not clean, or his wife didn't do what she has to do as a wife, for sure there will be violence. FG 11, P3

Hence, participants reported that men or women not filling expected gender roles in regard to household duties, reproduction, or children was a cause of family violence perpetration. This could be related to infertility or lack of sons. Upbringing strategies that established gender norms in children were another cause of violence.

Stigma and social norms

Participants noted that stigma related to social norms compounded family violence. For example, participants noted that disclosure of abuse was associated with so much stigma and increased violence, that victims typically silently bore abuse, without seeking help or trying to stop it.:

> …my sister doesn't know if I have a problem at home between me and my husband [and] I would not tell her. If I tell even one person…everyone will know about it. FGD 8, P2

Another example of social norms increasing violence was the sanctioning of abuse and stigmatizing of women who divorced violent husbands. This was reported among the divorced women. They noted that it made women less likely to divorce and while empowering men:

> Where shall she go? Wherever she goes, everybody will say that she is divorced, and they will keep watching her in everything she does. FG 6, P2

Participants also reported that social norms and traditions were often the reason for family violence in the community, rather than Islam advocating violence:

> An Egyptian on the farm slapped his wife…I asked him: "why did you hit her?" He said: "our traditions and customs say: when the woman does not do what the husband is asking for, she should be slapped." I asked him: "religion has said this?" He said: "no, religion says: treat them well, but we have our traditions." Here the tradition has the upper hand over religion and has become the stronger rule in our life. FG 15, P1

However, the women reported that some perpetrators did incorrectly apply religion as an excuse to justify family violence:

> It is written in Qur'an: "The men are caretakers of the women." It means that they are the ones who spend the money and take care of the women, but not to control them the way men are doing. FG 6, P3

In sum, participants reported social norms causing family violence and religious misapplication of violence, compounded by stigma that kept abuse private or secret instead of being addressed.

Extended family

Many women said living with in-laws critical of wives regarding infertility (as noted above), lack of boys, housework, financial dependence, or reputation caused family violence. This violence could be perpetrated either by in-laws directly or husbands incited to beat or abandon wives:

> I was humiliated from him…His sister used to beat me [because she covered my husband's and my expenses]…Once she hit me with a wooden stick while I was breast feeding my baby. And once my husband's sister and mother locked the door

> on me and started beating me both of them. He was sitting outside the room listing to me screaming. He didn't do anything. FGD 6, P1

Women reported that separation from their own male relatives contributed to violence from both in-laws and their own family. Such separation could occur through the physical separation of emigration or abandonment due to family believing allegations against the woman. Such events could lead to revenge for family honor:

> .. .her family is against her…and if she goes to any organization or foundation to ask for their help, she has to change her identity, and her place of living to be safe from her husband or the revenge of her family. FG 11, P1

Honor crimes or killings were rarely reported to have occurred, but could be from the woman's extended family or less frequently, her husband. Honor crimes reportedly could be caused by damage to a family's reputation, such as a married woman seeking help for family violence or falsely suspected of having an affair due to witnessed contact with a male:

> My husband's unmarried brother was sometimes coming and asking for a cup of tea. When my husband came and saw his brother sitting, he started slapping me and once he pulled me outside the house to his car where he wanted to get some gasoline for burning me…FG 14, P3

Hence, fear of such family reactions reportedly severely limited women's activities.

In sum, participants noted living close to or with in-laws as causes of violence. Other causes were wives' isolation from their own male relatives, social contact with unrelated males, or seeking aid for violence.

Effects on victims

Physical and psychological health was affected by physical abuse:

> …he bought a new set of knives, he tried them on his wife…He cut her skin, all over her body. FG 5, P4

Psychological abuse such as control, abandonment, deprivation, and threats reportedly damaged emotional and physical health, as perpetrated by intimate partners, in-laws, and male extended family. Sexual abuse was rarely mentioned, but included sexual trauma and forced unprotected sex after a husband had sex with another woman.

Reportedly related disorders included physical injuries from beatings with hands or objects, untreated infections or cancer, malnutrition, stomach ulcers, uterine fibroids, high blood pressure, paralysis, depression, and other mental illness. Reported negative effects of abuse were not always tangible and related to stigma, control, social isolation, and economics:

> [Violence] might have an effect that is deeper than beating…The painful words could lead you not to belong to yourself. You are hurt by words, by beating, or by insulting… FG 10, P3

Divorced women reported (as an outcome of violence) isolation due to community stigma, family rejection, and losing children. Although leaving the relationship could end the violence, divorce laws were reportedly unhelpful, resulting in minimal alimony payments and fathers receiving custody of children. Also, participants noted that shame from divorce could increase separation and violence from the woman's own family.

