



**The Approach
of Palestinian
Physicians Toward
Wife Abuse**



**Bisan Center for
Research and Development**

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Muhammad M. Haj-Yahia, Ph.D.

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موقف العاملين الصحيين من مسألة العنف ضد المرأة

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ما يرد في هذا الكتاب من آراء وأفكار يعبر عن وجهة نظر المؤلف، ولا يعكس بالضرورة موقف مركز بيسان للبحوث والإنماء

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Section One

*Literature
Review*





Literature Review

Violence against women is a multi-faceted and multi-dimensional problem, the health dimension being the most central beside legal, social, psychological, economic, and cultural dimensions. Until recently, health professionals tended to deny the existence of violence against women, tended to ignore its existence, or when they encountered battered wives in their work they tended to not view the problem as a problem of their area of responsibility. In light of the increasing evidence over the past three decades of the high rates of violence against women by their spouses, in society in general and among women turning to women's health services, professionals have begun to relate to the problem as a serious health problem. Hence, they have begun to recognize the active and essential role of prevention of violence against women, the detection of battered women, and the providing aid to the victims, the attackers, and the family in general. Lately, there is growing recognition of the problem of violence against women as a central factor in the decreased health of many women that seek help in various health settings. Gradually health professionals are becoming more and more sensitized to the problem and are becoming competent or, at least, interested in acquiring skills and competency in order to provide suitable services for battered women and their families (Hanvey & Kinnon, 1993). Many studies have been conducted in the world in the last three decades on the rates of problems of violence against women in general and among women turning to health services specifically, and on the approach of health professionals towards the problem, but there is a serious lack of similar studies in the Arab world in general, including Palestinian society. In this report we report a study we conducted among Palestinian physicians from the West Bank and East Jerusalem

about their approach to the problem of violence against women and their various beliefs about the problem. In the first chapter, we review the available literature in the world about the rates of battered women that turn to various health services, mainly emergency rooms, and about the approach of the physicians and health professionals in general, and afterwards we will report our study from the standpoint of the study's design, findings, and our discussion of these findings.

The Rates of Violence against Women

As stated, violence against women by intimate partners has been recognized for many years as a multi-faceted, multi-dimensional problem that includes health and public health problems that has epidemic proportions (Hamberger, 1997). The problem of violence by men against their intimate female partners is so common that certain authorities estimated that 60% of all women have been assaulted or abused by their spouses at some time during the course of their marriage (e.g., Hamburger, 1997; Walker, 1979). Additionally, a large portion of these assaults causes injuries and wounds (Pahl, 1995). Aside from the physical wounds, assaulting women causes harsh psychological consequences such as anxiety, depression, fear, anger, stress, PTSD, as well as many inter-spousal and marital consequences (e.g. Dutton, 1992; Haj-Yahia, 1998, 2000). Therefore, it is very reasonable to assume that many battered women will seek medical, psychological, and family services as a result of the consequences of violence against them (Hamberger, 1997; Hanvey & Kinnon, 1993).

The admittance of battered women to emergency rooms has received scientific attention over the last three decades. For example, Rounsaville and Weissman (1977-78) found that 37 battered women that were admitted to emergency rooms of a university medical center over the course of a month accounted for 3.8% of all women admitted to the above mentioned emergency rooms in the above mentioned month. Although 20 of these women came to the emergency room

in the past with injuries, only three of them, when previously admitted, identified themselves as battered women. Stark, Flitcraft and Frazier (1979) estimated that around 25% of women admitted to emergency rooms are battered women, although physicians only identified 2.8% of such women. Stark and Flitcraft (1985) reported that abuse may be the single most common etiology for injury presented by women, accounting for more injury episodes than automobile accidents, muggings, and rape combined. McLear and Anwar (1987) cite studies of different emergency rooms in the U.S.A. that found that between 16% and 19% of the women that present themselves at these departments with physical injuries were battered by their intimate partners. They also cite an unpublished study they conducted which demonstrated that triage nurses, using a protocol with direct questions regarding whether an injury was secondary to violent attacks and battering, identified 30% of injured women admitted to an emergency room as having been physically assaulted and battered. Self-report questionnaires that were completed anonymously by women in the trauma wards and emergency rooms showed that between 24% and 35% of them experienced violence by their intimate partners (Victim Support, 1992 cited in Pahl, 1995). In a study conducted in Australia among 453 women that were admitted to an emergency room indicated that 2% reported their experiences of violence and assault by their intimate partners during the course of 24 hours that preceded their admittance to the emergency room, and 9% of them reported their experience of physical violence and assault during the course of the year that preceded the completion of the questionnaires (Roberts, O'Toole, Lawrence, & Raphael, 1993). Roberts, O'Toole, Raphael, Lawrence, and Ashby (1996) carried out a retrospective, cross-sectional study, where a screening questionnaire was administered among adult individuals who were presented to a major public hospital emergency room. Roberts et al. (1996) replicated a previous study, where they aimed to investigate more accurately the presentation of current victims of domestic violence to emergency rooms. Of Roberts' et al. (1996) 1223 respondents, about 24% of women and 8.5% of men disclosed a history of domestic violence. They found that women were at greater risk than men

for abuse as adults (adjusted for age, history of child abuse, and country of birth). Women were also at greater risk than men for being doubly abused (as a child and as an adult). Roberts et al. (1996) indicate that the results of the second study confirm what had been indicated in the first study, i.e., that 2% of women who were presented to the emergency room (11.6% of all women with a history of adult domestic violence) were current victims of domestic violence and that these women were presented mainly between the hours of 5 p.m. and 8 a.m., when no social workers were available for referral of victims.

Besides the admittance of battered women to emergency rooms, they are also admitted to outpatient clinics. Mehata and Dandrea (1988) and Flitcraft (1990), among many, point out that many battered women seek services from outpatient medical clinics. The treatment that they seek in such clinics can be related to physical injuries that can be a result of abuse or assault by someone. Additionally, many women turn to outpatient primary care medical services for treatment of the indirect results of their experiences of violence (Hamberger, 1997). For example, Koss, Woodruff, and Koss (1990, 1991) found that victims of violent crimes comprise 57% of 5086 women that turned to outpatient medical clinics, with 29%-39% of them having been physically or sexually abused by an intimate partner. Drossman et al. (1990) surveyed women who were admitted to a gastroenterology clinic; among the 206 women that were surveyed, 44% reported a history of physical or sexual abuse when they were children, adolescents, or as adults. Although the studies of Koss et al. (1990, 1991) and Drossman et al. (1990) are not focused exclusively on women that were abused by their intimate partners, they undoubtedly provide us with estimates about the number and frequency of women who are the victims of domestic and extra-family violence that are admitted to outpatient medical settings.

Many studies have been conducted among women abused by their intimate partners that were admitted to various outpatient settings such as obstetrical clinics, general medical clinics, and family medicine clinics. Hillard (1985) conducted a study among women that were admitted to an obstetrical clinic

and found that around 11% of the women that were interviewed for the study reported that they were abused and battered at some point in the history of their relationship with their intimate partners, and about 4% of them declared that they were beaten while they were pregnant. In another study, a random sample of 290 pregnant women was taken of women admitted to public and private obstetrical clinics and were interviewed. Around 15% of the women reported their experiences of violence by their intimate partners before the pregnancy. Additionally, 8.3% of the sample reported their experiences of violence during the present pregnancy (Helton, McFarlane, & Anderson, 1987).

Studies were also conducted for prevalence rates of violence against women among women admitted to general medicine and family medicine clinics. Roth, Jarratt, and Leonardson (1989) conducted a study among women admitted to two family medicine clinics. The women anonymously reported their experiences of verbal and physical abuse. They found that 48% of the women reported their experiences of verbal abuse from their intimate partners, 44% of the women reported their experiences of some form of “minor” physical abuse, and 28% reported their experiences of severe physical abuse. In contrast to previously mentioned studies that were conducted in obstetrical clinics (Helton et al., 1987; Hillard, 1985), Roth et al. (1989) do not differentiate between present violence and violence that occurred in the past and violence that occurred during the course of a lifetime or during the course of a marriage. Undoubtedly, such a differentiation can help a great deal in diagnosis, assessment, and planning treatment, or referral to health, welfare, police, and other services. It is clear that women who are currently abused or have been recently abused can be currently in an immediate crisis, a matter that requires crisis intervention, stabilization of the crisis, and the planning of some kind of safety plan with and for the woman, including referring her to various protective and support services (such as a shelter for battered women, or other forms of safe houses in the community). On the other hand, women that report violence that they have experienced over the course of the lifetime of their marital history, and not current violence or that which has occurred in the past period of time, might

not need immediate intervention. However, they do need to undergo some form of assessment for level of post-traumatic stress disorder (PTSD) or psychological, marital, familial, and parental sequelae that are direct and/or indirect results of violence in their lives.

Hamberger, Saunders, and Hovey (1992) conducted a survey among women that were admitted to an outpatient family medicine clinic. The women that participated in the study were asked to answer the Conflict Tactics Scale (CTS; Straus, 1979), among many other scales that were included in the questionnaire. The women were asked to indicate if each of the tactics in the CTS were used against them during the course of the past year and in some period of time during the course of their lives in an intimate relationship. The women were also asked to indicate if they were injured (in one of the two above mentioned periods of time) by their intimate partner, and whether their doctor asked them about relationship distress during their last visit, and on their experiences of verbal or physical abuse.

Among the women that indicated that they were in an intimate relationship and felt at risk in the relationship, 25% indicated that they were assaulted in the last year. Around 60% of the women that indicated that they had been assaulted recently indicated that they were assaulted at least at the magnitude of bruising. Around 40% of the women that participated in the study indicated that they had been assaulted by their intimate partner during the course of their lives, and among these women, i.e., among the 40%, about 67% indicated that the assault on them caused them injuries. The findings of the study also revealed high rates of physician inquiry when the woman had a lengthy doctor's visit. Regarding all types of visits (including brief encounters between doctor and patient), only 6.5% of the women indicated that the doctor asked them about relationship distress, 2% of the women indicated that the doctor asked them about their experiences of verbal abuse, and 1.7% of the women indicated that the doctor asked them about their experiences of physical assault. Rath et al. (1989) conducted a file survey of 100 women in order to examine whether

abuse was documented in the list of problems in the file or the comments about the women's treatment progress. At the same time that the survey revealed that in a third of the files there was evidence that the doctor asked about the stressors in the women's lives, it was discovered in their examinations that only 4% of the physicians identified the women in their care as abused.

It is clear from this survey that the significant percentages of women that are admitted to various medical services were assaulted by their intimate partners. But it is also clear that a very small percentage of them are assessed, identified, and evaluated by physicians and by the medical staff in general, as women who have fallen victim to such violence. It is clear that violence against women is the greatest threat to the physical and psychological health of women and therefore it can be said that the health sector in all its components, and lead by a staff of physicians, can play a central and essential role in the identification and assessment of battered women, and accordingly can help both the victims and the professional staff (such as social workers, law enforcers, and others) save them from the continuation of violence against them. At times, in a certain way, failure of the medical staff to identify and assess battered women can stem from reasons inherent in the woman herself, for a number of reasons, such as the fear of the social stigma of being labeled a battered woman; her fear that she will not be believed by professionals if she reveals being beaten and that the abuse will be minimized or that blame will be attributed to them; some battered women, if they obtain access to services, still fear being disadvantaged by racism, cultural stereotyping, heterosexism, having a disability, and fear of the revenge of her abuser because of revealing his abuse and violence against her (e.g., Thurston, Cory, & Scott, 1998). In addition to this, a large portion of the battered women who have not been assessed can be greatly attributed to the approach of professionals in health services towards the problem of violence against women, something that causes, among other things, the lack of willingness to ask the women about the reason for their admittance to health services in general and on violence in their lives specifically (e.g., Pahl, 1995). The approach of the medical staff in the health services can be manifested in

negative opinions and distorted beliefs about women in general and about battered women and violence against women specifically (Thurston et al., 1998). In actuality, a portion of the factors that can be attributed to battered women that were indicated above, can be attributed to the medical staff and the approach of the medical staff towards them. We will discuss this approach at greater length in the next chapter.

The Approach of Physicians toward Wife Abuse

We have recently witnessed the growing interest in the approach of practitioners of the various therapeutic professions, including physicians, towards the problem of violence against women. This interest is manifest, among other ways, in the study of the approach of professionals, out of belief that the discovery and clarification of this approach can help us a great deal in understanding the obstacles that stand in the way of professionals in identifying and assessing battered women and in providing services that are appropriate to their needs, the needs of their children, for protection, and for treatment. Studies show that what is common to most professionals is their belief that the problem of violence against women is beyond their professional responsibilities and obligations and therefore is beyond their professional mandate (Eisikovits, Griffel, Grinstein, & Azaiza, 2000). Professionals tend to also view the problem more as a personal and inter-personal problem than as a social, legal, and health problem, and even a portion of them tends to deny the existence of the problem or ignores its existence (Davis, 1987; Hanson, Harway, & Cervantes, 1991). Therefore, it is no wonder that the social and therapeutic reaction of many professionals is to ignore the problem and deny its existence, or minimize its severity and consequences and accordingly attempt to lessen their involvement with the problem.

Physicians and nurses tend to relate only to the physiological element of the problem of violence against women and therefore focus on the treatment of physical

injuries and other physiological consequences of the problem. Hence, they tend to completely avoid relating to the psychological, familial, and legal consequences, and all other consequences of the problem. At the same time, they tend to deny their responsibility and their mandate to relate holistically, broadly, and comprehensively to the problem. They also tend to think that all other approaches to the woman's injuries and the condition of her physical health are time consuming which they don't have anyway (Kurtz, 1987; Pahl, 1995; Sugg & Indi, 1992; Thurston et al., 1998). And therefore, it is no wonder that medical professionals fail to identify signs of physical abuse and emotional and behavioral indicators of the problem among battered women. While this reaction can sometimes reflect the lack of willingness of battered women to report to medical professionals their experiences of violence against them, but in most times it reflects their feelings of shame and fear of their abusers' revenge. It also greatly reflects the lack of willingness of these professionals to ask women in depth about their experiences with violence and also reflects their approach of avoiding the problem as stated above (Pahl, 1995; Thurston et al., 1998; Warshaw, 1996). Medical staff tends to use indirect ways to treat violence against women. In a broad study, Kurz (1987) found that a significant portion of the medical staff that reported incidents of violence against women to the police did so because they wanted to fulfill their legal obligations and not because of their professional, moral, and ethical responsibility towards women or towards the problem in general. This study revealed that physicians also limit themselves in providing medical treatment and relating only to the physical injuries and pains of the women and to their complaints about other physical aspects. Few physicians asked questions about the women's experiences of violence. Therefore, the majority of the physicians do not contribute to the performance of legal, psychological, familial, and economical interventions that are undoubtedly very essential to battered women. The physicians in Kurz's (1987) study tended to include violence against women together with other types of anti-social behavior such as drinking alcohol, alcohol and drug addiction, which are given priority over intervention in violence against women.

Bell, Jenkins, Kpo, and Rhodes (1994) carried out a study where they investigated

whether emergency rooms in a metropolitan state in the U.S.A. had standard procedures or offered services that addressed the needs of victims of family violence. This study revealed that emergency rooms generally relied on patients' self-reports to determine whether a patient is a victim of violence. Standard operating procedures for reporting cases to state agencies and referrals for additional services were most likely to exist for areas in which the response of hospitals is mandated by law, such as sexual assault and child abuse. In addition, three-fourths of the hospitals had procedures for dealing with abuse of the elderly, an area in which there is strong reporting. Bell et al.'s (1994) study also revealed that most direct services received by victims were not specifically targeted to them, but were services offered to the general emergency room population. The most frequent referrals were to rape advocacy groups and battered women's groups. Based on Bell et al.'s (1994) study, several conclusions can be reached. First of all, hospitals are most likely to respond to victims in which their actions were mandated by laws, such as sexual abuse and child abuse, or strongly recommended, such as elder abuse. Second of all, the majority of emergency rooms do not conduct adequate epidemiological surveillance of injuries resulting from interpersonal family violence. The findings of the studies of Bell et al. (1994) are to a great extent consistent with the findings of Kurz (1987) from which it could be understood that in certain instances and conditions the medical staff tends to report incidents of family violence, but they do so by power of a legal mandate that is enforced on them, and less out of a sense of professional responsibility that is placed on them and that comes from their professional mandate. Flitcraft (1993) maintains that defining what it means for physicians to "recognize violence as their issue" has proven to be difficult, particularly as this involves issues that reach beyond the physician's office. She presents various rationales that come to explain the consistent distancing of doctor's from the problem of violence against women. One of the first explanations that was presented in the past, she claims, states that the identification and assessment of battered women in the various medical services is a result of the reluctance of the women themselves to discuss the real reasons for their injuries with the medical

staff. In contrast, it should be noted that, as was previously emphasized, there are researchers that use simple interviewing techniques and questionnaires that revealed that there are substantial percentages of battered women from among the women in general who are admitted to various medical settings. This attests to the fact that the identification and assessment of battered women is not so difficult as certain people think. Filcraft (1993) presents another explanation that states that there are physicians who are concerned that some patients would be offended by questions about violence at home; in deference, physicians were reluctant to discuss the issue. Again, the high rates of women that participated in studies on violence against women shattered and debunked this concern. Flitcraft (1993) maintains that “more recent explanations explore physicians’ projected helplessness and their belief that domestic violence is a “Pandora’s box” without solution” (p. 156). It could be argued that this rationale is inconsistent with physicians’ usual determination when faced with near-certain failure in other areas. Hence, other factors could be considered for this concern. Flitcraft (1993) claims that a small portion of what occurs during encounters between doctor and patient is determined by individual physicians. This encounter is greatly influenced, and actually shaped, by several factors, including its social and cultural context; by the policies and resources of the health services; and by the beliefs, values, and norms of the medical community. Therefore, it would be naïve to expect significant and serious changes in the way that individual physicians treat battered women as long as concurrent changes have not occurred in these factors.

A substantial number of studies provided empirical evidence for the claims of Flitcraft. Ferris (1994) carried out a study among Canadian family physicians (FP) and general practitioners (GP) where she attempted to determine their perceptions regarding their effectiveness in identifying and treating abused women among their female patients. Ferris (1994) reports that less than one third (about 31%) of the respondents believed that FPs and GPs are able to effectively diagnose physical abuse, and even less (about 25%) believed that they could effectively diagnose emotional abuse. She also reports that the number who thought that they could effectively treat such abuse was even lower:

about 22% for physical abuse and about 17% for emotional abuse. Interestingly, when participants in Ferris's study were asked whether other mental health practitioners (social workers, psychologists, psychiatrists, and others) are the most appropriate to diagnose emotional wife abuse, about 23% agreed, but about 30% were neutral, and about 47% disagreed. However, when questioned on the appropriateness of the other professionals for treating emotional abuse, 50% agreed, about 25% were neutral, and about 25% disagreed.

Ferris (1994) reports that almost all respondents (about 99%) believed they are missing cases of abuse. About 55% of the respondents estimated they are missing 30% of cases or more. About 68% of the respondents reported not having a standard method for detecting wife abuse and those who did have such a method, reported significantly higher percentages of detection. Of this group, about 65% reported that they believe that their method is always helpful. Participants in Ferris's study indicated 21 reasons for not detecting 100% of the cases, where the following were the most common reasons: Infrequent patient visits (about 64%), unresponsiveness of patient to questions (63%), no patient initiative (61%), lack of time (about 48%), not trained (about 32%), unresponsiveness of patient to referrals (about 29%), forget to ask (about 29%), and cultural barriers (about 24%).

