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Intimate Partner Violence in a Lebanese Population Attending Gynecologic Care: A Cultural Perspective

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Abstract

Occurrence of intimate partner violence (IPV) against women in the Lebanese society has been largely ignored by local legal and religious authorities. Our aim is to estimate the prevalence of IPV among married Lebanese women, and investigate perception of abuse, referral patterns, and measures taken to deal with abusive situations. In this cross-sectional study, married women aged 20 to 65 presenting to the American University of Beirut Medical Center for gynecological care were interviewed on various forms of IPV. Out of 100 women invited to participate, 91 consented to take part in the survey of whom 37 (40.67%) gave a history of physical abuse, 30 (33.0%) of sexual abuse, 59 (64.8%) of verbal abuse, and 17 (18.7%) of emotional abuse. Spouse-imposed social isolation was reported in 20 (22.0%) women, and economic abuse in 30 (33.0%). Reasons for deciding to stay in an abusive relationship were "lack of any family or social support" (40.5%), "lack of financial resources" (40.5%), and "fear that the partner may take away the children" (37.8%). Women expressed satisfaction with their spouse's

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treatment irrespective of the existence of various forms of violence. A significant increase in the risk of weapon use against wife was correlated with decreased monthly income of the household, whereas a protective effect was conferred by an increased number of children. This study highlights the need for routine screening in health care settings for better identification of victims of violence. The selective conventional perception of abuse and the reactive normalization of violence observed indicate the necessity for culturally informed interventional strategies to complement screening.

Keywords
intimate domestic violence, physical abuse, sexual abuse, verbal abuse

Introduction

Violence against women is a major risk factor for a wide range of adverse physical, mental, and reproductive health outcomes (Garcia-Moreno et al., 2006; Heise, Raikes, Watts, & Zwi, 1994; Krug, Mercy, Dahlberg, & Zwi, 2002). It is defined as any coercive physical, psychological, or sexual act used against adult or adolescent women (World Health Organization [WHO], 1996). Intimate partner violence (IPV) in which women are often the victims has gained momentum as a major public health issue in the last few decades (Olson et al., 1996; Schuler, Hashemi, Riley, & Akhter, 1996). It is construed as a manifestation of an unequal power relationship between men and women (Brismar, Bergman, Larsson, & Strandberg, 1987; Randall, 1991; Schmuel & Schenker, 1998).

A worldwide survey estimated that the prevalence of domestic violence against women ranges between 16% and 52% (Division for the Advancement of Women & Committee on the Elimination of Discrimination Against Women, 2002; WHO, 1997) with occurrences found to be much higher in developing and Arab countries (Al-Fayez, Ohaeri, & Gado, 2012; Al-Nsour, Khawaja, & Al-Kayyali, 2009; Barkho, Fakhouri, Arnetz, 2011; Hamdan-Mansour, Arabiat, Sato, Obaid, & Imoto, 2011). Evidence also reveals that women are at a greater risk of being abused by an intimate partner than by any other perpetrator (Kiss et al., 2012). Surveys in the Arab world show that one out of three women is beaten by her husband (Douki, Nacef, Belhadj, Bouasker, & Ghachem, 2003).

Several initiatives have been taken by major international organizations to curb this global public health epidemic. In 1979, the United Nations (UN) adopted "The Convention on the Elimination of All Forms of Discrimination Against Women" (CEDAW). Although the agreement was ratified in 1995 by

189 governments (United Nations, 1995), the only country in the Middle-East to develop legislation against domestic violence besides Israel was Jordan.

Intimate partner violence is an underestimated problem in Lebanon and has been largely ignored by the local authorities. The Lebanese health care system has failed so far to play a proactive role in identifying and referring abused women, mostly because the recognition of an abusive pattern in women is often blurred by cultural and societal taboos (Nauphal, 1997; Usta, Farver, & Pashayan, 2007). Resources available to support these women also remain very limited and clogged by the complex societal constitution. Following the ratification of CEDAW in 1996, the Lebanese government was urged in 2008 by the UN to enact legislation on violence against women (Human Rights Watch, 2011). Renewed commitment of civil society and private advocacy groups to build a national consciousness about violence against women has been on the rise since. Attempts at developing a comprehensive law to protect women rights however have been hampered by several obstacles. A draft law to protect women from family violence prepared by 41 civil society organizations was approved by the Council of Ministers in April 2010, but failed to pass in Parliament. Religious courts in Lebanon currently presiding over personal and marital affairs considered the draft law as an attempt to undermine their authority. In June 2011, the country's highest Sunni Muslim authority and the Higher Shi'a Islamic Council rejected the draft bill on the grounds that Islamic Sharia law protects the role and status of women and includes provisions governing legal issues related to the Muslim family.