> Now I take money from [the government]. I will never do anything shameful [prostitution], but…I am living alone, away from my family…my problem will remain the same, from where shall I cover all the expenses? FG 6, P2

In sum, participants reported extreme physical, emotional, and economic effects of family violence, yet ineffectiveness or worsening conditions from seeking help or divorce.

Protective qualities and help-seeking behaviors

Women described protective or assistive resources: family, spouse, family violence agencies, law enforcement, health services, religion, and community leaders. Healthcare providers were suggested to "cure" the perpetrator, since many women said psychological disorders caused battering.

> We should start with the medical check-up before marriage…there could be diseases that could be more dangerous than [physical disorders], which are the mental and psychological disorders. FG 12, P3

Women reported limited legal rights, agency shelters, or counseling for family violence, and discomfort seeking such assistance:

> There are…organizations [in Western countries] but here, there isn't any. Besides how could the woman go to anyone? FG 8, P2

> The law is against you; what does the law do when the man slaps you and when you have filed a complaint against him? Maximum he will have to sign a paper that he will not repeat that, but the moment you go back home he will slap you again because he is not scared. What would the law do to him!…We will be blamed and it would not be accepted…for a woman [to] complain against her husband. FG 14, P3

Family was noted to be the most appropriate source of help:

> They should go to the family…they might not listen to each other, and problems could happen, but they are not supposed to turn to anyone from outside the family. The police have got nothing to do with it. FG 7, P8

> My cousin…didn't have any children and her husband and his family started blaming her…They sent her to her family's house and her husband didn't want her anymore. The two families sat together to solve the problem and the wife's family suggested that each of them go and have medical tests. The results showed that it is the husband that can't have children, so she was back. Now they've been living together 12 years; nobody is bothering her like before. They are much happier FG 4, P2

Women described educated male relatives as protective, since they would be less likely to believe in male privilege and behave violently. Yet, they noted, a wife more educated than her husband could cause violence (described above):

Despite describing misuse of religion as justification for abuse, participants said being deeply religious could also be protective, as women and men could learn to prevent violence from liturgy:

> We have a lot of men who go every day to the mosque to pray, and …that commit violence against their children and wives, so why not have lectures for them at the mosques too? The sheikh could tell them about the Prophet Mohammed's life and how he treated His wives. The Sheikh could also tell them about the woman's rights in Islam. FG 5, P9

Additionally, women said clerics or community leaders could influence abusive relatives to decrease family violence:

> …the Sheikh of the tribe…the oldest and the most wise man in the family, or the mayor of the village, any of those could help in the beginning of the problem, and if this way was not effective they could go to the [family violence agency] later on. FGD 13, P2

In summary, family or clerics were seen as potentially most helpful. Police and laws were potentially helpful, but often were associated with stigma and legal barriers. Educational, religious, and healthcare workers were described as potential protective or help resources.

DISCUSSION

The themes and narratives from these 12 focus groups in Jordan demonstrated that adult women were deeply affected by family violence, in the form of physical abuse, control, or infrequently, sexual abuse. Homicide (sometimes so-called honor killing) was rarely noted, but could contribute to generalized fear. Abuse perpetrators included husbands, males or females from the wife's extended family, or male or female in-laws. Cues to family violence among Jordanian women that healthcare providers might not otherwise consider included: infertility, no male offspring, living with or near in-laws, divorce, husband unemployed or underemployed, and wife with higher level education or work than husband. Help-seeking barriers included fear of increased violence, keeping violence secret or within the family, abuse justification, fear of stigma, and geographic isolation from family. Religion could be protective or be an excuse for violence if incorrectly applied. Extended family and education could be protective or contribute to violence. Social isolation of the victim from family and community could result from seeking help or divorce. Favored help options included family and healthcare workers. Relatives were expected to mediate in marital conflict. Healthcare providers were looked upon to "cure" abusers. Social agencies were scarce and difficult to access. Law enforcement was less favored as a help resource, and rights were commonly unknown or favored abusers.