When participants in Ferris's study were asked what they see as their most important role in a case of wife abuse, the most common responses were as follows: 1) providing the woman with information concerning community resources (about 94%); 2) providing emotional support (about 93%); 3) arranging referrals (about 87%); and 4) protecting patient confidentiality (about 57%). These findings on physicians' perceptions of their roles that they are obligated (because they express an interest and, perhaps, even a sense of responsibility) to be involved, in one way or another, in assisting battered women. In addition, it should be noted that these responses express opinions and beliefs more than actual behaviors in the provision of aid to battered women.

About 72% of the participants in Ferris's study indicated that they did not know of any continuing medical education courses or workshops on wife abuse being

offered in their province in the last two years, yet 87% believed that more of such courses are needed. Over the past two years, only 10% of responding physicians in this study had attended a course concerning wife abuse, and 23% had read books or articles regarding wife abuse.

Sugg and Inui (1992) studied the experiences of primary care physicians with victims of domestic violence, where their main objective was to determine the barriers to problem recognition and investigation in the primary care setting. Sugg and Inui's (1992) study revealed that physicians found exploring domestic violence in the clinical setting analogous to "opening a Pandora's box". The main issues the physicians in Sugg and Inui's study indicated include: 1) lack of comfort; 2) fear of offending; 3) powerlessness; 4) loss of control; and 5) time constraints. With regard to the first issue, i.e., lack of comfort, physicians indicated that the close identification that they have with their patients may preclude them from considering the possibility of domestic violence in their differential diagnosis. Physicians who came from White, middle-class backgrounds, with no experience of domestic violence, often assumed that their patients with similar characteristics would likewise not be at risk for violence. Although most physicians in Sugg and Inui's study intellectually acknowledged that domestic violence cuts across all races, classes, and ethnic groups, the socio-economic status of the patients was clearly used as a marker for determining whether abuse was likely. Many physicians also admitted that they were more likely to ask patients of lower socio-economic status about abuse. Among women physicians, it was revealed that the close identification with patients created another problem. Uncovering domestic violence among patients similar to them would expose some of these physicians to their own fear of vulnerability and lack of control. Sugg and Inui (1992) concluded that diagnosis of abuse may also be hindered when physicians too closely identify with abused patients due to their own past experience of abuse or violence. When participants in their study were asked about a previous history of child abuse or physical violence with an intimate partner, 14% of male physicians and 31% of female physicians acknowledged their own experience. As a group,

abused physicians could not be distinguished from non-abused physicians in their major themes or patterns of responses.

With regard to the second issue, i.e., fear of offending, Sugg and Inui (1992) found that fear of offending patients was one of the strongest fears expressed by physicians. This fear often originated in the physician's discomfort with areas that are culturally defined as private, such as wife abuse and violence against women in general. The uncertainty of whether patients would consider domestic violence a legitimate area to probe was distressing to physicians in Sugg and Inui's study. The fear of offending the alleged batterer may underlie some physicians expressing the need to judge the truth of the situation and the discomfort they felt if the truth was not clear. Sugg and Inui (1992) concluded that it appears that to suggest the diagnosis of domestic violence is to "accuse" the partner of being a batterer. When this weight of judgment is placed on the diagnosis, full "truth" is required by some physicians. For some physicians in their study, blame needed to be assigned, and a "true victim" and "true perpetrator" needed to be identified. Anything less clear-cut was unsettling for the physicians.

With regard to the third issue, i.e., powerlessness, many of physicians in Sugg and Inui's study expressed frustration and feelings of inadequacy when discussing what constitutes appropriate interventions in cases of domestic violence. Many pointed to the complexity of the problem and the fact that they had no tools to help. Sugg and Inui (1992) maintain that there was a strong sense of powerlessness when physicians described their inability to treat cases of domestic violence. Many pointed to their lack of training on this issue, with 61% revealing that they had not received training on domestic violence in medical school, residency, or continuing medical education courses; as opposed to 8% who expressed that they had received good training in this area.

With regard to the fourth issue, i.e., loss of control, 42% of physicians in Sugg and Inui's (1992) study expressed frustration that although they would intervene with advice or referral to resources, ultimately, the control of the outcome was in the hands of the patients. Until the patient was motivated to change, these

physicians felt their attempt to intervene were useless. Many physicians in Sugg and Inui's study were frustrated by their inability to control the battered woman's behavior, and by the battered woman's inability to control the circumstances of their lives. This issue of control was most prominent when physicians described their frustration with the repetitive nature of domestic violence. This reaction was most marked among female physicians.

With regard to the fifth issue, i.e., time constraints, about 71% of physicians in Sugg and Inui's study identified the time constraints of a busy primary care practice as the major deterrent for asking their patients about violence in the home. Their greatest fear was that this is one more issue that will consume more of their, already scarce, time. In addition, the majority of physicians who participated in Sugg and Inui's study indicated that domestic violence was of such low prevalence in their patient population that pursuing it was not a good investment of time. Moreover, several physicians expressed frustration with the overwhelming role physicians were being asked to play.

Gerbert et al. (2002) conducted a nationwide survey among a representative sample of primary care physicians from the American Medical Association Physician Masterfile, where they compared physicians' behaviors and beliefs on screening and intervention for domestic violence with other risk behaviors, i.e., tobacco use, alcohol abuse, and HIV/STD- risk behavior. Gerber et al. (2002) report that significantly fewer physicians in their study reported screening new patients about domestic violence (19%) than about tobacco use (98%), alcohol abuse (90%), or HIV/STD risks (47%). Similarly, 13% reported that they ask regular, or returning, patients about domestic violence, compared with 82%, 61%, and 27% who reported asking returning patients about tobacco, alcohol, and HIV/STD risks respectively. Participants in Gerbert et al.'s study also reported significantly less discussions with patients over the past three months about domestic violence than about tobacco, alcohol, or HIV/STD risks. Once domestic violence was identified, physicians reported intervening at comparable or greater frequencies for domestic violence compared with tobacco, alcohol, or HIV/STD risk. Most physicians

reported that they documented cases of tobacco use (97%), alcohol abuse (96%), HIV/STD risk (83%), and domestic violence (84%). On the other hand, significantly more physicians reported that they provide counseling, arrange for follow-up visits or calls, and refer patients to additional resources for domestic violence victims than reporting these actions for patients identified with the other three health risks. In addition, physicians reported spending significantly more time counseling patients identified as victims of domestic violence than counseling patients identified with tobacco, alcohol, or HIV/STD risks. Gerbert et al. (2002) also report that relative to the other risk areas, physicians expressed beliefs that reflect a decreased likelihood of screening for and intervention with domestic violence. Fewer physicians agreed that they know how to screen patients for domestic violence, and fewer agreed that they know how to intervene with domestic violence, compared with the other three risks. Compared with their beliefs regarding tobacco use and HIV/STD risks, significantly less physicians believed that their intervention efforts in domestic violence are likely to be successful; there was no significant difference between their beliefs regarding the success of interventions for domestic violence and alcohol abuse.

Kurz (1990) found, in contrast to many mistaken claims in the literature that 68% of the battered women that are admitted to emergency rooms in hospitals that participated in the study are not reluctant or evasive to indicate the source of their injuries that caused them to come to the hospital. This finding shows that there is a certain percentage of battered women who are admitted to hospitals that are reluctant to talk about the assaults made on them and their suffering of abuse by their intimate partners because of the previously stated reasons. However, it also reveals that the majority undoubtedly are interested in disclosing their suffering and to indicate to the medical staff that they are being abused if they encounter a caring attitude and empathetic approach from the staff, and if the medical staff expresses the desire and the willingness to help them beyond the medical care they receive in the hospital. Kurz (1990) found that only a very small portion of the medical staff reacts in a positive manner towards such women and expresses that they are “unfairly victimized” and that they deserve all the time and attention that

is possible to grant them in the hospital. Kurz (1990) found that the majority of the medical staff claims that it is irritating to find that a woman comes into an emergency room and indicates that she was not abused by her spouse (for example, she fell because she slipped, was in a car accident, etc.) and afterwards it becomes apparent that she was indeed abused by her intimate partner. A portion of the physicians even indicated that it is a waste of time when they ask the woman the reason for her visit to the emergency room and she either doesn't answer or doesn't state the truth. In such cases, the medical staff tends to label the woman as "evasive". Labels such as these run contrary to the truth about the willingness of battered women to be forthcoming and cooperative with the medical staff. They also expresses the lack of understanding and empathy of the medical staff towards the fears, concerns, and anxieties of the battered women with regard to the reactions of the perpetrators if they disclose their abuse, as well as the lack of trust that that women develop towards the medical staff and their concerns that if this staff reveals their secret it will not understand them. In actuality, McLear and Anwar (1989) found, like many researchers, that the majority of battered women that are admitted to emergency rooms are indeed interested in disclosing the reasons for their injuries if they are asked, and are indeed interested in cooperating with the medical staff if they receive a caring, understanding, supportive, and empathetic attitude.

Referring to studies conducted in the U.S.A., Great Britain, Canada, and New Zealand, Easteal and Easteal (1992) concluded that physicians - as opposed to other professionals - identify and assess very small percentages of battered women that they meet in various medical settings. They claim that this can be greatly attributed to the failure of physicians to identify the "masked presentation of violence", i.e., the failure of physicians to look at the real reasons for the physical injuries, depression, anxiety, or drug abuse, and not to be content with simply looking at the symptoms. Although, according to the estimates of Kurz (1990) and Easteal and Easteal (1992), similar to the estimates of other researchers, in a certain way this failure can be attributed to the lack of training or inadequate training that the physicians received. However, this also can be undoubtedly attributed to the attitudes and negative opinions that physicians

have towards battered women and the problem of violence against women, which serves as a significant obstacle for physicians to assess battered women and to provide them with the necessary aid (Thurston et al, 1998).

Easteal and Easteal (1992) also claim that even when physicians identify women who are victims of violence, the attitudes of the physicians towards the etiology of the violence and their perception of their roles in working with battered women is limited only to the provision of medical treatment to battered women, hampering the level of their effectiveness in providing suitable aid to such women. Several studies revealed that, compared to other professional groups, physicians have a greater tendency to blame the victim. They generally tend to attribute equal responsibility for the violence both to the victim and the perpetrator and even attribute most of the blame to the personality of the victim and psychological state. Additionally, it was found that battered women, under treatment of physicians, who were uninterested in leaving their abusive spouses and/or those without “pleasant personalities” receive less sympathy and referrals to additional treatments, and battered women who also drink alcohol and/or are perceived as evasive receive less support from the medical staff (Borkowski, Murch, & Walker, 1983; Davis, 1984; Davis & Carlson, 1981; Kurz, 1987, 1990; Pahl, 1995).

It is therefore no wonder that battered women tend to express disappointment from the service and from the way they are treated by the medical staff. They report that physicians treat physical injuries and give prescriptions for tranquilizers for the treatment of psychological problems, but they tend to overlook and fail to understand the real reason for the injuries and problems of violence against women by their intimate partners.

Easteal and Easteal (1992) conducted a study among Australian physicians in which they examined their attitudes towards the etiology of violence against women and the role that, in their opinion, physicians need to play in identifying and assessing battered women and preventing violence against them. They report that around 47% of the physicians indicated that they met five or less

women a month that they suspected of being battered women, around 21% of them indicated that they met between six and ten women, around 6% indicated that they met 11 to 20 women, and 26% of the physicians indicated that they met more than 20 women a month that they suspected of being battered women. The physicians indicated many reasons that caused them to suspect women in their care of being victims of violence by their intimate partners, including: signs or physical injuries (56%); any association to alcohol, when, for example, a drunken husband was present with the woman in the hospital (11%); and the woman's history as recorded in the hospital (around 12%). Easteal and Easteal claim that it is difficult to determine for certain, from the responses of the physicians, the percentage of battered women from all the women who come for treatment. They maintain that the difficulty to identify battered women can be a result of their perception that it is not part of their roles to identify battered women and to work with battered women or as a result of their lack of ability to recognize valid or possible symptoms of violence.

Easteal and Easteal (1992) found that the majority of physicians expressed the belief that physicians need to play an active role in addressing the concerns of battered women. Around two-thirds of them agreed that they need to act in the same way as they act in cases of child abuse. Furthermore, around two-thirds agreed that the physicians need to ask the woman if she was abused the moment that they suspect it. However, there is a gap between the responses of the physicians to the closed questions and their responses to open questions regarding the appropriate role that physicians need to play in providing the appropriate treatment to battered women. Almost all of the physicians agreed that they should refer the battered women that come in to their care to the appropriate services, but only a third of them gave this response in their response to the open question. Three-fourths of the physicians indicated in their closed responses that battered women should be encouraged to leave their home, but only two physicians (2%) gave this response to the open question. Around 4% indicated that physicians need to encourage the woman to go to the police in order to report the violence committed against her.

The majority of the physicians that participated in the study of Easteal and Easteal indicated that they believe that the reasons for the violence against women include sociological factors, alcohol, or psychological problems of the abusive spouse, but does not include the provocation of the husband by the battered woman. Around 5% of the physicians indicated that the personality of the battered woman can be the reason for the violence against her and at the same time indicated that the personality of the spouse cannot be the reason for the violence against his wife. Nevertheless, around 48% agreed that the opposite was true, i.e., that they believed that the personality of the abusive spouse was the reason for his violence and at the same time they believed that the personality of the wife cannot be the reason for the violence against her.

Around 96% of the physicians that participated in the study of Easteal and Easteal (1992) indicated that they do not support violence against women even if the violent husband was provoked by his wife. Around 77% of the participants did not agree that wife battering is a private matter. Around 18% of the physicians that participated in that study indicated that they believe that violence against women is more common among uneducated women and of a low socio-economic class. Almost all of the physicians (around 98%) feel sympathy towards battered women under their care, and around 92% indicated that physicians need to behave sympathetically towards battered women. More than a third of the physicians that participated in that study agreed that violent men need to receive sympathy for their emotional problems. Nevertheless, around 32% of the physicians agreed that violent men need to be sent to jail. Around 13% of the physicians agreed that battered women remain with an abusive man because they are masochistic.

Abott, Johnson, Koziol-McLain, and Lowenstein (1995) found that negative opinions towards wife battering among health professionals indeed lead to the denial of the problem, the rationalization of the problem, the minimization of the problem, and the blaming of the victim for her situation. Many medical teams continue to treat wife abuse as a non-medical problem and therefore continue to refrain from screening such cases, despite new protocols that have been developed especially for this purpose and despite the training programs that physicians undergo on the

problem (Kurz, 1987, 1990). Even if medical teams do not express an opinion on how they view the problem as a non-medical problem, there are still additional barriers that prevent them from being involved in the screening cases of battered women and providing them with suitable treatment. For example, a survey that was conducted among family physicians revealed the following obstacles: lack of knowledge of available resources for the treatment of the problem, the necessities and constraints of time to provide additional treatment above and beyond the medical treatment that they are required to provide, restrictions in training, futility with respect to the women's compliance, and difficulties in interpreting the cycle of violence (Inicki, 1994). The difficulty to understand the process of leaving the violent partner creates a unique obstacle for medical teams. For example, the idea that after a simple directive or a referral will cause the woman to leave her violent spouse, and accordingly can break apart the marital relationship and the family, is naïve because the process of leaving can generally take years. Medical teams that work under the influence of this idea are left frustrated, angry, or they feel as if they failed when see that the woman returns to her abusive partner (Lazzaro & McFarlane, 1991; Thurston et al., 1998). Thurston et al. (1998) claim that denial, rationalization, minimization, and blaming the victim are obstacles that reflect the approach and beliefs of society towards the whole problem of violence against women. Empirical evidence for this can be found in Kurz's (1990) study that showed that medical teams change the degree of their reactions depending on whether they perceive that the woman possesses stigmatizing traits, (such as if she reeks of alcohol, hesitates to speak, behaves "inappropriately" from what is expected from her as a woman in general or as a battered woman specifically) or if they view violence as a priority in their medical treatment. Therefore, social beliefs about the appropriate behavior of girls, female youth, and mothers affect the way medical teams react. These reactions are mediated by perceptions and stereotypes of status and culture, when it has been found that medical teams often believe that the problem of violence against women is uncommon among people of high socio-economic class (Kurz, 1990) or it is accepted in certain ethnic social groups. Because of these perceptions and stereotypes, friends and family can contribute to the denial, rationalization, minimization, and the blaming of the victim. Therefore,

the socio-cultural context influences the approach of medical teams towards battered women in general, and their willingness to screen such cases specifically.

Thurston et al. (1998) indicate that there are also obstacles, or other difficulties, that prevent medical teams, to screen, identify, and assess battered women and to be involved in assisting them. They indicate that in order that the identification, assessment, and interventions will be made effectively there needs to be, at an organizational level, a number of aspects, such as: assessment and intervention that are perceived by the organization as essential and high priority, existing administrative facilities that allow for the screening and intervention, existing or available human resources and material resources, existing post-screening tests for diagnosis that are definite and precise, and existing and available treatment facilities because screening without treatment has no value and is meaningless. A portion of these factors are organizational (such as existing and available human resources and material resources) but, again, these factors are related to the socio-cultural context. At times, there are tensions between health services and other services (such as shelters, women centers or organizations, support groups for women, and other welfare organizations). These tensions often come from economic pressure and the lack of professional human resources, which limits their ability to take in cases that are referred to them by health services. But the tension between the health services and the above mentioned organizations can stem from the philosophical differences between them, i.e., whether the services that are provided for women need to be woman-centered or family-centered. Supporters of family-centered treatment tend to view the family as a nurturing social system and its continuation is essential for the welfare of each one of its members. Supporters of this treatment see themselves as bias-free regarding each member of the family and therefore their policies are explicitly gender-neutral. Therefore, it is very reasonable to assume that the supporters of family-centered treatment will have cohesion and preservation of the family, “domestic peace”, reconciliation, and appeasement, placed in front of them. Accordingly, they will see that the way to stopping the violence is a change in each person, assuming that each person contributes to the disagreements and conflicts between them and therefore both are equally responsible for the

violence of the husband against his wife. In contrast, supporters of women-centered treatment have a feminist orientation that views the family as the most dangerous place for women. Although feminist policies are made to support the family as a social unit, at the same time, they change certain practices and assumptions in order that the women, the husband, and their children benefit from living in a violence-free environment. Special emphasis in feminist practice is on the presentation of the battered woman as a victim and not the one responsible for the violence against her, and the abusive husband as the perpetrator and the one who is therefore solely responsible for his violent behavior. Feminist practice does not promote appeasement and reconciliation in and of itself but rather cessation of the violence and the prevention of its continuation as a primary and central goal that must be fulfilled.

Although we have recently witnessed the growing trend of studies that were conducted on the attitude of the medical staff, including physicians, towards violence against women, there is still a serious lack of studies on the relevance of the feminist perspective (i.e., patriarchal ideology) of the physicians and their exposure to violence in their families (i.e., social learning theory) in an integrative manner to their attitude towards the problem of violence against women. We will discuss this issue in the next chapter.