The urgency about the need for social and institutional reform has been largely driven by anecdotal reports of severe cases of abuse in the Lebanese population, without altogether any official national prevalence estimates. In an attempt to evaluate the magnitude of the problem in a segment of the Lebanese society, we, as members of the academic community in Lebanon, planned to estimate the prevalence of intimate partner violence among a sample of married women presenting to the resident clinics for gynecologic care at the American University of Beirut Medical Center. We also sought to investigate associated parameters, perception of abuse among women, referral patterns, and measures taken to deal with abusive situations.

Material and Methods

The survey was conducted over a 3-month period among women presenting to the resident clinics for gynecological care at the American University of Beirut Medical Center. Eligible participants were ever-married women

between 15 and 65 years of age, who consented to answer a structured questionnaire on this subject. After presenting the study objectives, informed consent was obtained from every enrolled woman. The interview was anonymous and conducted by the same female gynecologist in a private setting. Women participants were informed of their right to withdraw should they feel uncomfortable with the content. Approval by the Institutional Review Board was obtained.

The questionnaire consisted of 32 close-ended questions addressing sociodemographic, economic, and educational information; categories of inflicted violence; and type of support (familial/extra-familial) sought by the abused woman. Close-ended questions were dichotomous with a yes or no for answer (see appendix). The questions were designed in Arabic, the native language of participants; they were field-tested on 20 randomly selected participants before final implementation.

Life-time physical abuse was detected when a woman answered affirmatively to one or more of the following questions: "Have you ever had an argument with your partner that subjected you to pushing, shoving, slapping, hitting, or kicking?" "Has your husband ever inflicted on you an injury that required medical attention?" A woman was considered victim of weapon abuse if she answered by yes to the following question: "Has your partner ever used a weapon (knife, gun, club, belt, or any other object at home) to threaten or hurt you?" Identified victims of physical abuse were then asked how many accounts of abuse occurred over the past 1 year. *Sexual abuse* was investigated using the following questions: "Does your partner force you to have sex, vaginally or anally, against your own will?" "Does he force you to engage in sexual practices that make you feel uncomfortable, like touching your genital areas or breasts against your will?" "Does he force you to engage in sexual practices that make you feel uncomfortable, like making you touch his genital organs against your will?" The presence of *verbal abuse* was evaluated by means of the following question: "Does your partner address you verbal insults humiliating to you and/or old remarks degrading to you?" A woman was considered to suffer *emotional abuse* if she answered by yes to one of the following questions: "Does your partner repeatedly make fun of you or what you believe in, in public or in private?" "Are you afraid of your partner and/or do you feel intimidated by his presence?" Imposed *social isolation* was detected when a woman answered positively to the following question: "Does your partner prevent you from seeing your friends or your family?" The presence of *economic abuse* was assessed by the following question: "Does your partner control home expenditure denying you access to money?"

To evaluate the *perception of abuse* among participants, the following open-ended question was addressed to a sample of 33 women, randomly chosen regardless of their status of abuse: "Are you satisfied with the way your husband treats you and the degree of respect he shows to you? Why?" To explore the *reasons why women stay* in an abusive relationship, physically abused women were asked the following question: "Despite the physical abuse you receive from your partner, tell me the reasons why you are still in the relationship and still live together." The same women were also asked about the *measures taken* in response to abuse: "Did you seek assistance from outside your household? To whom and what was the outcome?"

The data were analyzed using Statistical Package for the Social Sciences (SPSS, version 19.0). After calculating descriptive statistics for the prevalence of different types of spousal abuse and various socio-demographic variables, we used multiple logistic regressions to examine bivariate associations between categories of abuse and the following variables: woman age, number of children, employment status of both partners, monthly income, living with in-laws, age at first pregnancy, level of education of both partners, and substance abuse by both (alcohol, smoking, antianxiolytic drugs, and illicit drug intake).