Although this study was conducted in Jordan, it has several implications for Western healthcare providers caring for Arab families from the Middle East. Considerable overlap exists among different Arab Middle Eastern cultures in attitudes towards family violence (Boy, 2008; Douki et al., 2003; Haj-Yahia, 2000; Kulwicki & Miller, 1999). Although some immigrants will be acculturated and ascribe to more liberal Western norms, it is common that isolated immigrants to Western cultures continue or amplify attitudes from countries of origin (En-Nabut, 2007; Landau-Stanton, 1990; Sluzki, 1992). Since September 11, 2001, Arab families who emigrate West from the Middle East can experience increased isolation, potentially reinforcing cultural beliefs. The 2006 US census indicates 1,467,000 people with ancestry from countries in the League of Arab States, with about 25% each in the Northeast, Midwest, South and West of the US (United Census Bureau, 2006). However, despite large numbers of effected people and high prevalence of family violence noted among Arab families from the Middle East (Boy, 2008; Clark et al., 2009; Government of Jordan & ORC Macro, 2008; Khawaja & Barazi, 2005), IPV resources are under-utilized by this population in the US. (Kulwicki & Miller, 1999). Hence, family violence is common in this population, often inadequately treated, and can affect those both in the Middle East and immigrants in Western countries.

Primary healthcare providers are integral to the care of those suffering from family violence. Primary care estimates of IPV prevalence are 24%, and up to 50% in inner-city practices (Breiding, Black, & Ryan, 2008; El-Bassel et al., 2003). Approximately 1/3 of women injured during their most recent physical assault received medical treatment, providing an opportunity for healthcare providers to intervene (Tjaden, 2000). Yet, IPV is generally under-documented in clinical settings (Kothari & Rhodes, 2006). Interviews with providers (Sugg & Inui, 1992) and transcripts of medical encounters (Rhodes et al., 2007) demonstrate

that healthcare providers often have difficulty discussing this issue with patients, both in regard to inquiry and addressing the issues raised. Hence difficulties for medical providers in addressing family violence among Arabs from the Middle East must be contextualized as an already challenging situation. Yet if one reason for deficiencies in care of family violence victims is a fear of opening Pandora's box (Sugg & Inui, 1992) or a lack of efficacy, increased understanding such as that provided by our data could be helpful.

Because healthcare providers are more socially sanctioned than police or IPV agencies, they have an obligation and opportunity to facilitate family violence victims finding culturally acceptable help, and such cultural awareness may improve patient satisfaction and information sharing. (Paez, Allen, Beach, Carson, & Cooper, 2009) Research has not adequately defined culturally competent strategies for healthcare providers to address family violence for Arab families from the Middle East, both in and outside their countries of origin. Cultural barriers to healthcare for family violence victims include obedience to patriarchal hierarchies and lack of clear practice guidelines. (Daoud, 2008; Hyder et al., 2007) Such patients, after emigration to the West, may continue to suffer from these barriers. (Ahmed, Abdella, Yousif, & Elmardi, 2003; En-Nabut, 2007; Landau-Stanton, 1990; Sluzki, 1992) Additionally, Western healthcare providers may be unfamiliar with cultural components of danger and safety in family violence such as those described in our data. In the West, immigrant women from the Middle East face numerous cultural barriers to family violence-related care. Misinformation regarding legal rights, language, stigma in their own community and health care settings, the need to avoid physical contact with men who are not blood-related or a spouse, child rearing approaches, discomfort with pelvic exams, and provider lack of understanding of Muslim obligations are some examples (Abu-Ras, 2007; Akala & El-Saharty, 2006; Chaliha, 1999; Hammoury, Khawaja, Mahfoud, Afifi, & Madi, 2009; HattarPollara & Meleis, 1995; Reitmanova, 2008).

Cultural implications of this study in healthcare settings include approaches to childbearing, gender norms, and stigma. If a couple of Arab Middle Eastern background has infertility or no sons, it could prompt wife battering, divorce, or abandonment by the husband or extended family. Healthcare providers could inquire of the wife, husband, or extended family separately whether lack of children or sons is difficult, how s/he manages her/his feelings, and if there is in-law pressure. Similar to other IPV patients if potential perpetrators do not readily leave the room, patients could be taken to other rooms for tests or tell the partner the patient is having tests in order to ask questions privately (Nicolaidis, 2004). If the patient and healthcare provider do not speak the same language, telephone interpreters if available may be preferred, to prevent discomfort with male interpreters and insure confidentiality if patient community members are interpreting. Providers could directly, separately, inquire of couples regarding violence at home, as is recommended for all cultural groups (Rhodes & Levinson, 2003).

Routine social history can have important clinical implications and prompt follow-up inquiry. For example, if a husband is unable to find employment at his educational level, follow-up questioning could address associated stress and whether there is violent or controlling behavior. Such behavior may relate to frustration due to acculturation and language barriers. Or, wives living with or near in-laws or other extended family may experience physical or verbal abuse, controlling behavior, or generous assistance. Providers could ask how in-law relationships are, and then directly inquire about violent or controlling behaviors. An implication of our study that could change the way IPV shelters and counselors function is for them to ask if extended family are violence perpetrators. Future studies could investigate such culturally informed approaches and devise studies to determine the prevalence of this phenomenon.