The Approach toward Violence against Women from an Integrated Perspective of Patriarchal Ideology and Exposure to Family Violence

In the present study we adopted the patriarchal ideology and social learning theory to explain the approach of physicians towards violence against women. The patriarchal perspective suggests that one needs to view the problem of violence against women from a social and individualistic viewpoint (i.e., Bograd, 1984; Dobash & Dobash, 1992). At the social level, the patriarchal nature of society allows for the oppression of women and relates leniently and forgivingly,

and at times even with understanding, towards violence against women. Advocates of the patriarchal perspective of the problem of abuse and battering of women (e.g., Dobash & Dobash, 1979, 1992) argue that humanity has always exhibited a lenient attitude towards violence in order to maintain the man's advantage in conjugal power relations. Traditional values regarding the roles of marital partners and regarding gender roles in society usually reflect a patriarchal approach toward conjugal power relations and justify male dominance. Men who believe their power and privileges are being threatened in any way, usually resort to various patterns and forms of violence in order to restore their dominance (Dobash & Dobash, 1979, 1992). According to this perspective, battering will end when society delivers clear messages that violence against women is unacceptable and must stop. On the individual level, a batterer uses violence to control and dominate his wife; and men with certain psychological characteristics are more likely to be wife abusers (Walker, 1984).

The feminist perspective regards the batterer as the perpetrator of a crime and as the one who is completely responsible for the abuse. For the marriage to become non-abusive, the batterer and his wife must accept that he is completely responsible for stopping the violence against her. The woman in no way causes the abuse; therefore, changing her behavior in the relationship is not connected to ending the abuse. In fact, a counselor who believes the wife contributes to the abuse actually endangers her. In Adam's (1988) feminist analysis of different treatment approaches to wife abuse, he concludes that "those approaches that advocate a shared responsibility between husbands and wives do so at the expense of the battered woman's right to expect changes without jeopardizing her own safety" (p. 196).

In the patriarchal social structure, the use of force against wives and female intimate partners comes to protect the male authority and is justified by the existence of male authority (Coleman & Stith, 1997; Haj-Yahia, 1997, 1998a, 1998b, 19998c). A patriarchal approach towards the problem of violence against women views differential socialization into two genders and the socialization of

sex-typed roles as that which encourages the development of aggressive, dominant, and authoritative males on one hand, and passive, dependent, self-sacrificing women on the other. Therefore, this social mechanism is most essential to the creation and justification of an ideology that supports male dominance and the need to preserve power through all available means, including violence against women. Evidence for these claims can be found in studies that were conducted among nursing students (Coleman & Stith, 1997), counselors in shelters for battered women (McKeel & Sporakowski, 1993), police officers (Saunders & Size, 1986), students from various disciplines and professions, and people in society in general (Glick, Sakalli-Ugurlu, Ferreira, & de Souza, 2002), and also studies that were conducted among ordinary people (Finn, 1986; Haj-Yahia, 1997; 1998a, 1998b, 1998c, 2002; Smith, 1990). In a study conducted among nursing students, Coleman and Stith (1997) found that sex-role egalitarianism was found to be the best predictor of sympathetic attitudes towards victims of domestic violence. Saunders and Size (1986) conducted a survey of police officers, battered women, and advocates in an attempt to gain insight into the controversy over police responses to violence against women. In the study, the male police officers were found to maintain relatively traditional views of women as property and believed that women need to be punished if they are unfaithful. In addition, it was found that the police officers' belief that victims bring on abuse can be attributed to their traditional perspective of women's roles in society and the family. At the same time, however, Saunders and Size found that respondents with feminist attitudes generally agreed that battered women neither cause abuse nor enjoy it. Glick et al. (2002) carried out a comparative study among Turkish and Brazilian students and men and women of the wider community, where they investigated the relevance of different types of sexism to attitudes toward wife abuse. They found that, in both nations, hostile sexism and benevolent sexism positively correlated with attitudes that legitimize abuse. They conclude that ostensible protectiveness of benevolent sexism is contingent, failing to shield women from abuse if they are deemed to have challenged a husband's authority or violated conventional gender roles.

In a series of studies I conducted among Palestinian men and women (Haj-Yahia, 1997, 1998a, 1998b, 1998c) and Jordanian women (Haj-Yahia, 2002), I found strong empirical evidence support to the relevance of participants' ideological patriarchy to their beliefs about wife beating. In essence, I found that the more men and women hold negative and traditional attitudes toward women, the more they hold rigid sex-role stereotypes, and the more they hold patriarchal and no-egalitarian expectations from marriage then the more they tend to justify wife-beating, the more they tend to believe that women benefit from beating, the less they tend to help battered women, the more they tend to hold battered women responsible for their beating, and the less they tend to hold violent husbands responsible their behavior. Similar studies among professionals in Arab societies are lacking.

According to the second theory we adopted in the study, i.e., social learning theory, human behavior and attitudes are largely learned by observing others, reading, and looking at pictorial illustrations. This theory predicts that infants learn violent behavior and attitudes that justify violence when they observe their parents or additional significant others using violent tactics to cope with various problems. Subsequently, they may emulate such behavior with their siblings and later, with their wives and children. This explanation has been referred to as "generational transfer" (Carter, Stacey, & Shupe, 1988) or "intergenerational transmission" of violence (Carroll, 1977; Kalmuss, 1984; Widom, 1989).

Empirical support for these arguments can be found in numerous studies conducted in Western societies (e.g., Carter et al., 1988; Kalmuss, 1984; O'Leary, 1988) as well as in Arab societies (Haj-Yahia, 1997; Haj-Yahia & Dawud-Noursi, 1998; Haj-Yahia & Edleson, 1994) on generational transfer or intergenerational transmission of behavior, attitudes, and perceptions. Similar studies among professionals, using social learning theory to explain their approach toward wife beating, are seriously lacking. Accordingly, this study attempts to fill this gap by studying Palestinian physicians' approaches toward wife beating from an integrated perspective that combines their patriarchal ideology and their exposure to violence in their families-of-origin, i.e., social, learning theory.

The Palestinian Context of Wife Abuse

Public, academic, and professional interest in wife abuse have been aroused in recent years in Palestinian society. Herein we present a summary of several studies we carried out about the rates and some correlates of wife abuse in Palestinian society and the approach of ordinary people in this society toward the problem.

Incidence of Wife Abuse

Two national surveys were conducted recently among systematic random samples of Palestinian women in the West Bank and Gaza Strip. Both surveys investigated the incidence of psychological, physical, sexual, and economic abuse (that is, whether such abuse occurred at least once during the year in which the survey was conducted) and its socio-demographic correlates (Haj-Yahia, 2000a). The first survey was conducted from January to March, 1994, among a sample of 2,410 married Palestinian women. The second survey was conducted from June to August, 1995, among a sample of 1,334 married Palestinian women.

As far as psychological abuse is concerned, the results of the first survey revealed that 19 percent to 74 percent of the Palestinian women had been psychologically abused by their husbands at least once during the 12 months that preceded the survey; and 16 percent to 73 percent of the women participating in the second survey indicated that they had been psychologically abused at least once during that period. Results of both surveys revealed that yelling was the most common act of psychological abuse against wives, whereas threatening to throw something, intimidating, and trying to control the wife's behavior by investigating, interrogating, and following her were the least common acts of psychological abuse against wives.

Regarding physical abuse, 8 percent to 34 percent of the women participating in first survey, and 7 percent to 37 percent of the women participating in the second survey reported that they had been physically abused by their husbands at least once during the 12 months preceding the survey. The results of both surveys also revealed that the most common acts of physical abuse were husbands throwing, kicking, or breaking something during an argument with their wives, and the least common acts were attacking wives with household equipment or other dangerous implements such as a knife or a metal rod.

With regard to sexual abuse of Palestinian women, 27 percent to 31 percent of the women who participated in the first survey, and 30 percent to 33 percent of the women who participated in the second survey indicated that they had been sexually abused by their husbands at least once during the 12 months preceding the survey. The findings also revealed that attempts to have sex with the wife without her consent was the most common act of sexual abuse; and actually having sex without the wife's consent was the least common act of husband-to-wife sexual abuse.

Finally, with regard to economic abuse of Palestinian women, the results revealed that 24 percent to 41 percent of the women who participated in the first survey, and 19 percent to 40 percent of the women who participated in the second survey reported that they had been economically abused by their husbands at least once during the 12 months preceding the study. For example, 40 percent to 41 percent of the Palestinian women participating in either of the surveys reported that their husbands had prevented them from using the family's money as they saw fit.

Socio-demographic Correlates of Wife Abuse

The findings of both Palestinian national surveys indicated that psychological, physical, sexual, and economic abuse occur in Palestinian society against women of different ages, levels of education, levels of income, and religions, as well as against women from different types of residential areas, different size families, and at different stages of marriage.

At the same time, however, the results of the two national surveys indicate that the incidence of different patterns of abuse, as mentioned, vary significantly in some groups. The following is a summary of some of the main findings revealed in both surveys: The older the woman, the more likely she is to be economically abused by her husband; the younger the Palestinian husband, the more likely he is to physically abuse his wife; the less educated the Palestinian wife, the more likely she is to be psychologically, physically, sexually, and economically abused by her husband; the less educated the husband, the more likely he is to psychologically, physically, sexually, and economically abuse his wife; Muslim women are more likely than their Christian counterparts to be psychologically, physically, sexually, and economically abused by their husbands; the larger the wife's family, the more likely she is to be psychologically abused and severely beaten by her husband; wives who do not work for a salary are more likely to be psychologically, physically, sexually, and economically abused by their husbands than are their counterparts who work outside of the home; women who have been married for at least six years are more likely to be severely beaten by their husbands than are those who have been married for a shorter period; the lower the family's income, the more likely the wife is to be psychologically, physically, and sexually abused by her husband; and wives whose level of education is higher than that of their husbands are more likely to be psychologically, physically, and sexually abused than are women whose level of education is identical to or lower than that of their husbands.

Implications for Future Research and Theory Development

Further analysis of the results of both surveys was undertaken in an attempt to identify differences between Muslim and Christian families, as well as differences between residents of rural areas and refugee camps versus urban residents. Compared with their Christian counterparts, Muslim women were

found to be less educated, less likely to work for a salary, subject to greater financial hardship, have more offspring, and tend to live in refugee camps and rural areas. Moreover, compared with their urban counterparts, rural and refugee women were less educated, less likely to work for a salary, subject to greater financial hardship, and lived in poorer housing conditions. These results give some indication of the main stressors encountered by Palestinian families and the main resources lacking in those families. Moreover, these factors were found to be relevant to wife abuse and battering, beyond the impact of family's religious affiliation and place of residence. Hence, the results provide a solid basis for integrating the family resources and family stress theories in future research.

With regard to domestic violence, family resources theory argues that when the wife's resources exceed those of her husband, the gap between them generates power and control conflicts which increase the likelihood that the husband will use violence against his wife (Allen and Straus, 1980). At the same time, family stress theory argues that low levels of family resources as well as major changes and transitions experienced by the family generate high levels of stress and tension which increase the likelihood of family violence (Farrington, 1980).

Beyond the variables examined in both Palestinian national surveys, future research based on this integrative approach might examine variables such as: husband's occupation; husband's unemployment; illness and disability among family members; power struggles between the husband and wife, and current political conditions in Palestinian society, including the Palestinian family's experience with conditions of occupation. Clearly, the studies must take into account the unique socio-cultural, political, and economic contexts of Palestinian society.

Two additional studies revealed that traditional and negative attitudes toward women, rigid sex-role stereotypes, sexual conservatism, non-egalitarian expectations of marriage, and patriarchal beliefs about marital relations and family life were significant predictors explaining Palestinian women's beliefs about wife abuse (Haj-Yahia, 1998a and 1998b). Moreover, Levinson (1989) revealed that out of the four main predictors of violence against women, financial

inequality between men and women is strongest. This factor is further reinforced by the husband's control over most family affairs and by the constraints that prevent battered wives from divorcing their husbands (including anticipated difficulties she will encounter if she wishes to divorce her violent husband). Another study found that experiencing and witnessing violence in the family of origin, together with patriarchal beliefs and failure to empathize with the woman's needs explained men's beliefs about wife abuse and battering and explain the causes for abusing their fiancée's (Haj-Yahia, 1991).

Consequently, it is highly recommended that future research on wife abuse and battering in Palestinian society also incorporate the patriarchal male dominance and feminist perspectives and aspects of social learning theory in research on risk factors and causes of wife abuse and battering in Palestinian society.

The recommendation to develop an integrative theory on wife abuse and battering in Palestinian society is consistent with the argument of Edleson et al. (1985), concluded that there is a crucial need to construct an integrated theory of battering that incorporates several theoretical approaches. These approaches include family stress theory (focusing mainly on normative life transitions and unexpected crises), social learning theory (focusing mainly on witnessing and experiencing abusive and violent behavior, as well as on reinforcement of such behavior in the past and present), systems theory, and theories focusing on the external environment. Clearly, development of such an integrative theory must take into account the unique socio-cultural, political, and economic contexts of Palestinian society.

Popular Definition of Wife Abuse

The results presented earlier on the incidence of wife abuse in Palestinian society were obtained on the basis of operational definitions commonly used in Western societies, although popular definitions of the problem were not incorporated into the studies. A recent study among a random sample of 625 participants (328 men

and 297 women) from the West Bank and Gaza Strip (Haj-Yahia, 2000b) examined attitudes toward various issues related to domestic violence. Items on the questionnaire included an open question, where respondents were requested to define, in their own words, what constitutes wife abuse. Initial content analysis of the responses revealed that the acts mentioned by participants were similar to those classified in the international literature as verbal and psychological abuse (see, for example, Tolman, 1989) and physical abuse (see, for example, Straus, et al., 1996). Palestinian men and women also mentioned acts defined in the literature as economic and sexual abuse, albeit less frequently than acts of verbal, emotional, psychological, and physical abuse. A wide array of responses was offered with respect to their definitions of wife abuse and different manifestations of the problem. Since this paper cannot provide a comprehensive presentation of those responses, the discussion will focus on definitions related to the socio-cultural context of Palestinian society.

With respect to psychological abuse, the most frequent acts included in respondents' definitions of wife abuse were: Taking the wife's jewelry away from her against her will; drinking alcoholic beverages; playing gambling games; preventing the wife from visiting her family of origin; harming the children and intervening excessively in their education; marrying another woman or threatening to marry again; unjust and unfair behavior toward wives (if the husband is married to more than one woman); willful unemployment, or failure to fulfill financial obligations toward the family (this act can also be considered economic abuse of the wife and family); forcing the wife to engage in religiously unacceptable behavior (for example, forcing her to go out without covering her hair) or socially unacceptable behavior (for example, forcing her to cut off relations with her siblings); insulting and damaging the good reputation of her family of origin (mainly her mother and sisters); abusing the wife's family inheritance; and degrading and humiliating her in the presence of others. Psychological abuse was also defined as cases when the husband allows his family of origin to intervene in the couple's marital affairs or in their family affairs; when he threatens his wife with divorce; when he supports his family after they have insulted his wife rather than supporting and defending her; and when he intentionally humiliates his wife by forcing her to apologize to his mother.

Regarding physical abuse, all of the acts mentioned by the respondents as physical battering were found in the definitions of these acts in the international research literature. Nonetheless, several of the acts mentioned by respondents are not found in the literature, yet are probably relevant to the socio-cultural context of Palestinian society, such as: A member of the wife's family of origin is attacked - especially her mother or sisters; husband attacks his wife's offspring; a member of her husband's family of origin attacks the wife; the husband behaves violently in the community after drinking alcohol or taking drugs.

The following are the main acts mentioned by respondents as acts of sexual abuse, which are relevant to the socio-cultural context of Palestinian society: Husband is unfaithful to wife; husband forces wife to engage in certain sexual acts that are against Islam; the husband talks about his sexual relations with his wife in public; the husband ridicules or jokes about his sexual relations with wife; and the husband forces his wife to watch pornographic films with him.

Finally, the following are the main acts mentioned by respondents as acts of economic abuse, which are relevant to the socio-cultural context of Palestinian society: Preventing the wife from continuing to study, if it was agreed prior to marriage that she would be allowed to do so; misusing the wife's inheritance that she received from her family of origin; and preventing the wife from managing the household economy as she sees fit.

It is important to note that family values such as the family's general reputation, the reputation of women in the family, and family solidarity are key values in Arab society (Al-Khayyat, 1990; Barakat, 1993; Haj-Yahia, 1995, 1996, and 1999). Therefore, many of the respondents, as expected, indicated that they consider harm to their family of origin - especially to their mother or sisters - and preventing women from visiting the families of origin are forms of severe psychological abuse against women. In addition, it should be mentioned that many of the behavior codes in Palestinian society are influenced by religious values and beliefs. Hence, it is not surprising that many of the respondents believed that forcing women to engage in behavior that is against religious law, or husband's behavior such as

drinking alcohol or gambling, are psychologically abusive. Similarly, many of the behavior codes are influenced by central cultural values in Palestinian society. For example, one of the values in spousal relations is stereotypical gender-based division of roles, that is, the husband is usually the main breadwinner (but not the sole one) and protects the family, whereas the wife is responsible for household tasks, and all that this entails (such as raising children) (Barakat, 1993; Haj-Yahia, 1995 and 1996; Sharabi, 1987). In line with these values, many of the respondents defined husband's willful unemployment or excessive intervention in the wife's tasks such as child raising, abusing the wife's honor in front of the children, as highly detrimental and abusive to the wife. These are only a few examples of the relevance of the acts mentioned by respondents in their definitions of abuse to the socio-cultural context of Palestinian society. Clearly, most of the above acts are highly relevant to this context. It is also important to emphasize that the acts presented here were highlighted in the respondents' definitions of wife abuse, and we considered them relevant to the socio-cultural context of Palestinian society. However, the definitions mentioned by respondents also included numerous acts that resemble those frequently mentioned in international literature on wife abuse.

Attitudes toward Criminalizing Wife Abuse

In Arab societies in general and in Palestinian society in particular, the tendency is to view wife abuse as a private, personal, and family problem rather than as a social and criminal problem. Consequently, it does not justify intervention by social welfare and social control agents (Haj-Yahia, 1996; 1999). Accordingly, while most of the men and women participating (about 80 percent) in Haj-Yahia's (2000b) study indicated that they are willing to consider wife abuse as a crime in the sense that it is "unacceptable and undesirable" behavior, but not in the sense of "behavior that justifies reporting the husband to the legal authorities". Specifically, while almost all of the respondents (98 percent) that viewed wife abuse as a criminal problem, 80 percent clearly emphasized that they are willing to consider all of the

acts included in the definition of abuse, as mentioned above, as acts of crime in the sense that they would condemn it and consider it humiliating, defamatory, and unjustified behavior but would not consider those acts as part of a legal definition of violence against women. This trend, which rejects the legal approach toward wife abuse as a crime, is relevant to the socio-cultural context of Palestinian society, where emphasis is placed on family privacy, family reputation, and family solidarity (Haj-Yahia, 1996; 1999). This might reflect fear that acknowledging wife abuse as a problem that justifies intervention of welfare and legal services will break through the boundaries of the family, ruin the family's good reputation and thereby damage the cultural, social, economic, educational, political, and religious status of all family members - not to mention breaking up the family, for example through separation, imprisonment, or divorce. However, this trend of rejecting the legal dimension of wife abuse as a crime is also related to the historical and sociopolitical background of Palestinian society prior to the establishment of the Palestinian Authority in 1994. It should also be recalled that previously, the Israeli occupation of the West Bank and Gaza Strip was solely responsible for the governmental welfare services. (Prior to 1967, those services were under Egyptian control and supervision in Gaza, and under Jordanian supervision and control in the West Bank and East Jerusalem.) The Israeli-Arab conflict in general, and the Israeli occupation of the Gaza Strip, the West Bank, and East Jerusalem in particular naturally generated an atmosphere of hostility, antagonism, and animosity. Therefore, cooperation with the Israeli occupation authorities was considered undesirable, deplorable, and sometimes even as treasonous.