Results

Out of 100 women invited to participate, 91 consented to take part in the survey, a 91% participation rate. The mean age was 32 ± 9 years. Twenty-eight women (30.8%) were smokers and 1 (1.1%) reported drinking alcohol more than three times per week. Seven women (7.7%) were currently employed, 35 (38.5%) previously employed, and 49 (53.8%) never employed. Six women (6.6%) were illiterate, 38 (41.8%) had primary-level education, 43 (47.3%) had secondary-level education, and 4 (4.4%) had college degrees. Monthly income was below 500 USD in 56 (61.5%) households, between 500 and 1,000 USD in 35 (38.5%), and above 1,000 USD in none. The socio-demographic data are shown in Table 1. Among women interviewed, 37 (40.67%) gave a lifetime history of physical abuse, 30 (33.0%) of sexual abuse, 59 (64.8%) of verbal abuse, and 17 (18.7%) of emotional abuse (Table 2). Spouse-imposed social isolation was also detected in 20 (22.0%) women, and economic abuse in 30 (33.0%).

Of 37 women aggressed physically, 19 (51.3%) mentioned more than three accounts of physical abuse during the past year, and 3 (8.1%) reported the use of a weapon. Injury types and locations are shown in Table 2. Eight cases (22.2%) required medical attention and 3 (8.1%) necessitated hospital admissions. Reasons for these admissions reportedly were vertebral fractures

Table 1. Demographic and Reproductive Characteristics of Women Presenting for Gynecologic Care at a Tertiary Care Medical Center in Beirut, Lebanon ($N = 91$).

Characteristics	*n* (%)
Current age of women, years (*SD*) range	32 ± 9
Marital status	
Currently married	90 (98.9%)
Divorced	1 (1.1%)
Age at first pregnancy, years (*SD*)	24 ± 12
Number of children	
Two or less children	60 (65.9%)
Three or more children	31 (34.1%)
Employment (self)	
Never employed	49 (53.8%)
Previously employed	35 (38.5%)
Currently employed	7 (7.7%)
Employment (spouse)	
Currently unemployed	35 (38.5%)
Currently employed	56 (61.5%)
Monthly income of household	
Below 500 USD	56 (61.5%)
Between 500 and 1,000 USD	35 (38.5%)
Above 1,000 USD	0
Duration of marital relationship	
Less than 5 years	37 (40.7%)
Between 5 and 10 years	22 (24.2%)
Above 10 years	32 (35.2%)
Religion	
Muslims	91 (100%)
Christians	0
Level of education (self)	
Illiterate	6 (6.6%)
Primary	38 (41.8%)
Secondary	43 (47.3%)
College	4 (4.4%)
Level of education (spouse)	
Illiterate	7 (7.7%)
Primary	37 (40.7%)
Secondary	37 (40.7%)
College	10 (11.0%)

(continued)

Table 1. (continued)

Characteristics	*n* (%)
Substance abuse (self)	
Alcohol intake three or more times/week	1 (1.1%)
Smoker	28 (30.8%)
Drugs for anxiety, insomnia, depression more than three times/week	12 (13.2%)
Illicit drug abuse	0
Substance abuse (spouse)	
Alcohol intake three or more times/week	4 (4.4%)
Smoker	50 (54.9%)
Drugs for anxiety, insomnia, depression more than three times/week	0
Illicit drug abuse	2 (2.2%)
Living circumstances	
Living by themselves	76 (83.5%)
Living with in-laws	15 (16.5%)

and miscarriages. Mechanisms of injury are also shown in Table 2, hitting being the most frequent mechanism of injury followed by slapping and pushing.