Our study confirmed numerous barriers to divorce in Arab Middle Eastern countries. Although our adult participants mention it rarely, others have noted increased risk of honor violence or honor killing when women seek outside help or divorce (Araji & Carlson, 2001; Cohen & Savaya, 1997; Douki et al., 2003; Faqir, 2001; Haj-Yahia, 2002; Kulwicki, 2002; Maziak & Asfar, 2003). Thus, if couples are undergoing divorce, it may be beneficial for healthcare providers to ask general questions of wives or husbands separately, progressing to risk of severe violence from extended family or husband. It is important to note that Islam does not sanction honor crimes, and that numerous groups are attempting to address this complex issue (Faqir, 2001; Gill, 2006).

Many study participants justified family violence, making resisting or leaving less likely. Other studies have shown justification for wife beating among Arab women and men in the Middle East (Amowitz, Kim, & Reis, 2004; Boy, 2008; Btoush & Haj-Yahia, 2008; Douki et al., 2003; Government of Jordan & ORC Macro, 2008; Khawaja & Barazi, 2005; Oweis, 2009; Sorensen, 1996). One survey of over 10,000 Jordanian women demonstrated that 88% believed wife beating was justified for at least one reason such as insulting (66%) disobeying (55%), or arguing (16%) with her husband (Government of Jordan & ORC Macro, 2008). Religious justification from the Qur'an is oft cited for wife beating in Muslim populations (Ammar, 2007; Douki et al., 2003). Our data substantiated the view that it was the patriarchal culture, not Islam, validating family violence. Yet healthcare providers cannot assume patients justify violence or that they do not, as neither is universal among the population. Also, what is being called justification may actually be helplessness against long standing behaviors and further study is needed to better understand this issue.

If family violence is detected, therapeutic options should be considered carefully and collaboratively. Ideally, a healthcare provider would refer patients to culturally informed local resources or remote options (in the US the Muslim Community Center for Human Services Hot Line 817-589-0200) with social work assistance, to maximize safety and prevent reactions such as shame, fear, and honor crimes from occurring. Religious, family, or community resources may or may not be helpful and the patient may be the best judge (Haj-Yahia, 2000). Use of domestic violence agencies or law enforcement could cause more violence in the short term. Planning with patients, involved agencies, and experienced social workers is crucial. Additionally, violence victims may be unaware of immigration rights or that abuse could provide sanctuary eligibility; such information may increase interest in help (Sorensen, 1996). Regardless of patients' choice of action, maintaining contact is important, as is generally true for IPV victims. Routine IPV inquiry is recommended by many medical organizations, preceded by normalizing statements to avoid stigmatization, such as, "I ask all my patients about safety at home." (Rabin, Jennings, Campbell, & Bair-Merritt, 2009). Although our data informs direct inquiry by healthcare providers of Arab patients from the Middle East regarding family violence, it is important not to assume that patients will perpetrate or be victims of violence. Culturally informed approaches include asking all patients about their preferences in the context of patient, relationship and family-centered medical care without assuming individuals will follow a cultural stereotype (Kagawa-Singer, 2001). This seems prudent when asking about family violence, especially with some regional increases in anti-Arab and anti-Muslim bias in Western countries (En-Nabut, 2007). For immigrants, cultural transition can stress families, particularly regarding gender roles, potentially contributing to family violence (Gill, 2006; Landau-Stanton, 1990).

Limitations of this study include timing of data collection in 2003, hence legal and social conditions for women in Jordan have changed variably, depending upon local enforcement (Douki et al., 2003; En-Nabut, 2007). However, many patients, both in and outside of Jordan have been raised with prevailing beliefs of earlier times, and may still be acting on them. Other limitations as noted above are that focus group participants spoke in Arabic and safety

concerns precluded audio-taping. Hence the analysis was done with transcriptions of focus groups translated into English and clarified. Although the team addressed this through multiple culturally informed steps, including three women co-investigators with direct knowledge of Jordan, Arab culture, and family violence in the Middle East, possibly nuances of data were lost. Lastly, social desirability can prevent frankness, particularly in focus groups, in contrast to individual interviews; however, the degree of potentially stigmatizing information shared makes this seem less likely. Thus, the use of these focus groups members as key informants for health care providers seems reasonable and could help focus future studies.