Failure to cooperate with the occupation authorities also included resistance toward using government welfare services controlled by the Israeli military government, and preference of Palestinian charitable and voluntary organizations. Failure to cooperate with the occupation authorities also included resistance, to the extent possible, toward using the criminal justice system, including the police and courts, to resolve conflicts and disputes. Here, preference was given to social and political leaders or institutions as mediators in conflict situations. It can be assumed that these traditions still affect attitudes

toward formal services in Palestinian society, even after the establishment of the Palestinian Authority. Consequently, Palestinian society is still hesitant to recognize wife abuse as a criminal issue.

Concomitantly, numerous respondents were willing to recognize wife abuse as a criminal issue that justifies intervention by the criminal justice system only under certain conditions, such as: (1) when such violent behavior has clear and serious physical consequences (for example, death, disability, or other bodily injury); (2) in cases of brutal sexual abuse of the wife, with the intention of humiliating her; and (3) when it is proven beyond reasonable doubt that the violence was unjustified (this aspect will be discussed later in more detail) (Haj-Yahia, 2000b).

Beliefs about Justifying Wife Abuse

Between 22 percent and 66 percent of the respondents strongly agree or agree that husband-to-wife violence is justified, and base this justification on the wife's behavior (Haj-Yahia, 2000b). For example, 22 percent of the respondents indicated that a husband can beat his wife if she interferes with his social life (for example, when he visits his family or comes home late); 48 percent justified wife beating if she chatters, talks too much, nags, or complains too much; and 66 percent justified wife beating if he catches her with another man.

Other conditions mentioned by the respondents as justifying violent behavior (in descending order of frequency) were: unfaithfulness; rebelliousness, failure to obey the husband and challenging his word; failure in educating the children and in maintaining the household; spending long hours away from home, especially without the husband's consent; impolite behavior toward the husband's parents; extreme jealousy on the part of the wife; teasing or mocking the husband due to his low economic status or low level of education, and disgracing him in public on those grounds; refusing to have sexual relations

with her husband, without any medical reason; gossiping about others instead of devoting to her husband and children; spreading secrets about her husband; making numerous demands of the husband without taking his economic situation into account; continuing to remind her husband of his weak points (sexually, economically, socially, educationally, etc.).

These findings are consistent with other two studies conducted among Palestinian men and women, which revealed that between 26 percent to 71 percent of Palestinian men (Haj-Yahia, 1998a) and 10 percent to 69 percent of Palestinian women (Haj-Yahia, 1998b) strongly agree or agree that husband-to-wife violence is justified in certain cases. For example, 55 percent of the men and 42 percent of the women indicated that the husband is justified in beating his wife if she challenges his masculinity; 47 percent of the men and 35 percent of the women indicated that they justify husband-to-wife violence if she constantly disobeys him and does not listen to him; and 71 percent of the Palestinian men and 69 percent of the Palestinian women indicated that they justify husband-to-wife beating if she is sexually unfaithful to him.

These findings are relevant to the patriarchal socio-cultural context of Palestinian society, which advocates male dominance and subordination of women in public as well as in the private spheres of life (Haj-Yahia, 1995 and 1996; Mann, 1986). In the public sphere of patriarchal Palestinian society, power is shared by male patriarchs based on whatever other principles of stratification operate. In the private sphere of Palestinian society, senior males prevail in extended and nuclear families alike, and use forms of subordination and control over women that transcend cultural and religious boundaries (Abdo-Zubi, 1992). In addition, the husband is culturally accepted as the ruler of the family, and regarded as the authority to whom the wife and children must ultimately respond. Thus, family roles follow a hierarchy, in which lower status roles are clearly delineated by the husband and must be adhered to by the wife and children (Al-Khayyat, 1990; Barakat, 1993; Haj-Yahia, 1996). The husband's role is thus authoritarian, and he assumes responsibility for maintaining the family structure by whatever means

he feels are justified, including violence. In addition, the prevailing standard of morality for women stresses the values and norms associated with traditional ideas of femininity, motherhood, wifeness, and sexuality (Barakat, 1993). Along these lines, it is not surprising that justifications for wife abuse expressed by Palestinian men and women were significantly related to patriarchal and non-egalitarian marital role expectations, as well as to negative and traditional attitudes toward women, familial patriarchal beliefs, sexual conservatism, rigid sex-role stereotypes, and high levels of religiosity (Haj-Yahia, 1998a and 1998b).

Beliefs about Responsibility for Wife Abuse

The general tendency in Arab societies is to understand violent husbands and try to avoid holding them fully responsible for their violent behavior. In line with this tendency, the husband's violent behavior is attributed to the difficult conditions of his life (for example, difficulties at home and work, political tensions). Similarly, the blame is placed on the wife, and even on external forces that cannot be controlled (that is, a fatalistic approach). Although there is a tendency to place some responsibility on the violent husbands, they are rarely perceived as solely responsible for their violent behavior. Fifty-six percent of the men and 76 percent of the women agree that "a husband who beats his wife is responsible for his behavior because he could control himself regardless of what she does". Nonetheless, 60 percent of the men and 50 percent of the women still agree that "a violent husband is not solely responsible for his behavior because it is caused by his wife and the conditions of his daily life" (Haj-Yahia, 1998a and 1998b).

Moreover, findings indicate that there are men and women who place sole responsibility on the wife for violence against her. Specifically, 49 percent of the men and 43 percent of the women strongly agree or agree that "a battered woman is solely responsible for being beaten because she obviously did something that irritated her husband"; 29 percent of the men and 25 percent of

the women strongly agreed or agreed that “a battered woman is solely responsible for being beaten because she obviously keeps talking nonsense to her husband”; and 28 percent of the men and 22 percent of the women strongly agree or agree that “sometimes wives intentionally provoke their husbands to make them angry and beat them” (Haj-Yahia, 1998a and 1998b).

These findings are consistent with the patriarchal approach of Palestinian society regarding relationships between men and women, spousal relations, and general responsibility for managing the household, which emphasizes the superiority and dominance of husbands versus the inferiority and obedience of women. These findings are also consistent with prevailing norms in traditional socio-cultural contexts such as Palestinian society, which attribute life situations to external factors (that is, lack of external locus of control) for example, God, economic conditions, or the evil eye rather than on internal and personal factors (that is, lack of internal locus of control). This conclusion leads to the fifth dimension related to perceptions of the problem of wife abuse in Palestinian society, that is, the perceived causes of wife abuse.

Perceived Causes of Wife Abuse

An open question was presented in Haj-Yahia’s (2000b) study, in which respondents were asked to indicate their attitudes and perceptions in their own words, regarding causes for husbands’ violence against their wives. The Palestinian men and women revealed perceptions that could be divided into four categories or facets of causes for wife abuse, as follows: (a) causes related to the wife (50 causes were presented); (b) causes related to the husband (25); (c) causes related to both partners (13); and (d) causes related to the life conditions of the husband, wife, and family as a whole or the nation as a whole (5).

The first category of causes mentioned by respondents (that is, causes related to the wife) were consistent with expectations of women in traditional, patriarchal

contexts such as Palestinian society, as mentioned above, and reflected the wife's failure to live up to those expectations, as follows: (1) The wife fails to conform with "moral codes" of behavior for women; (2) the wife fails to conform with religious norms of behavior for women; (3) the wife's behavior that is not feminine; (4) the wife fails to conform to the role of housewife; (5) the wife fails to conform with expectations of her as a mother; and (6) the wife fails to conform with expectations of her as a sister-in-law and daughter-in-law.

Clearly, the above-mentioned perceptions of causes reflect the respondents' patriarchal perspectives and traditional and conservative expectations of women. As indicated, these causes are consistent with expectations that a woman should be obedient, submissive, and make concessions for her husband, children, and family in general. In addition, these perceptions of causes are consistent with the perspective that places most of the responsibility for violence on the wife herself, since "her behavior toward her husband, children, family, and in-laws does not conform with expectations of her as a woman, wife, mother, sister-in-law, and daughter-in-law".

The second category of participants' perceptions of causes for wife abuse, perceptions that were presented as related to the husband, was also found to be consistent with expectations of men in traditional, patriarchal societies such as Palestinian society and his failure to conform to those expectations. These causes were mentioned despite the overall tendency to minimize the husband's responsibility for violence against his wife because of his own difficult life conditions. At the same time, however, respondents also mentioned causes that are actually related to the husband's macho, oppressive, and domineering behavior and contradict traditional expectations of husbands in the marital relationship. Therefore, the causes for wife abuse that were perceived as being related to the husband can be divided into the following categories: (1) The husband fails to conform with expectations of men in patriarchal, traditional societies; (2) the husband has numerous personal problems; and (3) the husband has a macho personality and feels a need to be domineering.

As mentioned, participants' perceptions of the causes for wife abuse point to several trends. One trend is to blame the husband for not being masculine enough.

Another trend highlights medical problems and psychopathology as causes of violence, which absolve the husband of responsibility for his violent behavior. A third trend, which contradicts the first two, places full responsibility on the violent husband and attributes the problem to his traditional and patriarchal orientation toward women (contrary to the prevailing expectation in Palestinian society). However, it should be emphasized that the third trend was less frequent than the first two in the participants' answers. It is very likely that this trend reflects the changes taking place in Palestinian society, as reflected in the growth of the women's movement and increasing awareness of the problem of violence.

The third category, participants' perceptions of the causes of wife abuse as related to both partners, can be divided as follows: (1) Each partner feels more power and wants to dominate the other; (2) each partner has independent attitudes about various issues related to spousal relations and family life and lack skills for dealing with their differences; (3) discord, disharmony, and lack of intimacy between partners; and (4) neither partner is emotionally or intellectually mature.

Clearly, attributing the causes of wife abuse to both partners implicates that they are each responsible for violence (that is, the wife is responsible as the victim, and the husband is responsible as the perpetrator). This trend is consistent with the tendency to blame the wife for violence against her, in addition to being consistent with the concomitant tendency to blame the violent husband in certain cases - although there is also a tendency to understand the husband and even to absolve him of responsibility for his violent behavior. In addition, the tendency to attribute the causes of wife abuse to both partners is consistent with the view that "spousal conflict is undesirable and can be prevented," "in order to achieve harmony in the family and between spouses, agreement and congruency must prevail between the two partners".

The fourth category, participants' perceptions of the causes of wife abuse as related to the husband's life conditions, as revealed in the study mentioned earlier (Haj-Yahia, 2000b) can be divided as follows: (1) Difficult life conditions; (2) family problems resulting from difficulty with one of the children; (3) discord and

conflictual, unstable relations with both partners' extended families or families of origin; (4) discord and conflicts with society; and (5) difficult political conditions.

Clearly, these explanations by Palestinian men and women, like many of the others presented above, absolve the husband of responsibility for wife abuse. Concomitantly, these explanations place the responsibility for such behavior on external forces, which the husband is not always able to control (for example, forced unemployment, illness or disability, the implications of Israeli occupation, etc.). This approach is also consistent with the traditional perspective, which attributes the problem to "external forces" (that is, lack of external locus of control).

Attitudes toward Strategies for Coping with Wife Abuse

The argument regarding attitudes toward coping with wife abuse is supported by findings from a study conducted by Haj-Yahia, et al. (1995) among 1,153 young Palestinian women (16 to 28-year-olds), which examined their perceptions of help-seeking behaviors in situations of violence. Between 77 percent and 86 percent of the participants agree that a woman who has been psychologically, physically, or sexually abused by a family member should not keep the problem to herself and rejected the option of passive coping. However, 83 percent of the participants indicated that women who are psychologically abused by a family member (notably father, mother, or siblings) are justified in trying to solve the problem within the family and avoid seeking help from external agencies. Similarly, 83 percent and 88 percent of the respondents agree with women who cope with moderate and severe physical violence, respectively, by solving the problem within the family. In addition, 84 percent, 79 percent, and 77 percent of the respondents agree with women who cope in that way with sexual harassment by brothers, sexual assault by brothers, and sexual abuse by fathers, respectively.

At the same time, it was found that 43 percent to 59 percent of the respondents agree with women who seek help from immediate family members (notably uncle, aunt,

grandparent, sibling) in order to prevent psychological, physical, and sexual abuse by family members. In addition, the above findings revealed that 32 percent to 47 percent of the respondents agree with women who seek help outside of the family (for example, from a political or religious leader, or from Palestinian philanthropic services) to deal with psychological, physical, and sexual abuse. The strongest support for seeking help from relatives was in cases of psychological and moderate physical abuse, while the strongest support for seeking help outside of the family was in cases of severe physical violence or sexual abuse (Haj-Yahia, et al., 1995).

Haj-Yahia (2000b), also included the following open question: “If a woman (relative or friend) tells you that her husband beats her, what would you advise her to do?” Interestingly, the two most frequent responses to this question were: “It is important to me to hear both sides of the story before I make a decision,” and “it is important to me to know what caused the husband to beat his wife”. Although these responses did not indicate a desire to maintain neutrality or refrain from intervening, they definitely reflected a desire to understand the violent husband and ascertain what motivated him to behave in that way toward his wife instead of holding him solely responsible for his behavior. Of course, this perception is highly consistent with the findings presented above.

Respondents’ recommendations for various patterns of coping with wife abuse are consistent with central values of Palestinian society, including: Patience, maintaining family unity, solving problems within the family, mutual support, family peace and rapprochement, maintaining the family’s reputation and honor, and giving priority to children’s well-being (Al-Khayyat, 1990; Barakat, 1993).

It is also noteworthy that some of the respondents recommended seeking help from welfare services and courts, and there was even a recommendation to initiate divorce. However, these recommendations were infrequent, and only referred to the most severe cases, when violence persists, and when it is proven beyond a doubt that the responsible party is the husband and not the wife, while the husband has been given numerous chances to change and cease his violent behavior but never followed through.

Finally, it should be noted that the respondents were against reporting to the police. This can be explained by the value system mentioned above, as well as by negative attitudes toward the police and toward the Israeli occupation authorities that prevailed when the study was conducted. Although there is a lack of empirical evidence on the approach of Palestinian society toward police intervention, there was obviously a strong tendency to refrain from involving police in family disputes, including cases of violence.

In this study, the following research questions are investigated among Palestinian physicians:

1. How Palestinian physicians define wife abuse?
2. Do Palestinian physicians hold misconceptions and myths about the problem of wife abuse, and more particularly about abused wives and abusive husbands?
3. To what extent Palestinian physicians tend to approve minor/moderate acts of violence (e.g., slapping) and severe violence (e.g., attacking with an object) against wives, under what conditions, and to what extent these attitudes can be explained by physicians' patriarchal ideology and exposure to violence in their families of origin?
4. What are the causes of wife abuse as perceived by Palestinian physicians?
5. What are the most preferred responses to and solutions for wife abuse, as perceived by Palestinian physicians?
6. To what extent Palestinian physicians tend to justify wife beating, blame battered wives and/or abusive husbands for the beating, believe that abused women benefit from their battering, and believe in helping battered women, and to what extent these beliefs can be attributed to physicians' patriarchal ideology and exposure to violence in their families of origin?

Section Two

Method





Method



Sample

The study was conducted among a convenience sample of 396 Palestinian physicians from the West Bank and East Jerusalem, who work in four major hospitals in those areas. The research took place between September 2001 and April 2002. Considering to the tense political situation in that area (including curfews, restrictions imposed by the Israeli military on travel between cities in the West Bank, and other obstacles), and owing to the lack of a comprehensive framework for sampling Palestinian physicians, it was not possible to carry out the study among a random sample.

The mean age of the participants was 39.50 years (range 27-62, *s.d.*=8.40). About 73.6% of the participants were male; about 19% were single, about 78% were married, about 1.5% were either divorced or separated, and about 1.5% were widowed at the time the study was conducted. Regarding religious affiliation, 93.4% of the participants were Muslim and the remaining 6.6% were Christian. About 59.6% were living in urban areas, 32.4% were living in rural areas, and the remaining 8% were living in refugee camps at the time of the study. Thus, the sample was heterogeneous with regard to the variables age, gender, religious affiliation, and place of residence even if it was a convenience sample.

Instrument

The instrument used in this study was a self-administered questionnaire in the Arabic language, and it consisted of several parts. Most of the items were closed questions, and the participants were asked to choose the most appropriate response out of several possible answers. Some of the items were based on standardized scales and measures that are known for their established psychometric properties, and which have been extensively utilized in social and behavioral research. In addition, the questionnaire included items and scales that were developed specifically for this study, as well as several open questions. The following is a detailed breakdown of the items on the questionnaire.

Questions about demographic background: The questionnaire included questions on the following demographic variables: age, gender, religion, marital status, and place of residence.

Definition of wife abuse. This variable was measured by an open-ended question in which the participants were asked to define wife abuse in their own words, and to describe their husbands' behavior or expressions which they would consider to be wife abuse. About 91% of the participants answered this question.

Perceived causes of wife abuse. An open-ended question was presented to the participants regarding their perceptions of the causes of wife abuse. About 92% of them answered this question.

General approach toward abused wives and abusive husbands. Eighteen items were presented to the participants, in order to measure their approach toward or misconceptions about abused wives (11 items) and abusive husbands (7 items) (see Table 1). Most of the items were derived from the literature on myths and misconceptions about domestic violence (e.g., Walker, 1979). The participants were asked to indicate their response toward each of these items, by choose one out of the following possible responses: 1="agree", 2="undecided", and 3="disagree".

Approval of wife abuse: Twenty-five items were utilized in this study to measure participants' approval or disapproval of the husband's minor violence (e.g., slapping) and severe violence against his wife (e.g., beating her with a belt, stick, shoe, etc.) (see Table 2). All 25 items were developed specifically for this study, based on previous research in Arab societies, which revealed certain situations in which wife abuse is approved (El-Zanaty et al., 1996; Haj-Yahia, 2000a,b). The items were all phrased in a way that depicts the wife's approaches, behavior, or attitudes, as they are manifested in her daily life, or in relation to her children and husband. The approaches, behavior, and attitudes reflected in the items are consistent with traditional expectations of her as a woman, wife, and mother. Hence approval of wife abuse in each of the 25 cases may also be perceived as blaming the wife for her husband's violence. Participants were asked to express their response toward each of the 25 items by choosing an answer on a 5-point scale ranging from 1 ("strongly agree") to 5 ("strongly disagree"). The Cronbach's Alpha internal reliability for this scale was .92, and the factor loadings for the 25 items ranged from .43 to .81.