Analysis of the responses given by 33 women randomly sampled to answer open-ended questions revealed that all of them were satisfied with their spouse's treatment, 18 (54.5%) of whom were victims of IPV and 6 (33.3%) of physical abuse. Reasons stated by physically abused women (n = 37) for accepting IPV and deciding to stay in the abusive relationship were "lack of any family or social support" (15; 40.5%); "lack of financial resources" (15; 40.5%); "fear that the partner may take away the children" (14; 37.8%); "love" (5; 13.5%); "fear that the partner may hurt her" (3; 8.1%); and "hope that the partner's treatment may change for the better" (1; 2.7%). When the same group of women was asked about measures previously taken in response to physical violence, 20 (54.0%) reported having sought family support, 2 (5.4%) police support, 1 (2.7%) religious authorities, and 1 (2.7%) court. There was one legal action for divorce involving also child abuse. Families provided support to their daughters in 11 cases (55.0%) and denied it in 9 (45.0%) for "the duty to obey one's spouse" and "the shame it can bring to the family."

The results of the multivariate logistic regression analysis are shown in Table 3. The smoking status of women was found to be a significant co-factor for physical (adjusted odds ratio [AOR] = 2.6; p = .05) and verbal abuse

Table 2. Prevalence and Pattern of Spousal Abuse Against Ever-Married Women Presenting for Gynecologic Care at a Tertiary Care Medical Center in Beirut, Lebanon.

Characteristics	Life Time
Types of abuse	*n* = 91
Physical	37 (40.6%)
Sexual	30 (33.0%)
Verbal	59 (64.8%)
Emotional	17 (19.0%)
Social	20 (22.0%)
Economic	30 (33.0%)
Types of physical injury	*n* = 37
Ecchymosis	25 (67.5%)
Contusions	14 (37.5%)
Broken bones	5 (13.5%)
Miscarriage	2 (5.4%)
Location of physical injury	*n* = 37
Head	34 (91.8%)
Neck	4 (10.8%)
Extremities	14 (37.8%)
Abdomen	2 (5.4%)
Thorax	1 (2.7%)
Back	1 (2.7%)
Mechanisms of physical injury	*n* = 37
Hitting	22 (59.4%)
Flapping	20 (54.0%)
Pushing	15 (40.5%)
Shoving	13 (35.1%)
Throwing objects	6 (16.2%)
Kicking	4 (10.8%)
Strangulation	1 (2.7%)
Knife	3 (8.1%)
Firearm	1 (2.7%)

(AOR = 2.5; $p = .05$), in addition to spouse-imposed social isolation (AOR = 3.3; $p = .02$). A history of spousal alcohol abuse increased significantly the odds of imposing social (AOR = 7.6; $p = .03$) and economic isolation (AOR = 5.5; $p = .05$) on the wife. An employed spouse constituted a protective factor against the odds of verbal abuse of the wife (AOR = 0.05; $p = .02$). A significant increase in the risk of weapon use against the woman partner

Table 3. Adjusted ORs (*p*) for Selected Characteristics Associated With Different Types of Marital Abuse in Women Presenting for Gynecologic Care at a Tertiary Care Medical Center in Beirut, Lebanon.

Characteristics	Marital Lifetime AOR	*p*
Physical abuse		
Substance abuse (self)		
Nonsmoker	1.0	
Smoker	2.6	
		.05
Weapon use		
Monthly income of household		
Between 500 and 1,000 USD	1.0	
Below 500 USD	17.2	
		.02
Number of children		
Two or less children	1.0	
Three or more children	0.03	
		.02
Verbal abuse		
Substance abuse (spouse)		
Nonsmoker	1.0	
Smoker	2.5	
		.05
Sexual abuse		
Maternal age at first pregnancy	0.8	.01
Number of children		
Two or less children	1.0	
Three or more	0.7	
		.04
Social abuse		
Substance abuse (spouse)		
Alcohol intake less than three times/week	1.0	
Alcohol intake three or more times/week	7.6	
		.03
Substance abuse (spouse)		
Nonsmoker	1.0	
Smoker	3.3	
		.02
Emotional abuse		
Employment (spouse)		
Currently unemployed	1.0	
Currently employed	0.05	
		.02
Economic abuse		
Substance abuse (spouse)		
Alcohol intake less than three times/week	1.0	
Alcohol intake three or more times/week	5.5	
		.05

Note. AOR = adjusted odds ratio.

was correlated with decreased monthly income of the household (AOR = 17.2; $p = .02$), whereas a protective effect was conferred by an increased number of children (AOR = 0.03; $p = .02$). The odds of sexual abuse decreased as maternal age at first pregnancy increased (AOR = .8; $p = .01$) and as the number of existing children also increased (AOR = 0.7; $p = .04$).