CONCLUSION

The Jordanian women in our study reported that family violence is taboo or kept secret, but contributes to significant health problems. We noted unexpected nuanced hidden or silent indicators of family violence in this population that could prompt healthcare providers to sensitively inquire and explore the possibility of violence. Given the steadily increasing immigration of Arab families from the Middle East throughout the West, knowledge of these risks is important for Western healthcare providers. Healthcare providers could be prompted to address family violence in this population in response unmet gender role expectations, such as infertility, lack of sons, husband unemployment, or wives having higher education. Providers should be aware that family violence perpetrators can include nearby or cohabiting male and female extended family, as well as husbands. Seeking help or divorce can lead to increased danger from perpetrators and social isolation due to stigma. Many are unaware of rights and help options in their native country, and could be less so as immigrants. Healthcare providers are uniquely positioned to assist women and their families regarding family violence.

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Appendix

Excerpts from focus group discussion guide

1. When you think of domestic violence, what is the first thing that comes to your mind?
2. What do the words "domestic violence" mean to you?
3. Can you describe a situation that you would consider domestic violence?
4. Why does domestic violence occur?
5. Under what circumstances would someone be entitled to use domestic violence?
6. What effect does domestic violence have for individual family members?
7. What effect does domestic violence have on the community?

8. If a person decides that they need help, to whom should they turn?
9. How effective is this help?
10. If you were in charge of a program to help families that are affected with domestic violence, what would that program do?
11. What do you think are reasons why domestic violence does NOT occur in many families?

Table 1

Focus group demographic characteristics

Marital Status & Focus group location	Number of Participants	Average Age	Average Number of Children	Average Years of Education
Currently Married				
Sisterhood is Global Institute	9	36.4	4.9	11.7
University of Jordan	6	45.3	3.7	18.0
Al Wihdat Refugee Camp	6	34.8	6.3	10.3
Jabal Hussein Refugee Camp	6	29.8	3.2	12.2
YWCA	6	33.5	1.5	14.3
Divorced				
Single Parents' Club	4	43.3	1.5	15.0
Sisterhood is Global Institute	4	37.3	3.3	12.0
Al Wihdat Refugee Camp	5	29.8	2.4	10.2
Al Baqa'a Refugee Camp	4	30.3	3.0	3.5
Widowed				
Single Parents' Club	3	45.7	3.3	15.3
Jabal Hussein Refugee Camp	8	41.4	5.6	9.4
Al Baqa'a Refugee Camp	9	45.9	6.2	5.4

Table 2

Theme 1: Unmet gender role expectations		
	n	**%**
Woman more educated	30	1.30
Husband unemployed/economic stress	109	4.74
Male entitlement/began in childhood and continues	85	3.70
Infertility/birth of girls	47	2.04
Unfulfilled household duties by women	36	1.57
TOTAL FOR THEME	307	13.35

Theme 2: Stigma and social norms		
	n	**%**
Victims silently bear abuse	81	3.52
Victim's reaction/Seek Help	31	1.35
Stigma of divorce and sanctioning of abuse	7	0.30
Social norms and tradition	122	5.30
Islam incorrectly applied	16	0.70
TOTAL FOR THEME	226	9.83

Theme 3: Extended family		
	n	**%**
In-laws critical: infertility/no sons, housework, financial dependency, reputation/contact with unrelated males, seeking aid for abuse	72	3.13
Who were abusers: beatings by extended family	464	20.17
Husband incited by extended family	37	1.61
Marital in-law extended family (ie mother-in-law, sister-in-law, brother-in-law)	54	2.35
Victims' own extended family (ie parents, siblings, cousins)	323	14.04
Victims' marital extended family (ie sons, daughters)	50	2.17
Separation from victim's male relatives through abandonment or emigration	30	1.30
Honor crimes/fear	56	2.43
TOTAL FOR THEME	657	28.57

Theme 4: Effect on victims		
	n	**%**
Forms of adult abuse:	459	19.96
Abandonment or Neglect	24	1.04
Domination or Control	84	3.65
Emotional or Verbal	123	5.35
Homicide	5	0.22
Physical	210	9.13
Sexual	13	0.57

Theme 4: Effect on victims		
	n	**%**
Physical health	53	2.30
Psychological health	36	1.57
Stigma/social isolation/economic	50	2.17
Divorce negative effects: isolation, financial	17	0.74
TOTAL FOR THEME	615	26.74

Theme 5: Protective qualities and help-seeking		
	n	**%**
Family- most appropriate and helpful	106	4.61
Spouse protective factors: upbringing/personal qualities	95	4.13
Agencies- limited interest and helpfulness	76	3.30
Law enforcement-less appropriate/unhelpful	55	2.39
Healthcare to cure perpetrator	27	1.17
Religion		
1) Being religious	54	2.35
2) Clergy	16	0.70
Community leaders	20	0.87
Educated male relatives	50	2.17
TOTAL FOR THEME	499	21.70