Beliefs about wife beating: Thirty-eight items of Saunders, Lynch, Grayson, and Linz's (1987) Inventory of Beliefs About Wife Beating (IBWB) were utilized to measure the following four beliefs: (1) justifying wife beating; (2) blaming women for their beating; (3) the belief that women benefit from beating; and (4) helping battered women (see Table 3). Participants in this study were asked to answer each one of the 38 items by choosing an answer from a 5-point scale ranging from 1 ("strongly agree") to 5 ("strongly disagree"). Saunders et al. (1987) reported several steps in the development of the inventory and described the tests used for scale dimensionality, reliability, and validity. In addition, they reported on the factors that were derived and were analogous to some of the factors found in studies on attitudes toward rape, such as the belief that the victim is responsible for precipitating the attack. Saunder et al. (1987) indicated that support was found for the construct validity of the subscales that pertain to attitudes toward victims. They also maintained that "as with attitudes toward rape, negative attitudes toward victims were linked with traditional views of

women's roles in a variety of samples" (Saunders et al., 1987, p. 52). The Arabic version of the IBWB, as utilized in previous studies, proved to have very good internal reliabilities (Haj-Yahia, 1991, 1998a,b). The Cronbach's Alpha internal reliability coefficients for all four subscales of the IBWB as utilized in this study range from .91 (justifying wife beating) to .78 (the belief that women benefit from beating).

Perceptions of appropriate interventions with and solutions for wife beating:

An open-ended question measured the participants' perceptions of appropriate interventions with and solutions to wife beating. About 89% of the participants answered this question.

Participants' interventions with abused wives: The participants were asked to indicate whether, since they began working as physicians, one or more of their clients had mentioned an incident of beating by their husbands. About 20.3% of the participants answered "yes" to this question, and the remaining 79.7% answered "no". Those who answered "yes" were requested to answer an open-ended question about their reactions and responses to what the battered woman had told them. About 93% of those who answered "yes" to the first question also answered the open-ended question.

Sex-role stereotypes: An Arabic version of Larsen and Long's (1988) scale for measuring sex-role stereotypes was used in this study. The instrument consisted of 20 items, where participants were requested to indicate the extent to which they agree or disagree with each item, on a 6-point scale ranging from 1 ("strongly agree") to 6 ("strongly disagree"). Larsen and Long (1988) provided detailed information on the procedures and phases of developing the questionnaire, as well as information on its psychometric properties. According to their report, an item-analysis study yielded 20 items with part-whole correlations $<.48$, and the corrected split-half reliability coefficient was found to be .91 ($p \leq .001$). In addition, five other phases of their research showed promising concurrent and construct validity. In particular, the phases revealed that traditional sex-role stereotypes are related to rigidity, as measured

by authoritarian, religious, same-sex touching, rape acceptance, divorce, and conservative attitudes. Overall, varimax-rotated factor analysis revealed one major factor that accounted for 84.6% of the variance. Factor analysis carried out for the Arabic version of this scale, as utilized in this study, revealed factor loadings ranging from .44 to .79 for all 20 items. Cronbach's Alpha internal reliability coefficients for the Arabic version of the questionnaire used in this study was .88.

Attitudes toward women's social involvement and integration: A 15-item scale was developed specifically for this study, in order to measure participants' attitudes toward women's social involvement and integration. Factor analysis based on the results of the study revealed that 9 out of 15 items belonged to one major factor, with factor loadings ranging from .41 to .84; and varimax-rotated factor analysis revealed that this major factor accounted for 86.2% of the variance. The Cronbach's Alpha measure of internal consistency for all 9 items was .89. The participants were asked to indicate the extent to which they oppose or support each item on a 6-point scale ranging from 1 ("strongly disagree") to 6 ("strongly agree").

Attitudes toward women: This study used a short version of 14 statements in Spence and Helmreich's (1978) Attitudes toward Women scale (ATW). The scale measured traditional-patriarchal versus liberal-egalitarian attitudes toward women. Spence and Helmreich (1978) reported that the short version of the ATW had a correlation of .91 with the original, longer version of the ATW administered among a sample of 715 students in psychology classes. In addition, the researchers provided strong evidence and support for the scale's construct validity. The Cronbach's Alpha values of the shorter English version of the ATW was reported to be .89; and the Arabic version of the ATW utilized in previous studies proved to have good internal reliabilities (Haj-Yahia, 1991, 1997, 1998a,b,c). Factor analysis carried out for the Arabic version of the ATW used in the study revealed factor loadings that ranged from .41 to .78 for all 14 items. The Cronbach's Alpha internal reliability coefficient for the Arabic version

of the questionnaire used in this study was .89. The participants indicated the extent to which they agree or disagree with each item on a 4-point scale ranging from 1 (“strongly agree”) to 4 (“strongly disagree”).

Marital role expectations: A short 18-item version of the Marital Role Expectations Inventory (MARI) (Dunn & DeBonis, 1979) was used in this study to measure marital role expectations. Dunn and DeBonis (1979) reported a Spearman-Brown reliability coefficient of .975 for the measure on a split-half correlation analysis. The Arabic version of the MARI utilized in previous studies proved to have very good internal reliabilities (Haj-Yahia, 1991, 1997, 1998a,b,c). Factor analysis carried out for the Arabic version of the MARI used in this study revealed factor loadings ranging from .43 to .82 for all 18 items of the instrument. The Cronbach’s Alpha internal reliability coefficient for the Arabic version utilized in this study was .91. Participants indicated the extent to which they agree or disagree with each item on a 5-point scale ranging from 1 (“strongly agree”) to 5 (“strongly disagree”).

Witnessing and experiencing violence in the family-of-origin: Four different forms of the Arabic version of the Conflict Tactics Scales (CTS) (Straus, 1979) were used to measure the extent to which the participants had experienced (i.e., by parents or siblings) or witnessed (i.e., between parents) psychological aggression and physical violence while they lived with their parents. Straus (1979) developed the CTS and tested its reliability, validity, and norms on a representative national sample of 2,143 couples in the United States. These tests included calculation of the Cronbach’s Alpha coefficient (at least .78 on the violence scale), as well as item analysis, which indicated that the reliability of the measure was adequate. Haj-Yahia (1991) translated the CTS into Arabic and adapted it to the unique social, political, and cultural context of Arab societies. The Arabic version of the CTS utilized in previous studies proved to have excellent internal reliabilities (Haj-Yahia, 1991, 1997, 1998a,b,c, 2001; Haj-Yahia & Ben-Arieh, 2000; Haj-Yahia & Dawud-

Noursi, 1998; Haj-Yahia & Edleson, 1994; Haj-Yahia, Musleh, & Haj-Yahia, 2002). The Cronbach's Alpha internal reliability coefficients for all four forms of psychological aggression and four forms of physical violence measured in this study ranged from .87 to .93 and .86 to .94, respectively. The participants were requested to report how many times they had experienced and witnessed each of the acts specified in the measures of psychological aggression and physical violence while they lived with their families of origin (mainly before getting married or before age 18). Responses were based on the following scale: 0=never, 1=1-2 times, 2=3-5 times, 3=6-10 times, and 4=11 times or more.

Procedures

As indicated previously, due to the current tense political conditions in the Palestinian Authority, and due to the lack of an updated sampling framework, it was not possible to obtain a random sample of Palestinian physicians. Therefore, a convenience sample was derived, which comprised physicians employed at four Palestinian hospitals in the West Bank (in the cities of Jenin, Nablus, and Ramallah), and in East Jerusalem. Physicians who were working at the emergency wards or in other wards at the hospitals on the day the questionnaire was distributed were approached by research assistants and asked to participate in a study on physicians' attitudes toward and responses to wife abuse.

The physicians were instructed to fill out the questionnaire at their convenience, to place the completed forms in an envelope, and put the sealed envelope in a locked box in the emergency room at each participating hospital. The research assistants were instructed to collect the completed questionnaires at the end of each week, for three weeks after the questionnaires were distributed (i.e., the questionnaires were collected three times). About 48% of the completed questionnaires were collected at the end of the first week,

about 23% were collected at the end of the second week, and about 12% were collected at the end of the third week. Ultimately, 83% of the physicians who were approached to participate in the study and given a questionnaire actually completed it.

Data Analysis

Several statistical methods were used to analyze the data obtained in the study.

First, descriptive statistics (i.e., the distribution of the answers by percentages, means, and standard deviations) were examined for each item that measured the dependent variables of the study. Accordingly, Table 1 presents findings on the participants' general approach toward abused wives and abusive husbands; Table 2 presents the means and standard deviations of responses to items about supporting a husband who slaps and beats his wife; and Table 3 presents descriptive statistics regarding the participants' beliefs about wife beating.

Second, zero-order correlation analyses were computed for the participants' demographic characteristics (age, religion, place of residence, and gender), independent variables (sex-role stereotypes, attitudes toward women's social involvement and integration, attitudes toward women, marital role expectations, witnessing father-to-mother and mother-to-father violence, and experiencing violence by the father and mother) and the dependent variables (approval of minor and severe wife abuse, justifying wife beating, blaming battered women, the belief that women benefit from beating, and helping battered women) (see Table 4).

Third, regression and multiple regression analyses were conducted in order to examine the extent to which the participants' demographic characteristics and the above-mentioned independent variables combined to explain the variance

in each of the above-mentioned dependent variables. Before carrying out these analyses, new independent variables were produced on the basis of the above-mentioned independent variables. The new independent variables were as follows: (1) due to the very high and significant multicollinearity among all patterns of violence witnessed between parents ($r=.53$, $p<.0001$), participants' scores on witnessing father-to-mother and mother-to-father psychological aggression and physical violence were added to produce one score for the new variable "witnessing interparental violence"; (2) due to the very high and significant multicollinearity among all patterns of violence that participants experienced by their parents ($r=.56$, $p<.0001$), participants' scores on experiencing psychological aggression and physical violence by the father and mother were added to produce one score for the new variable "experiencing parental violence"; (3) due to the very high and significant multicollinearity between participants' attitudes toward women and their attitudes toward women's social involvement and integration ($r=.33$, $p<.0001$), participants' scores on those two variables were added to produce one score for the new variable "attitudes toward women"; and (4) due to the very high and significant multicollinearity between the participants' sex-role stereotypes and their marital role expectations ($r=.33$, $p<.0001$), participants' scores on these two variables were added to produce one score for the new variable "marital role expectations". Tables 5 and 6 present the results of regression and multiple regression analyses conducted in the study.

In addition to these methods of statistical analysis, the responses to the open-ended questions were examined in several stages. In the beginning, each statement was examined separately, taking associations and contexts into account. The responses were considered in relation to existing literature as well as in relation to other responses, in an attempt to identify logical relationships, similarities, and contradictions between them. In addition, intrinsic relationships were examined for each statement, taking into account their relevance to existing knowledge and to sociocultural contexts of Palestinian society in particular and Arab societies in general. Thus, an attempt was made to identify general

characteristics, patterns, and themes. Furthermore, responses to all of the open-ended were examined collectively along every dimension, in order to identify patterns, consistency, and contradictions. This procedure was adopted in order to portray and analyze the general picture obtained from the questions, and to identify general patterns of thought and action among Palestinian physicians regarding these issues (McCracken, 1988).

The author's previous knowledge of and experience with the topic as well as his analytical and inferential capabilities clearly contributed toward the process of data analysis. In addition, three Palestinian graduate students of public mental health were supervised separately in the process of implementing the stages of analysis mentioned above. Each student was instructed to produce categories of responses for every open question. Comparison of the students' lists revealed high consistency and reliability among them for most categories. Afterwards, the three lists were reviewed by an expert in the field of domestic violence practice and research. There was a high level of correspondence between the interpretations of the expert and my own interpretations of the categories formulated by the graduate students.

Section Three

Results





Results

Definition of Wife Abuse

As indicated earlier, participants were asked to respond to an open question about their definitions of wife abuse, and about 91% answered it. Content analysis of the responses revealed that most of the definitions referred to acts that are classified in the literature as a verbal and emotional abuse (e.g., screaming, degrading, swearing, cursing, calling names, intimidating accusations, etc.), and physical violence (e.g., slapping, kicking, attacking with an object, pulling and pushing, shoving, etc.) (see Haj-Yahia, 1999, 2000a,b; Straus, Hamby, Boney-McCoy, & Sugarman, 1996; Tolman, 1989). The participants also listed acts defined in the literature as economic abuse (e.g., preventing the wife from using the family's money as she sees fit, etc.) and sexual abuse (e.g., having sex with the wife without her consent, etc.) (see Haj-Yahia, 1999, 2000a,b; Straus et al., 1996) - although these acts were listed less frequently than acts of verbal, emotional, and physical abuse.

Clearly, the Palestinian physicians' definitions of wife abuse reflect their awareness of the nature of the problem to a great extent - at least in terms of blatant acts of abuse. Moreover, their definitions are consistent with those presented in the research and professional literature. Nonetheless, three main trends in the physicians' definitions are noteworthy. First, a substantial percentage of the physicians (about 63%) referred mainly to acts of severe and

persistent types of abuse, and less to acts defined in the literature as minor or moderate abuse. Second, a substantial percentage of the physicians (about 47%) qualified their definitions in a way that might be taken as implicitly or explicitly blaming the woman for her husband's violent behavior (for example "hurting a woman *when she didn't do anything wrong*", or "hurting a woman *without any justification and for no reason*" (emphasis by the author). In other words, the physicians who mentioned such conditions tended to refer to specific acts that are considered to be wife abuse in the literature were referred to as behavior that does not harm the woman under certain conditions (e.g., reflecting a tendency to justify wife abuse - this issue will be discussed later in more detail). Third, besides the definitions that were consistent with those presented in the literature, there was a clearly tendency among a substantial percentage of the physicians (about 42%) to provide definitions of wife abuse that are related to the socio-cultural context of Palestinian society. In the category of verbal and emotional abuse, they included acts such as: insulting the wife in front of her children and/or in front of family members (mainly in front of the husband's mother and sister); humiliating the wife and criticizing her in front of strangers; harming her reputation (as a mother and wife) or the reputation of her mother and sisters; ridiculing or belittling the wife's family of origin (mainly her mother and sisters); excessive intervention (by the husband) in the way the wife brings up the children; forcing the wife to apologize to her mother-in-law for the sole purpose of appeasing the latter; taking the wife's jewelry away against her will (this act may also be viewed as economic abuse); preventing the wife from visiting her family of origin; marrying another woman or threatening to marry again; forcing the wife to engage in religiously unacceptable behavior (e.g., to go out without covering her hair) or socially unacceptable behavior (e.g., to sever relations with her siblings); abusing the wife's family inheritance (this act may also be considered economic abuse); and supporting his family rather than supporting and defending his wife after they have insulted her.

Regarding physical violence, although the physicians mentioned several acts that were found in the international literature, others were not found in the

literature, and appear to be relevant to the specific socio-cultural context of Palestinian society and that of other Arab societies in general. Such acts include: Attacking the wife in front of the children, using hands or an object; attacking the wife in front of the husband's mother, sisters, mother-in-law, or sisters-in law; having a tantrum or throwing things so that the neighbors can hear; attacking the wife's family of origin - especially her mother or sisters; physical attack against the wife by a member of the husband's family of origin; and violent behavior by the husband after he has been drinking alcohol or taking drugs, which the neighbor may know about.

As mentioned, fewer participants referred to acts that would be defined in the literature as sexual or economic abuse. The following are the main acts of sexual abuse that may be considered relevant to the socio-cultural context of Palestinian society and Arab societies in general: The husband is unfaithful to his wife; the husband forces his wife to engage in certain sexual acts that violate Islamic law (e.g., anal or oral sexual intercourse); the husband talks about his sexual relations with his wife in public; the husband ridicules or jokes about his sexual relations with his wife; and the husband forces his wife to watch pornographic films with him.

Finally, the following are the main acts defined by the physicians as economic abuse, which may be considered relevant to the socio-cultural context of Palestinian society in particular and Arab societies in general: Preventing the wife from continuing to study or work for a salary, if it was agreed upon prior to marriage that she "would be allowed" to do so; and misusing the wife's inheritance or gifts that she received from her family of origin.

The above-mentioned acts, which represent four different forms of abuse and violence, do not conform to values that prevail in many Arab societies and Palestinian society in particular. These values include: women must be respected by their offspring, and their status as mothers should be strengthened; the wife's honor must be maintained in relations with her husband's relatives, and her status in the extended family should be enhanced; family privacy must be preserved, and outsiders should be prevented from intervening in family affairs;

the reputation of the wife and her family should be maintained, and they should not be insulted in public; the wife's status as the partner in charge of caring for the children and maintaining the household should be enhanced; the wife should undertake to maintain the reputation of her household and family of origin; the issue of marital sex is highly personal and must remain confidential at all costs; sexual fulfillment and pleasure in marriage must derive from direct sexual relations and not from "instrumental" relations such as pornographic films (Al-Khayyat, 1990; Barakat, 1993; Haj-Yahia, 1995, 1996, 2000c,d). In addition, it should be mentioned that many of the behavior codes in Palestinian society, like most other societies, are influenced by religious values and beliefs. Hence it is not surprising that many of the participants believed that forcing women to engage in behavior that is against religious law, or husband's behavior such as drinking alcohol or gambling, are considered abusive.

Perceived Causes of Wife Abuse

As indicated, the participants were asked to respond to an open question about their perceptions of the causes of wife abuse, and about 92% of them answered it. The Palestinian physicians mentioned about 40 causes, that can be divided into four categories or facets of causes of wife abuse, as follows: (a) causes related to the wife; (b) causes related to the husband; (c) causes related to both partners; and (d) causes related to the life conditions of the husband, the wife, or the family, as well as to the socioeconomic and political conditions in society at large.

As far as the first category (i.e., causes related to the wife) is concerned, the participants presented causes that are commonly indicated by lay persons as well as by practitioners from different societies and cultures and other causes that are consistent with expectations of women in traditional and patriarchal contexts such as Palestinian society and most Arab societies. For the most part,

these causes reflect the participants' perceptions of the wife's failure to live up to those expectations, as follows: (1) the wife behaves disobediently towards her husband (e.g., she is stubborn, she fails to fulfill her husband's requests, and she behaves in a way that undermines her husband's authority); (2) the wife fails to conform to moral codes of behavior for wives and mothers (e.g., she discloses family secrets in public, she is unfaithful to her husband, or she goes out of the house without her husband's permission); (3) the wife fails to conform to religious norms of behavior for women as wives and as mothers (e.g., she does not dress according to religious codes, she does not pray, and she is not religiously observant); (4) the wife's behavior is not feminine (e.g., she talks loudly, she laughs loudly at social gatherings); (5) the wife fails to conform to the role of housewife (e.g., she neglects her husband, her children, and her family responsibilities); (6) the wife fails to conform to expectations of her as a wife, mother, sister-in-law, and daughter-in-law (e.g., she doesn't respect her husband, his mother, or his sisters and she doesn't take care of them when they need her assistance); (7) the wife is not considerate of her husband's difficult situation (e.g., she constantly nags him to buy her things despite his difficulties).

Clearly, the perceived causes of wife abuse mentioned above, which are attributed to the wife herself, largely reflect the participants' patriarchal perspectives as well as their traditional expectations of women. As indicated, these causes are consistent with the perspectives and expectations that a woman should be obedient, submissive, and feminine, and that she should make concessions to her husband, children, and family. In addition, these perceived causes are consistent with the perspective that the wife is largely to blame for violence against her and she bears responsibility for such violence, since "her behavior toward her husband, children, family, and in-laws does not conform with expectations of her as a woman, wife, mother, sister-in-law, and daughter-in-law".