Discussion

This study highlights the prevalence of intimate partner violence in a segment of financially underprivileged Lebanese women. Our findings reveal that 40.6% of women presenting to the Resident Clinics at the American University of Beirut Medical Center are physically abused by their spouse. These results are compatible with those reported elsewhere (Garcia-Moreno et al., 2006; Naciri, 2002; WHO, 1997). Our study also shows that verbal abuse is the most common type of domestic violence in our population followed by physical abuse. The head and the extremities are the most frequent sites of physical injury, while hitting is the most frequent mechanism of injury followed by slapping and pushing. Similar findings have also been reported by other studies as well (Muelleman, Lenaghan, & Pakieser, 1996; Olson et al., 1996).

Despite the high occurrence of intimate partner violence in the sample population studied, the Lebanese Law does not mandate health care institutions to screen and report on incidents of violence against women. The Lebanese government provides no resources for referral. Scattered support efforts are only available through civil society and private advocacy groups. The figures found in this report nonetheless are alarming, and constitute substance for intervention on the ground of ethical and moral obligations. These findings therefore raise internal concerns and debate on whether routine screening should be implemented at the level of contact with the health care provider. The findings of this study show clearly that women expressed satisfaction with their spouse's treatment irrespective of the existence of various forms of violence, and therefore failed to perceive their spouses' behavior as unacceptable. They also support the concept of conventional perceptions of abuse that preside in some societies, often excluding family-based violence from the definition (Ellsberg, Pena, Herrera, Liljestrand, & Winkvist, 1999; Horne, 1999; Kulwicki, 2002; Ofei-Aboagye, 1994; Yoshihama, 2002). These perceptions stem from beliefs deeply rooted in cultural perspectives based on an unequal gender power relationship. One problematic issue therefore arises in connection with the definition of IPV by women themselves as it relates to their own perceptions of violence. It follows that the efficacy of

preventions and interventions designed to address IPV could be severely impaired by changing personal and societal perceptions of violence. As global advocacy campaigns promoting institutional reforms to safeguard women's rights are mounting, the implementation of these changes is expected to meet resistance because of their incompatibility with the existing cultural framework. Similarly, the execution of legislative reforms by law reinforcement authorities may not necessarily be faithful to the spirit of the intended changes (Sagot, 2005). The intended beneficiaries of these reforms themselves may become re-victimized as they attempt to seek the protections and sanctions promised (Fernández, 2006). This underlines the importance of exploring culturally informed perspectives and a system of shared beliefs that women use in coping with societal hegemony (Fernández, 2006) before prevention intervention approaches are introduced.

While most interventional programs meant to deal with IPV victims are designed around supporting women's effort to leave the violence situation, they are often built on faulty assumptions regarding women perception of abuse and desire for independence. The findings of this study show that many abused women are totally resigned to their situation and decide to stay in an abusive relationship because of the fear of losing their children, the need to conform to social expectations, the lack of financial independence, the lack of family support, and the duty to obey their spouses. Similarly, a qualitative study revealed the five reasons why abused Jordanian women decide to stay despite abuse (Gharaibeh & Oweis, 2009) to be the inherited social background, the financial dependency, the lack of family support, sacrificing self for the sake of children, and the adverse social consequences of divorce. Asian women have also been described to prioritize family needs over their own individual ones (Yoshihama, 2002) observing strict obedience to their husbands (Rydstrom, 2003). It has been suggested that a woman's response to violence may be intimately influenced by her perception of gender roles and identities (Boonzaier & De La Rey, 2003). The stigma of divorce in some Arab societies may be equivalent to social suicide (Hassouneh-Phillips, 2001) because of the perceived dual failure to act responsibly as a wife and to fulfill ones role as a mother (Haj-Yahia, 2000). In response to societal hegemony, abused women are forced to justify and normalize violence as a means of survival (Oweis, Gharaibeh, Al-Natour, & Froelicher, 2009), and may therefore be less willing to part with the cultural background that gives them a sense of meaning and identity (Fernández, 2006). In some communities, violence against women for a corrective purpose is widely accepted practice (Ellsberg et al., 1999). Palestinian women were shown to blame victims of abuse for the violent act (Haj-Yahia, 1997, 1998a, 1998b, 2000). A medical student's survey in Sri Lanka found that one third of interviewees justified

wife beating, and more than half blamed the wife for the violence perpetrated against them (Haj-Yahia & de Zoysa, 2007). Understanding the role of cultural beliefs in promoting violence against women may therefore be crucial in the design and implementation of preventive strategies while taking into consideration variables affecting the decision of victims to seek help (Kasturirangan & Williams, 2003). Such an approach underscores the importance of understanding what violence means to those experiencing it (Fernández, 2006). The plain incorporation of cultural prototypes based on the western model of values into the fabric of other societies may not be productive.