The second category of perceived causes of wife abuse, i.e., perceptions related to the husband, was also found to be consistent with expectations of

men in traditional and patriarchal societies such as Palestinian society and Arab societies in general, and reflects the husband's failure to conform to those expectations. These causes were mentioned by the participants despite their overall tendency to minimize the husband's responsibility for violence against his wife and to emphasize the difficulty of his life conditions. At the same time, however, the participants also mentioned causes that are actually related to the husband's macho, oppressive, and domineering behavior on the one hand and causes that contradict traditional expectations of husbands in the marital relationship on the other. Therefore, the causes of wife abuse that were perceived by the participants as being related to the husband can be divided into the following categories: (1) the husband fails to conform to expectations of men in traditional patriarchal societies (e.g., he has a weak personality or lacks self confidence; he is unable to show his wife who makes decisions in the home, and since the beginning of the marriage he has not succeeded in showing his wife who "wears the pants" - consequently he feels compelled to use violence against her in order to force her to respect and obey him); (2) the husband has numerous personal problems (e.g., he is addicted to drugs and/or alcohol, he is jealous, paranoid, mentally ill, has failed to fulfill himself, or is overly temperamental); (3) the husband has a macho personality and feels a need to domineer his wife (e.g., he has an intense need to be dominant, he has an overly authoritative personality, or he believes that women only understand force).

As mentioned, these three categories of perceived causes of wife abuse related to the husband point to several trends. One trend reflects the tendency to blame the husband for not being masculine enough. Another trend highlights medical problems and psychopathology as causes of violence, which absolve the husband of responsibility for his violent behavior. A third trend, which contradicts the first two, places full responsibility on the violent husband and attributes the problem to his traditional and patriarchal orientation toward women (contrary to the prevailing expectation in Palestinian society). However, it should be

emphasized that the third trend was noted less frequently than the first two in the participants' answers. It is very likely that this trend reflects changes that are taking place in Palestinian society, such as the growth of the women's movement and increasing awareness of the problem of violence.

The third category of perceived causes of wife abuse, i.e., causes related to both partners, can be divided as follows: (1) each partner feels powerful, needs more power, and wants to dominate the other (e.g., both partners believe that by dominating the other it is possible to have a satisfactory marriage; each of the partners believes they are the "highest authority on earth", and for that reason it is important to them to control the world, including their partner); (2) each partner has independent attitudes about various issues related to spousal relations and family life, and lacks the skills to deal with differences (e.g., each partner still has the mentality of a single person who is completely independent and self sufficient; each partner wants to control the marital relationship and family life according to their desires, and is not aware that marriage and family life require compromise, cooperation, and mutual understanding); (3) discord, disharmony, and lack of intimacy between partners (e.g., the partners are not compatible, they have major differences, they don't know how to love); (4) neither partner is emotionally or intellectually mature (e.g., both of them married at a young age or never learned what marriage or family relations are, both of them are immature and quarrel about the slightest thing). Clearly, the tendency to attribute the cause of wife abuse to both partners implies that both of them are responsible for violence (i.e., the wife is perceived as responsible for violence against her, despite being the victim of beating and despite the husband's responsibility as perpetrator, although the participants' responses included several expressions that portray wives as victims and abusive husbands as perpetrators). This trend is consistent with the tendency to blame the wife for violence against her, in addition to being consistent with the tendency to blame the violent husband in certain cases - although there is also a certain

tendency to understand the husband and even to absolve him of responsibility for his violent behavior. In addition, the tendency to attribute the causes of wife abuse to both partners is consistent with the view that “spousal conflict is undesirable and can be prevented”, and that “in order to attain peace and harmony in the family and between spouses, agreement and congruency must prevail between the two partners”.

The fourth category, i.e., the perception that wife abuse is related to the life conditions of the husband, the wife, and the family, can be divided as follows: (1) harsh life conditions (e.g., the family’s difficult economic situation, poor living conditions, unemployment); (2) family problems resulting from difficulty with one of the children (e.g., one of the children is ill, the children fail in school); (3) discord and conflictual, unstable relations with both partners’ extended families or families of origin (e.g., the mother-in-law intervenes excessively in the couple’s life, the mother-in-law influences her son to beat his wife; the couple lives in the same house with the husband’s family of origin, which leads to unnecessary discord and tension); (4) discord and conflicts with society (e.g., the family is in conflict with its neighbors, which causes tension within the family; the couple’s extended family is in conflict with another extended family, which causes tension among the entire family of the couple); (5) difficult political conditions (e.g., the Israeli occupation, which oppresses the husband and causes him to project his anger and humiliation on his wife; the occupation imposes stressful life conditions such as curfews, unemployment, restriction of movement, which upset the entire family).

Clearly, these explanations, like many of the other explanations and perceptions presented above, largely absolve the husband of responsibility for wife abuse. Concomitantly, these explanations and perceptions place and project the responsibility for wife abuse on external factors, which the husband is not always expected to be able to control. This approach is also consistent with the traditional perspective, which attributes the problem of wife abuse to “external forces” that control the life of people (i.e., lack of external locus of control).

General Approach toward Abused Wives and Abusive Husbands

The results in Table 1 reveal that a substantial percentage (44%, Mean=1.87, s.d.=.05) of Palestinian physicians agreed with the statement that “a very small percentage of Palestinian women are abused by their husbands”. The results also indicate that although a small percentage (10%, Mean=2.45, s.d.=.67) agreed with the statement that “most abused wives feel relieved after their husbands batter them”, almost one-third (29%, Mean=2.06, s.d.=.79) of them agreed that “wives are abused because of the abnormal way they treat their husbands”. The results in Table 1 also reveal that substantial percentages (38%, Mean=1.88, s.d.=.79, and 43%, Mean=1.75, s.d.=.74) agreed with the statements that “if the abused wife understood her husband’s life conditions, he certainly would not have abused her”, and “if the woman had supported her husband when he was going through hard times, he certainly would not have abused her”, respectively. Although these results indicate a tendency among a considerable share of the Palestinian physicians to attribute wife abuse to the wife’s behavior (e.g., “the abnormal way she treats her husband”, “failing to understand the husband’s life conditions”, etc.), a small percentage (16%, Mean=2.31, s.d.=.73) agreed with the statement that “most abused wives deserve to be treated violently by their husbands”.

The results in Table 1 reveal that about two-thirds (63% and 63%) of the participants agreed with the statements “if the husband truly believes in God, he will never abuse his wife” (Mean=1.49, s.d.=.70), and “drinking alcohol causes husbands to abuse their wives” (Mean=1.47, s.d.=.67), respectively. About one-third (34%) and about one-fourth (23%) of the physicians agreed with the statements that “abusive husbands are usually failures, and can’t deal with difficult situations in their lives” (Mean=1.90, s.d.=.76), and “abusive husbands are mentally ill” (Mean=2.05, s.d.=.72), respectively.

Approval of Wife Abuse

The results in Table 2 indicate that between 14.2% (Mean=3.54, s.d.=1.09) and 35% (Mean=3.06, s.d.=1.44) of the Palestinian physicians supported or strongly supported the husband's minor violence against his wife under certain circumstances and for different rationalizations. For example, 13.6% (Mean=3.66, s.d.=1.06) and 18.4% (Mean=3.34, s.d.=1.05) of the participants agreed or strongly agreed that the husband has the right to slap his wife if she "doesn't prepare food for him and her children, despite the fact that she doesn't work outside the home", and if she "keeps criticizing her husband and accusing him of being a failure", respectively. Furthermore, about 25%, 30.6%, and 33.3% of the participants approved or strongly approved of a husband slapping his wife if he "suspects she is having an affair" (Mean=3.38, s.d.=1.18), if the wife "insults her husband in front of their children" (Mean=3.20, s.d.=1.30), and if she "neglects the home while spending most of her time visiting relatives" (Mean=3.10, s.d.=1.37), respectively.

The results in Table 2 also reveal that between 11.2% (Mean=3.97, s.d.=1.19) and 31.3% (Mean=3.32, s.d.=1.63) of the participants support or strongly support a husband who severely beats his wife (i.e., by attacking her with a belt, a stick, a shoe, etc.) under certain circumstances and for different reasons. For example, 11.2% and 15% of the participants approved or strongly approved of the husband's severe violence against his wife if "he has been told (after getting married) that his wife had an affair before their marriage" (Mean=3.97, s.d.=1.19), or if "the wife doesn't fulfill the requests of her husband" (Mean=3.68, s.d.=1.21), respectively. Furthermore, about 24%, 27%, and 31.3% of the participants approved or strongly approved of a husband's severe violence against his wife if "she irritates and provokes her husband by constantly putting him down" (Mean=3.69, s.d.=1.14), "if the wife returns home drunk" (Mean=3.32, s.d.=1.54), and if "the husband finds his wife in bed with another man" (Mean=3.32, s.d.=1.63), respectively. The results also

reveal that participants tended to show greater support for minor violence than for severe violence by husbands against wives in all of the circumstances presented in Table 2.

The results of correlation analysis presented in Table 4 reveal no significant correlations between the extent of supporting minor and severe violence by husbands against wives on the one hand, and the participants' demographic characteristics (age, religion, place of residence, and gender) on the other. In addition, no significant correlations were found between participants' sex-role stereotyping and attitudes toward women's social involvement on the one hand, and the extent to which they support minor and severe violence against wives on the other. However, the extent of support for minor and severe violence against wives was found to correlate significantly with the following variables: participants' attitudes toward women, marital role expectations, witnessing father-to-mother and mother-to-father violence, and experiencing violence from father and mother. Specifically, the more the participants held traditional and negative attitudes toward women, and the more patriarchal and nonegalitarian their expectations of marriage, the more they supported husbands' minor violence ($r=.21$, $p<.01$, and $r=.24$, $p<.001$, respectively) and severe violence against wives ($r=.19$, $p<.05$ and $r=.29$, $p<.0001$, respectively). In addition, the results in Table 4 reveal that the more participants witnessed father-to-mother violence and mother-to-father violence, the more they supported minor violence ($r=.33$, $p<.0001$ and $r=.21$, $p<.01$, respectively) and severe violence against wives ($r=.37$, $p<.0001$ and $r=.23$, $p<.01$, respectively); and the more they were abused by the father and mother, the more they supported minor violence ($r=.36$, $p<.0001$ and $r=.27$, $p<.0001$, respectively) and severe violence against wives ($r=.37$, $p<.0001$ and $r=.32$, $p<.0001$, respectively).

The results of regression and multiple regression analysis presented in Table 5 reveal that 36% and 44% of the variance in the participants' approval of minor and severe wife abuse, respectively, can be attributed to all of the variables that were entered into the formula of that analysis. The results indicate that the

participants' experience with parental violence ($\beta=.23$, $p<.05$), traditional attitudes toward women ($\beta=.20$, $p<.05$), and patriarchal and nonegalitarian expectations of marriage ($\beta=.21$, $p<.05$) were the most significant predictors of the husbands' approval of minor wife abuse. The results also indicate that participants' gender (men more than women, $\beta=.18$, $p<.05$), witnessing interparental violence ($\beta=.25$, $p<.05$), traditional attitudes toward women ($\beta=.18$, $p<.05$), and patriarchal and nonegalitarian expectations of marriage ($\beta=.31$, $p<.001$) were the most significant predictors in explaining the variance in participants' approval of severe violence against wives.

Beliefs About Wife Beating

As indicated earlier, four beliefs about wife beating were investigated among the Palestinian physicians. The results regarding each belief are presented below.

Justifying wife beating. In contrast to the results regarding approval or disapproval of husbands' violence against wives at different levels of severity (i.e., minor and severe violence), the severity of violence was not considered in the items we used to measure justifying wife beating. Specifically, the word "beating" was indicated in all of the items that were used to measure this variable, without reference to the severity of beating (see Table 3).

The results in Table 3 indicate that while 34% of the Palestinian physicians agreed or strongly agreed with the statement that "there is no excuse for a man to beat his wife", 38% disagreed or strongly disagreed with this statement (Mean=3.02, $s.d.=1.28$) and 30% of the participants agreed or strongly agreed with the statement that "it would do some wives good to be beaten by their husbands" (Mean=3.23, $s.d.=1.28$). In addition, results reveal that between 24% and 47% of the participants agreed or strongly agreed that wives deserve to be beaten in different marital circumstances. For example, 47% and 35%

of the participants agreed or strongly agreed that “a husband has the right to beat his wife if she makes fun of his manhood” (Mean=2.79, *s.d.*=1.22), and “if she keeps reminding her husband of his weak points” (Mean=3.03, *s.d.*=1.17), respectively. Furthermore, 31% and 26% of the participants agreed or strongly agreed with the statements that “a wife who constantly refuses to have sex with her husband is asking to be beaten” (Mean=3.24, *s.d.*=1.26), and “a wife who lies to her husband deserves to be beaten” (Mean=3.20, *s.d.*=1.09), respectively.

The results of correlation analysis presented in Table 4 indicate that the extent to which the participants justified wife beating correlated significantly with all of their demographic characteristics. Specifically, the results revealed that the older the participants, the more they tended to justify wife beating ($r=.19, p<.01$); male physicians were more likely than their female counterparts to justify wife beating ($r=.15, p<.05$); Muslim physicians showed a greater tendency than their Christian counterparts to justify wife beating ($r=.13, p<.05$); and physicians from rural areas and refugee camps were more likely than their counterparts from urban areas to justify wife beating ($r=.13, p<.05$).

In addition, the results revealed that the extent to which participants justified wife beating correlated significantly with all of the patriarchy-oriented independent variables measured in the study (i.e., sex-role stereotyping, attitudes about women’s social involvement, attitudes toward women, and marital role expectations). For example, the more participants maintain sex-role stereotypes and nonegalitarian and patriarchal expectations of marriage, the greater their tendency to justify wife beating ($r=.31, p=.0001$, and $r=.42, p<.0001$, respectively). Furthermore, the extent of justifying wife beating correlated significantly with two out of four of the independent variables related to social learning. Specifically, the more the participants witnessed father-to-mother violence and the more they experienced violence by their mothers, the greater their tendency to justify wife beating ($r=.20, p<.001$, and $r=.19, p<.01$, respectively).

The results of regression and multiple regression analysis presented in Table 5 revealed that 32% of the variance in the participants' tendency to justify wife beating can be attributed to all of the predictors entered into the formula of that analysis. The results indicate that participants' witnessing interparental violence ($\beta=.17$, $p<.05$), traditional and negative attitudes toward women ($\beta=.22$, $p<.0001$), and patriarchal and nonegalitarian expectations of marriage ($\beta=.36$, $p<.0001$) were the most significant predictors that explained that amount of the variance in justifying wife beating.

Blaming women for violence against them: The results in Table 3 reveal a tendency among a substantial proportion of Palestinian physicians to blame women for violence against them, where between 21% and 41% agreed or strongly agreed with the items that measure this variable. For example, 27%, 32%, and 41% of the participants agreed or strongly agreed with the statements that "sometimes the wife's provocative words cause her husband to beat her" (Mean=3.25, $s.d.=1.15$), "when a woman is beaten, it is caused by her behavior during the weeks beforehand" (Mean=3.13, $s.d.=1.19$), and "if the wife had known her boundaries, her husband wouldn't have beaten her" (Mean=2.81, $s.d.=1.23$), respectively. At the same time, it should also be noted that 33% of the participants agreed or strongly agreed with the statement that "men are incapable of controlling themselves, and therefore they beat their wives" (Mean=3.13, $s.d.=1.22$).

The results in Table 4 reveal that male physicians were more likely than their female counterparts to blame women for being battered ($r=.15$, $p<.05$), and the older the participants were, the greater the likelihood that they would blame women for being battered ($r=.13$, $p<.05$). In addition, the results reveal that the extent to which participants blame women for being battered correlated significantly with all of the patriarchy-oriented independent variables of the study. For example, the more the participants opposed women's social involvement, and the more traditional and negative their attitudes toward women, the greater their tendency to blame women for

being battered ($r=.17, p<.01$ and $r=.43, p<.0001$, respectively). The results also revealed that the participants' tendency to blame women for being battered correlated significantly with two out of the four variables related to social learning. Specifically, the more the participants witnessed father-to-mother violence and the more they experienced violence by their mothers, the greater their tendency to blame women for being battered ($r=.18, p<.01$, and $r=.12, p<.05$, respectively).

The results of regression and multiple regression analyses presented in Table 6 revealed that 31% of the variance in the extent to which the participants blamed women for being beaten can be explained by all of the predictors that were entered into that regression formula. The results indicate that traditional and negative attitudes toward women ($\beta=.21, p<.01$) and patriarchal and nonegalitarian expectations of marriage ($\beta=.22, p<.01$) were found to be the most significant predictors that explain that amount of variance in the participants' tendency to blame women for being battered.

Women benefit from beating. The results in Table 3 revealed that 62% of the Palestinian physicians agreed or strongly agreed with the statement that "women feel pain and no pleasure when they are beaten up by their husbands" (Mean=2.29, $s.d.=1.24$). This statement simplifies the tendency among a substantial proportion of physicians who sympathize with women's suffering that result from their battering. However, the results also revealed that between 21% and 30% of the participants expressed some extent of support for the statements that reflect a tendency to believe that women benefit from being beaten. For example, 21% of the participants agreed or strongly agreed that "battered wives try to get their partners to beat them in order to gain attention from others" (Mean=3.35, $s.d.=1.18$).

The results of correlation analysis presented in Table 4 indicate that the older the participants were, they greater their tendency to believe that women benefit from battering ($r=.15, p<.05$); male and Muslim physicians showed a greater tendency than women and their Christian counterparts to believe that women

benefit from beating ($r=.20, p<.01$, and $r=.16, p<.01$, respectively). The results also reveal that the more the participants held sex-role stereotypes and patriarchal and nonegalitarian expectations of marriage, the more they tended to believe that women benefit from being beaten ($r=.17, p<.01$, and $r=.17, p<.01$, respectively). In addition, the results reveal that the more the participants experienced violence by their fathers, the more they tended to believe that women benefit from being beaten ($r=.18, p<.01$).

The results of regression and multiple regression analysis presented in Table 6 indicate that 27% of the variance in the extent to which the participants believed that women benefit from being beaten can be explained by all of the predictors that were entered into the formula of that analysis. The results reveal that among all of the predictors, religion (Muslims more than Christians, $\beta=.15, p<.05$), gender (men more than women $\beta=.17, p<.05$), experiencing parental violence ($\beta=.19, p<.05$), holding traditional and negative attitudes toward women ($\beta=.30, p<.0001$), and holding patriarchal and nonegalitarian expectations of marriage ($\beta=.21, p<.01$), were found to be the most significant predictors that explain the variance in the extent to which the participants believed that women benefit from being beaten.

Helping Battered Women: The results in Table 3 show that 33% of the participants agreed or strongly agreed with the statement that “if a wife tells me that her husband abuses her, I prefer not to intervene” (Mean=3.01, s.d.=1.12). Nonetheless, they still exhibited a noticeable tendency to support different forms of help for battered women. About 56% and 55% of the participants agreed or strongly agreed that “the Palestinian Authority should give wife abuse very high priority over other social problems” (Mean=2.53, s.d.=1.19), and that “social agencies should do more to help battered women” (Mean=2.50, s.d.=1.26), respectively. Although these responses do not indicate the participants’ attitudes regarding the type of assistance that should be offered to battered women, they expressed support in principle to the notion that the state should

recognize wife abuse as a problem and that agencies should devote more efforts toward combating the problem. Although 59% of the participants agreed or strongly agreed that “women should be protected by law if their husbands beat them” (Mean=2.45, s.d.=1.21), only 27% of the participants agreed or strongly agreed that “husbands who beat their wives should be arrested” (Mean=3.28, s.d.=1.17), and the same percentage agreed or strongly agreed that “if I heard a husband beating his wife, I would call the police” (Mean=3.31, s.d.=1.16). These seemingly contradictory responses could reflect the participants’ ambivalence regarding the best ways to protect abused wives. While they believe that abused wives should be protected by law, they are against the enforcement of such protection by police officers. This ambivalence may reflect the participants’ sense of conflict between the need to protect battered women on the one hand, and the need to preserve family values on the other (e.g., family privacy, family solidarity, family cohesion, family reputation, family togetherness, and maintaining closed boundaries around the family so that the family remains intact and is protected from “invasion by outsiders”). Nonetheless, while 54% of the participants agreed or strongly agreed that “if a woman is battered, her family should give the problem high priority as a family problem” (Mean=2.60, s.d.=1.32), 22% and 26% of the participants agreed or strongly agreed with the statements “I think that any woman who is beaten by her husband should get a divorce” (Mean=3.47, s.d.=1.19), and “I would advise any abused woman to leave her husband and move in with her family of origin” (Mean=3.31, s.d.=1.18), respectively. These results are consistent with the above-mentioned familial values, and place special emphasis on family solidarity and cohesion, mutual support in the family, family reputation, maintaining strict and closed family boundaries, and maintaining family boundaries and offering protection against wife abuse within the family unit. This emphasis is intended to prevent outsiders such as the police from intervening in the family’s affairs, as well as to prevent the dissolution of the family as a result of wife battering.

The participants' responses reveal an additional point of ambivalence: 48% and 48% agreed or strongly agreed with the statements "if a woman tells me that her husband beats her, I will help her in any way I can" (Mean=2.67, s.d.=1.13), and "I believe that the hospital I work at should offer the best services and assistance to battered women" (Mean=2.80, s.d.=1.21), respectively. However, 30% agreed or strongly agreed with the statement "if I try to help a battered woman, it will make things worse" (Mean=3.05, s.d.=1.14).

The results in Table 4 reveal that older and male physicians are less likely than younger and female physicians to support the provision of assistance to battered wives ($r=-.17$, $p<.01$, and $r=-.12$, $p<.05$, respectively). In addition, the results reveal that all four patriarchy-oriented variables correlated significantly with the participants' tendency to support the provision of assistance to battered women. For example, the more the participants held sex-role stereotypes and patriarchal and nonegalitarian expectations of marriage, the less likely they were to support the provision of assistance to battered women ($r=-.28$, $p<.0001$, and $r=-.29$, $p<.0001$, respectively). The results also reveal that the more the participants experienced violence from their fathers, the less likely they were to support the provision of assistance to battered women ($r=-.14$, $p<.05$).

The results of regression and multiple regression analysis presented in Table 6 indicate that 28% of the variance in the participants' tendency to support or oppose the provision of assistance to battered women can be explained by all of the predictors that were entered into the formula of the analysis. Among all of the variables, traditional and negative attitudes toward women ($\beta=-.19$, $p<.05$) and their patriarchal and nonegalitarian expectations of marriage ($\beta=-.25$, $p<.001$) were found to be the most significant predictors that explain the variance in the extent to which the participants support or oppose the provision of assistance to battered wives.

Perceptions of Appropriate Interventions and Solutions for Wife Abuse

As indicated, an open-ended question was presented to the Palestinian physicians, regarding their perceptions of appropriate interventions and solutions for wife abuse. About 89% of the participants responded to the question.

The responses can be divided into seven categories of suggested interventions and solutions, as follows: (1) direct intervention with abused wives; (2) direct intervention with abusive husbands; (3) intervention with both partners; (4) improving the family's life conditions; (5) involvement of external parties; (6) legal interventions; and (7) divorce.

With regard to the first category, i.e., direct intervention with abused wives, three main themes can be elicited from the participants' responses: teaching the abused wife to change her behavior toward her husband, helping to alleviate the feelings aroused in the abused wife as a result of violence against her, and empowering the abused wife to resist violence. A substantial majority (about 56%) of the responses presented by the Palestinian physicians suggested interventions aimed at teaching the wife to change her behavior toward her husband, as a way of encouraging him to change his behavior toward her. In this connection, the following suggestions made by the physicians are noteworthy: "enhancing the wife's insight, in order to help her gain a deeper understanding of her behavior toward her husband"; "helping the wife understand what she did wrong to her husband or to his family"; "encouraging the wife to appease her husband whenever he makes accusations against her"; "teaching the wife when to leave her husband alone so as to avoid upsetting him too much"; "teaching the wife how to pamper her husband and treat him intimately"; "helping the wife learn how to be more patient with her husband"; "helping the wife realize that if she obeys

her husband, she may prevent him from becoming angry”; “helping the wife realize that if she shows respect toward her husband and his parents, she will ingratiate herself with them and prevent her husband from acting violently toward her”, etc.

About one-fourth of the suggested interventions aimed at helping the wife deal with the feelings aroused by the experience of violence. For example: “calming the wife down”, “supporting the wife in order to alleviate her fears and anxieties”; “improving the wife’s self image”; “showing the wife that she is not alone and that the hospital staff is interested in supporting her”; “understanding that the wife is experiencing extreme stress, and that it is important to help her overcome that before taking any other measures”, etc.

A small percentage (about 9%) of the responses to the above questions included suggestions such as: “enhancing the wife’s awareness of her right to live a life free of fear or tyranny in the family”; “encouraging the wife to resist tyranny, including violent behavior by her husband”; “teaching the wife to be assertive and confident, and encouraging her to oppose her husband as well as to challenge the tradition that prevents her from opposing him and his family”, etc. The third theme reflects appreciable support for interventions aimed understanding the battered woman, strengthening her, and encouraging her to resist violence against her. Nonetheless, based on the first two themes, the predominant approach was to blame the wife for her situation, to moralize to the wife and to persuade her to be more patient and assume responsibility for violence against her, to teach her to respect her husband and his family, to act more intimate, to be conciliatory and obedient, and to avoid provocation.

With regard to the second category of suggestions, i.e., direct intervention with abusive husbands, two main themes can be elicited from the participants’ responses: understanding the husband and helping him overcome his difficulties on the one hand, and increasing the husband’s sensitivity to his wife’s feelings on the other.

A substantial percentage (about 34%) of the responses included suggestions such as: “understanding the husband’s problems and helping him overcome them”; “probing the conditions of the husband’s life and helping him improve them”; “determining whether the husband had traumatic experiences during his childhood and, if so, helping him understand the extent to which those experiences affect his life with his wife”; “determining whether the husband has problems at work and, if so, helping him overcome them”; “determining whether the husband is addicted to drugs or alcohol and, if so, helping him give up his addiction”; “determining whether the husband is taking psychiatric medication or undergoing psychological therapy and, if so, encouraging him to continue treatment”, etc.

A substantial percentage of the responses (about 28%) also included suggestions such as: “enhancing the husband’s awareness of his wife’s problems”; “helping the husband understand that his wife also works hard during the day”; “helping the husband treat his wife with consideration and understand that she may not always meet his expectations”; “encouraging the husband to be forgiving toward his wife”; “helping the husband understand that women are usually weak, and that he should therefore understand her, support her, and be patient if she irritates him”, etc.

These responses reflect a strong tendency to medicalize and pathologize the problem of wife abuse, and to absolve the husband of direct responsibility for violence against his wife. Moreover, although the Palestinian physicians indicated that the husband should be more aware of his wife’s hard work and develop more sensitivity toward her problems, they also tended to implicitly blame the wife for violence against her (in addition to explicitly blaming her, as indicated). In addition, the physicians’ responses implied that the wife is inferior to her husband, and that he has no choice but to “understand her” and “be forgiving toward her”.

With regard to the third category of suggestions, i.e., intervention with both

partners, one main theme can be distinguished, i.e., enhancing marital relations. About one-fourth (close to 23%) of the physicians' responses included suggestions such as: "enhancing mutual understanding between partners"; "facilitating adjustment between partners"; "teaching both partners skills for peaceful problem-solving based on mutual understanding"; "enhancing mutual intimacy and affection between partners"; "enhancing mutual trust"; "enhancing both partners' awareness of their rights and obligations in marital relations and in the family"; "enhancing mutual respect between partners"; "teaching the couple to avoid unnecessary arguments", etc.

These responses reflect a certain tendency to view wife abuse as a problem caused by problems or difficulties in spousal relations (e.g., lack of intimacy and love, lack of mutual respect, and failure to adjust to each other). Thus, the blame for violence was placed both implicitly and explicitly on both partners. Clearly, the Palestinian physicians also failed to acknowledge the legitimacy of spousal conflicts and tended to view such conflicts as harmful and unhealthy. These suggestions are also consistent with the prevailing approach in traditional societies, such as Palestinian and Arab societies, which considers wife abuse as an issue that primarily concerns the family and the couple. This approach does not attribute the problem as much to the abusive husband, and it is even less inclined to consider the wife's need for protection and support as a victim. This tendency is consistent with the traditional perspective, which emphasizes the importance of preserving and maintaining marriage and the family at all costs, even if the battered wife continues to suffer and even if her safety is threatened. It can be assumed that these suggestions also reflect the Palestinian physicians' tendency to medicalize and pathologize wife abuse by seeking solutions to marital problems while placing less emphasis on supporting the wife and ensuring her safety.

These arguments, assumptions, and explanations are supported by the relatively high percentage (about 36%) of Palestinian physicians who gave suggestions in the fourth category, i.e., improving the family's life conditions. In this

context, most of the suggestions focused on: “increasing the family’s income and helping both partners overcome financial problems (e.g., debts and unemployment)”, “improving the family’s living conditions”, “helping the family overcome the stressful conditions affecting the children (e.g., illness, disability, low grades in school, etc.)”; “helping the family improve relations with their in-laws in particular, and with friends and neighbors in general”, “strengthening the family’s relations with the community”. Consistent with the other categories, it can be assumed that the suggestions regarding improvement of the family’s living conditions reflect the traditional emphasis on preserving the family at any cost. It can also be assumed that these suggestions reflect a minimal level of willingness to acknowledge the problem of violence as a socio-legal one and a low tendency to recognize the woman’s physical and emotional insecurity, as well as the physicians’ unwillingness to recognize wife abuse as a problem deriving from the behavior of the husband. Undoubtedly, the solutions that focus on improving the family’s living conditions divert attention from the husband’s behavior, and even more from the wife’s need for security and protection.

With regard to the fifth category of suggestions for intervention, i.e., involving external agencies, three main themes can be elicited from the participants’ responses: involving relatives (mainly in-laws), involving community figures (mainly traditional facilitators and mediators, political leaders, and clergymen), and applying for social services.

In this category, the Palestinian physicians expressed a clear preference for involving family members (especially the parents of both partners, followed by other relatives such as siblings, uncles and aunts, cousins, etc.). These relatives were expected to “mediate”, to “ease tensions”, to “persuade the wife to be more patient”, to “show the husband that the wife is always weaker, and that it’s not worthwhile to hurt her”, to “show the couple that staying together is in the best interest of the family”, to “show the couple that for the benefit of the family it is best to avoid airing dirty laundry in public”, “the wife’s relatives

(especially her parents and brothers) should support her and give her shelter when she needs it” “both partners should receive financial assistance if they need it”, etc.

The physicians’ responses clearly indicated that “in order to maintain the family’s reputation it is best to ease tensions and to avoid the escalation of violence”. They also maintained that “efforts should be made to keep the family together, so that the children do not grow up without one of their parents”. At the same time, the physicians indicated that if there is no other choice - and especially if the violence persists or escalates - certain parties in the community should be involved. In the first instance, they recommended approaching prominent community figures such as mediators, clergy, or respected political leaders. Surprisingly, the physicians’ expectations of these people were highly similar to their expectations of family members who intervene, as mentioned. Notably, however, these expectations also focused on “easing tensions between the couples’ extended families in case the husband’s violence toward his wife has aroused family conflicts”, “mediating between the partners in cases where family members are not objective enough in their efforts to do so”, etc.

A very small percentage (about 8%) of the suggestions to involve external parties made reference to intervention by governmental or non-governmental social agencies. The participants who suggested involving these agencies expressed expectations that were highly similar to their expectations of family members and community figures. However, those participants were aware that in some cases there is no choice but to seek professional intervention from social services. Such intervention was recommended, for example, when the wife doesn’t have relatives who will protect her when she is in need, or when the husband is addicted to drugs or alcohol and needs professional assistance. Moreover, they noted that intervention by family members is not always effective, because they may be in conflict and one relative may seek revenge against another.

The physicians who suggested involving social services showed a preference for governmental services over women's organizations. It can be assumed that this preference reflected the negative attitudes toward women's organizations in part of Palestinian society, as in many other traditional societies. These attitudes are expressed in statements such as: "women's organizations are financed by international foreign institutions that have a patronizing and condescending view of Palestinian society"; "those organizations tend to agitate women and are less interested in reconciliation between partners", "those organizations always favor women and are against men, even though the woman is often to blame for violence against her".

As can be seen, the physicians gave first preference to intervention by extended family members before involving any of the other parties mentioned above - if anyone outside of the nuclear family is involved in any case. This tendency reflects the traditional and collectivist orientation of Arab and Palestinian societies, where the problem of wife abuse is kept within the family and priority is given to maintaining marriage and the family. In these contexts, the woman is usually implicitly or explicitly blamed for violence against her. In addition, such societies are less inclined to view wife abuse as a social problem that calls for treatment of the violent husband (except in cases where there is no choice but to acknowledge that the husband has a problem that causes violent behavior such as drug or alcohol addiction or mental illness - Haj-Yahia, 2000a,b,c). In those responses, the physicians' expectations of community figures, clergy, and political figures were also similar to their expectations of relatives. Even when the participants suggested involving social services, their expectations of those services were highly similar to their expectations of the other external parties, i.e., community members and family. Thus, the physicians' suggestions to involve social services were provisional: "they should not incite the woman against her husband", "they should ease tensions and not cause rebellion", "the husband's problems should be treated, but the wife should learn to understand him", etc.

With regard to the sixth category, i.e., legal interventions, about 6% of the participants indicated that they would also be willing to recommend such intervention in cases of wife abuse. The vast majority of participants who mentioned legal intervention qualified their suggestion with conditions such as: “as long as the woman has done everything she can to placate her husband”, “as long as the woman has shown her husband and her family that she is indeed patient, that she understands her husband, and that she is willing to keep giving him chances”, “as long as the families of both partners indeed failed to help the couple”, “only in extreme and very severe cases of wife battering... or in cases where the violence has continued to escalate over time”, “by no means is legal intervention appropriate for initial episodes of violence”, “by no means is legal intervention appropriate in cases where the husband has an outburst of rage aroused by his wife’s provocative behavior and complaints”, “by no means is legal intervention appropriate in cases where the husband has a violent outburst due to temporary or ongoing stress that he or the family are experiencing”, “in cases where the husband has insulted his wife’s family origin and failed to give them the respect they deserve”; “in cases where the husband behaves as if he is scorning respected members his own extended family and the extended family of his wife, or respected members of the community who have tried to mediate between him and his wife without accepting their suggestions for reconciliation and without fulfilling his commitment to stop his violent behavior toward his wife”, etc. Clearly, these conditions reflect the values and norms of Palestinian society and other Arab societies, as well as most other traditional societies in the world. These values emphasize and reflect the inferior and submissive status of women on the one hand, and the superior and dominant status of men on the other. They also reflect and emphasize central values such as family honor and the family’s reputation in the community, family unity and continuity, family cohesion, self sacrifice for the family network and collective, mutual support among all family members, respect for members of the extended family and community leaders, etc.. Furthermore, they are

indicative of attitudes toward wife beating in those societies, as reflected in the lenient approach toward wife abuse as well as in the view of the problem as a personal issue that concerns the family, and not as a public, social, or legal issue. This point will be discussed later in further detail.

It should be mentioned that a very small percentage of the participants who suggested legal intervention as a possible way of dealing with certain cases of wife abuse indicated that it is primarily a legal issue and should be treated accordingly. For example, out of the 6% of the physicians who suggested legal intervention, 15% indicated that the police should be involved from the very outset. The minimal percentage of these responses is consistent with the familial and social values of Palestinian society described earlier, and with the prevailing attitudes toward wife abuse in Palestinian society. Moreover, in Palestinian society - as in many other traditional societies - battered women who call the police may be considered rebellious and may be accused of overstepping family boundaries that all family members (including the wife) are expected to maintain. Therefore, the strong tendency of the Palestinian physicians to oppose legal intervention in cases of wife abuse may reflect their view that battered women should obey their husbands on the one hand, and consistent with the traditional view of the family institution on the other. Concomitantly, this tendency may result from the doctors' fear of being accused by society in general and the wife's relatives in particular of provoking her and encouraging her to rebel against her husband, her family, and prevailing social values. Therefore, the doctors are afraid that by making such accusations they may be ostracized by society, in addition to risking conflict with the wife's family. Moreover, the Palestinian Authority, like most Arab countries, has not enacted a law for the prevention of wife abuse. Consequently, it can be assumed that most of the Palestinian physicians, like the other members of their society, believe that wife abuse is not a legal, public issue but as a personal and familial issue, and as such it should be kept within the boundaries of the family.

Finally, a relatively small percentage (about 6%) of the Palestinian physicians participating in the study indicated they would recommend divorce as a way of preventing the persistence and perpetuation of wife abuse. However, like the participants who mentioned the possibility of legal intervention in such cases, they qualified their support for divorce by specifying numerous conditions. Notably, before they would advocate divorce they repeatedly emphasized almost all of the conditions mentioned above for cases that would warrant legal intervention. Moreover, it was clear that the physicians considered divorce to be the most extreme solution to wife abuse. Therefore, most of the participants who suggested the possibility of divorce indicated that every other solution mentioned here must be pursued before reaching the conclusion that there is no other way to stop the cycle of violence. Most of the physicians who suggested divorce as a possible solution in cases of persistent wife abuse phrased their suggestions in a highly ambivalent way. For example: “Divorce means dissolving the family as a sacred institution”; “divorce means that the children will live without one of their parents - usually without their father; therefore, the boys will not grow up to be real men, and the girls will not have male supervision”; “divorce may not stop violence all of the time, because the wife will inevitably move in with her parents after she leaves her husband - and that is not always an ideal situation for her”; “it is important to realize that the alimony payments determined by religious courts in the Palestinian Authority are usually minimal; therefore, the wife and her children will pose a financial burden for her family of origin and this may be a source of conflict between the wife and her family”; “divorce may arouse severe guilt feelings in the woman, because society will often blame her for it and consider her to be an inadequate wife and mother who broke up the family; therefore, it is very likely that the mother and her family will be blamed for the failure in her education... such accusations may harm the family’s reputation, and particularly the reputation of her mother and sisters. This may harm the unmarried sisters’ chances of finding a husband”; “although divorce is not forbidden in Islam, God views it as undesirable”, etc.