This pilot study is associated with several limitations, mostly inherent to its self-reporting design promoting recall bias and under-reporting bias given the sensitivity of the topic. The population sample chosen may not necessarily be representative of the Lebanese population, as it consisted of patients who are generally financially underprivileged. As low socio-economic status is a recognized risk factor of IPV, calculated prevalence estimates may therefore be over-rated. The main strength of the study, nonetheless, is that it adopted a broad operational definition of IPV incorporating various forms of violation that women experience within a socio-cultural context. This approach allows the attenuation of the variations in conventional perceptions of violence by incorporating a collective understanding of violence across a range of societies. It resembles in its conception the NorVold Domestic Abuse Questionnaire (NORAQ) designed to serve as a psychometric tool to measure gender violence (Swahnberg & Wijma, 2003, 2007; Wijma et al., 2003), in that it included detailed questions with elaborate examples of abusive acts and subdivided abuse into various forms. Our questionnaire however differed from NORAQ in that it did not intend to quantify the intensity of abuse.

Conclusions

Despite being a serious violation against human rights, violence against women is still not perceived as a major public health issue in many Arab societies (Usta et al., 2007), in which the family structure is patriarchal and characterized by male authority and dominance (Keenan, El-Hadad, & Balian, 1998). It remains a hidden problem viewed by many as a private internal matter, making it difficult to document and study (Usta et al., 2007). This pilot study highlights the seriousness of intimate partner violence as a highly prevalent public health condition in a sample of Lebanese women, providing additional arguments in favor of the need to expand local research in this field and explore means to alleviate the silent sufferings of a community who continues to pay the price for a social system that tolerates largely

spousal violence. Furthermore, it lays direct evidence and raises awareness for the existence of a genuine problem of public health dimension, thus far widely ignored by local authorities.

The findings of this study also support calls in favor of routine screening in health care settings for better identification and quantification of violence victims. It should be noted, nonetheless, that while several studies indicate that routine screening helps identify victims of violence (Abbott, Johnson, Koziol-McLain, & Lowenstein, 1995; McCloskey et al., 2005), there is little evidence to support that it is useful to improve the outcome of the abused (MacMillan et al., 2009; Moracco & Cole, 2009). The selective conventional perception of abuse and the reactive normalization of violence observed indicate the necessity for culturally informed interventional strategies to complement screening. Such approach should ensure that programs safeguard the cultural values of women while being responsive to their personal expectations.

Appendix

Questions About Intimate Partner Violence

Physical abuse

Have you ever had an argument with your partner that subjected you to pushing, shoving, slapping, hitting, or kicking?

Has your husband ever inflicted on you an injury that required medical attention?

Has your partner ever used a weapon (knife, gun, club, belt, or any other object at home) to threaten or hurt you?

Sexual abuse

Does your partner force you to have sex, vaginally or anally, against your own will?

Does he force you to engage in sexual practices that make you feel uncomfortable, like touching your genital areas or breasts against your will?

Does he force you to engage in sexual practices that make you feel uncomfortable, like making you touch his genital organs against your will?

Verbal abuse

Does your partner address you verbal insults humiliating to you and/or old remarks degrading to you?

Emotional abuse

Does your partner repeatedly make fun of you or what you believe in, in public or in private?

Are you afraid of your partner and/or do you feel intimidated by his presence?

Social isolation

Does your partner prevent you from seeing your friends or your family?

Economic abuse

Does your partner control home expenditure denying you access to money?

[a]Dichotomous closed-end questions with a yes or no for answer.
[b]Considered positive for abuse when a woman answered affirmatively to one or more of the above questions.

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