Although the Palestinian physicians were clearly in favor of helping battered women, they were hesitant about providing such assistance if it conflicts with traditional social and familial values. Besides the prevalence of these values and approaches, the participants' reluctance to advocate divorce can also be attributed to the economic situation in the Palestinian Authority and to the lack of an institutional social security system that provides support to battered women. This situation often makes battered women dependent on financial assistance from their family of origin. Notably, the strong social and familial control over battered women in Arab societies is not only a source of severe emotional stress for the women, but also constrains her and prevents her from working and supporting herself and her children independently (Cohen & Savaya, 1997; Haj-Yahia, 2000d, 2002). Therefore, it is not surprising that not only were most of the Palestinian physicians who participated in the study hesitant to support divorce as a deterrent to wife abuse, but other studies revealed that the women themselves were hesitant to support that solution and viewed it as a last resort (Haj-Yahia, 2000d, 2002).



Section Four

Discussion





Discussion



Summary and Implications

The report documented a study conducted among Palestinian physicians, which examined several issues: their definitions of wife abuse, their perceptions of the causes of wife abuse, their general approach toward abused wives and abusive husbands, their tendency to approve or disapprove of wife abuse, their beliefs about wife beating (with emphasis on justifying wife beating, blaming women for being beaten, and the belief that women benefit from beating), and their approach toward helping battered women. The report presented and discussed some of these beliefs and perceptions, in terms of the sociocultural context of Palestinian society in particular and Arab societies in general. Other beliefs were presented, in an attempt to examine their relationship to the physicians' patriarchal ideology and exposure to violence in their families of origin.

As shown in the Results section, substantial percentages of the Palestinian physicians are aware of different types of wife abuse, and their definitions of acts of wife abuse are highly consistent with definitions presented in the professional literature (e.g., Haj-Yahia, 1999, 2000,a,b; Hudson, 1983; Straus, et al., 1996; Tolman, 1989). At the same time, the findings revealed a relatively strong tendency to recognize severe and ongoing acts of violence as wife abuse, whereas they were less inclined to recognize episodic acts of mild or moderate violence as such.

Numerous studies have shown that the disposition of physicians to be involved in assessment and identification of battered women is largely influenced by definitions of the problem (Acierno, Resnick, & Kilpatrick, 1997; Flitcraft, 1993; Gerbert et al., 2002; Harvey & Kinno, 1993; Kurz, 1987, 1990). This study did not examine how Palestinian physicians respond when they actually encounter a battered woman, when they themselves recognize and assess the woman's experience as violent, or when she actually identifies herself as a battered woman. Based on the approaches described in this report, it is likely that the physicians would respond by ignoring the situation or by remaining oblivious to it as long as the woman has not specifically identified herself as abused, or as long they view the experience as a "mild" or "moderate" incident of episodic violence. Hence, physicians may fail to accurately assess the risk to the woman's life. Accordingly, it would be worthwhile for future studies to examine physicians' actual responses to battered women under their care, as well as the extent to which those responses are affected by their definitions of the women's experience with violence.

The present study also revealed that the physicians' tendency or lack of inclination to define a woman's experience with violence as wife abuse is affected by the extent to which they blame the woman for the situation. The findings indicate that the extent to which the physicians tend to blame battered women for violence is strongly related to the traditional and patriarchal sociocultural context of Palestinian society in particular and of Arab societies in general. In addition, the more the physicians had been exposed to violence in their own families of origin (either by personally witnessing or experiencing such violence), the more likely they were to justify wife abuse, to blame the battered wife for her situation, and to believe that she benefits from battering. Nonetheless, the physicians also expressed a desire to help battered women. These findings are highly consistent with the results of other studies conducted among human service providers and therapeutic professionals, including medical staff (Easteal & Easteal, 1992; Eisikovitz et al., 2000; Hansen, Harway, & Cervantes, 1991; Henderson, 2001; Johnson, Singler, & Crowley, 1994; Kurz, 1987, 1990; McKeel & Sporkowski,

1993; Saunders & Size, 1986; Sporakowski, McKeel, & Madden-Derdich, 1993; Tang, Pun, & Cheung, 2002), as well as studies conducted among students (Finn, 1986; Harris & Cook, 1994; Kristiansen & Giulietti, 1990; Locke & Richman, 1999; Muehlenhard & MacNaughton, 1988; Sugarman & Cohn, 1986; Summers & Feldman, 1984; Willis, Hallinan, & Melby, 1996), and studies conducted among the general public (Ewing & Aubrey, 1987; Gentemann, 1984; Greenblat, 1983, 1985; Haj-Yahia, 1997, 1998a,b,c, 2002; Hillier & Foddy, 1993; Paquin, 1994; Simon, Anderson, Thompson, Crosby, Shelley, & Sacks, 2001; Yick & Agbayani-Siewert, 1997).

Saunders & Size (1986) found no differences between three groups - police officers, advocates, and victims - regarding the extent to which they accept violence against women in general, or violence in cases where the wife has verbally abused her husband. At the same time, the police officers showed a greater tendency than the other two groups to support wife battering as a response to the woman's infidelity. Saunders and Size attribute this difference to the police officers' more traditional attitudes toward women. The police officers also tended to view women as "property", and therefore felt it is proper to punish wives who are unfaithful. Although Saunders and Size (1986) indicated that police officers generally agree that battered wives neither cause violence against them nor benefit from battering, their opposition to these views was no greater than that of the other two groups of participants. Again, Saunders and Size (1986) attributed these results to gender differences between the three groups, as mentioned above. Essentially, they found that the more the police officers maintained negative attitudes toward women and traditional views of women's roles, the greater their tendency to agree that battered women are to blame for violence against them. Most of the police officers who participated in the study by Saunders and Size viewed wife battering as a criminal problem. In contrast to the group of victims, however, very few of them thought that arrest is the best solution. This difference between the police officers and the victims may be attributed to the dissatisfaction expressed by numerous victims with the responses of police officers when they ask for help from the police.

Johnson, Singler and Crowley (1994) studied professionals in social service organizations and in criminal justice agencies. They examined the extent to which professionals share similar attitudes and perceptions with respect to definitions of different acts of family violence (mainly physical and sexual abuse of children and wife abuse), the best method of dealing with family violence, criminalization of family violence, endorsement of therapy for cases of family violence, and the best agencies for coping with or responding to cases of family violence. Here we focus on the findings of that study regarding wife abuse. Our research findings are highly consistent with the results of Johnson et al. (1994) with respect to the professionals' definitions of wife abuse. The categories elicited from the definitions of the participants examined by Johnson et al. (1994) included physical, verbal, and mental abuse. Physical abuse included use of physical force, and verbal abuse included insults, offensive verbal behavior, or inappropriate language. Mental abuse included any use of offensive behavior that could cause mental or emotional distress. Johnson et al. (1994) found that social service professionals were most likely to define spouse abuse in terms of mental abuse (55.5%), whereas justice agencies tended to define spouse abuse as physical assault (54.3%). Interestingly, and in contrast to the findings of our study, neither of the groups of professionals examined by Johnson et al. (1994) included sexual and economic abuse in their definitions of spouse abuse. In addition, our findings differ from those of Johnson et al. with respect to the methods preferred by professionals for dealing with wife abuse. Based on answers to open questions about the best method of dealing with the problem, the study by Johnson et al. revealed three categories: handling the problem as a crime, handling it as a social problem, and handling it as a civil problem. The method of handling the problem as a crime was cited whenever the participants indicated the use of police, jail, or noncivil judicial process. The social problem method was coded whenever the participants indicated referral to a social service agency, including religious counseling. The civil problem method included divorce proceedings, custody proceedings, or a lawsuit for damages and/or support from the offender.

As could be expected, professionals in criminal justice agencies showed a greater tendency than social service personnel to support the justice system approach, whereas social service personnel showed a greater tendency to suggest that the problem be handled as a social one. Concomitantly, both groups showed a greater tendency to support the justice system approach than the social problem approach. Both social service professionals (53.2%) and criminal justice personnel (76.8%) were likely to indicate that domestic violence is best handled as a crime. Notably, a higher percentage of criminal justice professionals endorsed criminal procedures as the best method for dealing with such cases. Social service professionals (41%) were more likely than criminal justice professionals (13.7%) to perceive the social problem approach as the second-best method of handling such cases. Thus, more social service personnel believed that domestic violence is best handled as a social problem, while more criminal justice personnel believed that the problem is best handled through criminal procedures. Both groups of professionals were least likely to perceive civil procedures as the best method of handling domestic violence.

By and large, our findings regarding causal attributions for wife abuse are consistent with those of Easteal and Easteal (1992). In keeping with some of our findings, most of the physicians who participated in their study attributed wife abuse to sociological causes, to alcoholism, or to psychological problems of the violent husband. However, while the physicians in Easteal and Easteal's (1992) study did not mention provocation of the perpetrator by the victim as a cause of violence, we found that a large share of the Palestinian physicians mentioned causes that can be attributed to the battered woman (e.g., provocative behavior). Whereas approximately 96% of the Australian physicians who participated in Easteal and Easteal's study disapproved of wife abuse, a substantial share of the Palestinian physicians who participated in our study tended to justify wife abuse under certain conditions. Essentially, the percentage of Palestinian physicians who approved of wife abuse and justified such behavior is similar to the percentage of men and women in Palestinian society and in other Arab societies who approve of such behavior, as revealed in earlier studies

(Haj-Yahia, 1998a,b, 2002). Even the aforementioned situations where the Palestinian physicians tended to justify wife abuse are similar to those in which men and women in Palestinian society and other Arab societies justify such behavior, as revealed in earlier studies (Haj-Yahia, 1998a,b, 2002). Notably, the percentages of Palestinian physicians who occasionally blamed the husband and sometimes blamed the wife but usually blamed both partners for wife abuse, were highly similar to the percentages of men and women in Palestinian society as well as in other Arab societies who usually blamed the wife but occasionally considered the victim and the perpetrator to be equally responsible for wife abuse (Haj-Yahia, 1998a,b, 2002, 2003). The present study of Palestinian physicians and earlier studies conducted among the general population in Palestinian society and in other Arab societies revealed that these attitudes toward battered women can be largely attributed to the patriarchal perspectives prevailing in Arab societies. In particular, earlier studies revealed that these attitudes can be attributed to the negative and traditional attitudes toward women as well as to nonegalitarian expectations of marriage, and to sex-role stereotypes (Haj-Yahia 1998a,b, 2002, 2003). In addition, the findings of this study are consistent with the results of earlier research conducted among men in Arab societies at large (Haj-Yahia, 1991, 1997, 1998c). These results attribute the negative attitudes toward battered women to the participants' own experiences with abuse by their parents and siblings as children, as well as to their witnessing of interparental violence or parental abuse of their siblings. The present findings regarding the tendency of Palestinian physicians to attribute wife abuse - among other causes - equally to the husband and wife, in addition to family life conditions are similar to the results of a study conducted by Eisikovits et al. (2000) among Arab social workers. Eisikovits et al. found that the causes attributed to the violent husband were most frequently mentioned by the social workers. They also found that social causes (such as the influence of education and the media) were mentioned least by the social workers, and that about one-fifth of the social workers tended to consider men and women equally responsible for wife abuse. Less than 11% of the social workers examined by Eisikovits et

al. perceived the battered woman as responsible for violence against her. In contrast to our findings and those of Eisikovits et al., McKeel and Sporakowski (1993) conducted research among shelter counselors, and found that none of them believe that the woman is primarily or completely responsible for wife abuse. At the same time, 8% of the counselors indicated that the husband and wife are equally responsible for wife abuse, while about 54% indicated that the husband is primarily responsible for wife abuse, and about 38% believed that the husband is completely responsible for wife abuse. Notwithstanding their substantial evidence, McKeel and Sporakowski did not investigate any theoretical framework for explaining their findings.

Our research findings on the Palestinian physicians are highly consistent with the results of Tang, Pun and Cheung (2002), who examined Chinese public service professionals in Hong Kong (mainly physicians, lawyers, and police officers). According to their findings, attitudes toward women were the most significant predictor of the professionals' tendency to view the battered woman as being primarily responsible for violence against her. According to Tang et al. (2002), the more the Chinese professionals held negative attitudes toward women and sex-role stereotypes, the more likely they were to blame the battered woman and less likely they were to blame the violent husband. This finding is consistent with our previous contention about patriarchal ideology, that in patriarchal societies such as Palestinian society and Chinese society as well as many other societies, there is a tendency to perpetuate male prerogatives by approval of wife abuse, and to legitimize such behavior, in order to see that women maintain an inferior status to men in society (Dobash & Dobash, 1979, 1992; Yll? & Straus, 1990). Based on this approach, it is assumed that people with rigid gender norms tend to approve of wife abuse, that they tend to treat violent husbands leniently, and that they attribute wife abuse primarily to the woman and less, if at all, to the violent husband.

The findings of our study also provide empirical support for social learning theory. As indicated, the findings showed that the more the Palestinian physicians

were exposed to (experienced and/or witnessed) violence in their families of origin, the more they tended to approve of and justify wife abuse, the more they tended to blame women for violence against them, and the less they supported helping battered women. It should be mentioned that social learning theory was used by researchers mainly as a basis for explaining violent behavior of men against intimate partners and less as a basis for explaining perceptions of and attitudes toward violence against women. Among the few studies that adopted social learning theory as a basis for explaining approaches, attitudes, and perceptions related to wife abuse include those by Coleman and Stith (1997), Haj-Yahia (1991, 1997, 1998c), and Markowitz (2001).

In a study of young adult Arab engaged men, Haj-Yahia (1997) found that the more they experienced violence by their parents and siblings in childhood, the greater their tendency to justify wife-beating; and the more they witnessed interparental violence during childhood, the greater their tendency to believe that wives benefit from beating and the lesser their tendency to support wife battering. He also found that the more Arab men witnessed interparental violence during childhood, the greater their tendency to believe that women should be held responsible for being beaten and the lesser their tendency to believe that husbands are responsible for their violent behavior. In the same vein, they also showed less of a tendency to believe that husbands should be punished for violent behavior toward their wives (Haj-Yahia, 1998c).

Essentially, our research findings are consistent with patriarchal ideology and social learning theory, and high percentages of the variance in each of the dependent variables are explained by variables that were derived from those two theories. This emphasizes the importance of considering the problem of wife abuse from a broad, integrative perspective rather than from a narrow reductionist perspective. At the same time, it is clear that a substantial share of the variance in the dependent variables examined in this study was not explained by its independent variables. Hence the need to conduct further research, which will examine additional independent variables that can be derived from each of

the above theories as well as from other theories. This will provide a better understanding of the attitudes of physicians and other professionals toward abused women, and on how those professionals perceive different dimensions related to the overall problem of wife abuse. For example, variables such as family honor, perceptions of masculinity, and the significance of collectivism in the family (nuclear and extended), are relevant to patriarchal ideology and should therefore be examined in terms of their impact on the approach of professionals toward wife abuse. Moreover, future research in the field should not ignore the structural element of patriarchy as reflected “in the low status women generally hold relative to men in the family and in the economic, educational, political, and legal institutions” (Yll? & Straus, 1990, p. 384). Examination of the different dimensions of this element (i.e., the structural element of patriarchy) as delineated by Yll? (1984) and Yll? and Straus (1990) would contribute toward enhancing knowledge about the approach of professionals toward and their beliefs about wife abuse, as well as about the attitudes of professionals toward other issues that are related to domestic violence in Palestinian society. Furthermore, Haj’s (1992) discussion of the economic, sociocultural, and political transformations and transitions in Palestinian society over the past three decades and their impact on the society’s patriarchal character may provide a strong basis for studying the approach of professionals toward and their beliefs about wife abuse and other issues that are related to violence against women in Palestinian society. In this connection, Kandiyoti (1987, 1989) dealt extensively with the issue of patriarchal bargaining and the impact of government intervention or lack of intervention on emancipating women and empowering them to change or enhance the patriarchal character of the society. This may provide an additional conceptual framework for future research into the approach of physicians and other professionals toward wife abuse, based on the patriarchal perspective adopted in this study.

Future research on the approach toward wife abuse among professionals in general and physicians in particular should go beyond examining the consequences of witnessing interparental violence and experiencing family

violence. Besides those dimensions, which were examined in this study, it is necessary to examine other independent variables that derive from social learning theory. For example, Bevan and Higgins (2002) suggested that three essential factors be taken into account, as interrelated theoretical mechanisms that are relevant to the problem of wife abuse: identification with the aggressor, vicarious reinforcement, and positive reinforcement of aggression.

With regard to the first dimension, identification with the aggressor, people who are exposed to violence in their family of origin will behave violently in the future toward members of their family of procreation (e.g., their intimate partners and children), if they identified with the aggressor in their family of origin (Bevan & Higgins, 2002; MacEwen, 1994). The present study did not consider whether the Palestinian physicians identified with aggressors in their families of origin, but only examined whether they had witnessed and/or experienced violence in childhood. Therefore, it would be worthwhile to investigate the extent to which professionals identify with aggressors in their families of origin, and the extent to which such identification predicts or explains their approach toward wife abuse.

With respect to the second dimension, vicarious reinforcement, “the basic premise of this view is that physical aggression between family members provides a likely model for the learning of aggressive behavior, as well as for the appropriateness of such behavior within the family” (Bevan & Higgins, 2002, p. 225). Thus, intergenerational transmission of violence is caused primarily by principles of modeling. This dimension was adopted in the present study, as a basis for examining the extent to which there is a relationship between the physicians’ exposure to violence in childhood and their approach toward wife abuse. However, the study did not attempt to determine who served as the most significant model for formulating their attitudes toward this problem. Therefore, it would be worthwhile for future research in the field to examine whether the professionals had a violent role model in their childhood, who were the people that most influenced their behavior as well as their attitudes and approaches toward wife abuse.

As for the third dimension, positive reinforcement, people learn violence not only through exposure during childhood, but also through teaching approval for the use of violence (Bevan & Higgins, 2002). As mentioned, the present study examined the physicians' exposure to violence during childhood. However, it did not investigate whether they received approval and positive reinforcement for violence, and who gave such approval. Hence, it is recommended that future studies of professionals deal with this dimension, and that they examine which family members provided positive reinforcement for violence as well as the extent to which such reinforcement was related to the professionals' attitudes and approaches toward wife abuse.

In addition to the three dimensions discussed above, it is also recommended to examine the extent to which exposure to family violence has psychological consequences such as different types of anxiety, low self esteem, hostility (particularly toward women), frustration, etc. These dimensions can be examined as moderating variables, i.e., exploring the extent to which these consequences can enhance the relationship between such exposure and professionals' approach toward wife abuse.

In addition, it is recommended to examine how exposure of Palestinian professionals to community violence and violence between hamulot (extended families) as well as their exposure to violence in the context of the Arab-Israeli conflict affect their perspectives on battered women and violent men in particular and their approach toward the problem of wife abuse in general. It is hypothesized that exposure to these types of violence outside of the home may be conducive to approval and positive reinforcement of violence, in addition to constituting social prompts and additional sources of identification with aggressors. It is also hypothesized that these dimensions of exposure serve as additional independent variables that can explain the perspectives of professionals toward abused women.

Since the physicians' patriarchal ideology and their exposure to abuse as children predicted some of the variance in their approach toward wife abuse, it would

be worthwhile to examine additional theories that could be related to the unexplained variance in the attitudes of professionals toward wife abuse. For example, social exchange theory (Bersoni & Chen, 1988) can provide a basis for exploring the benefits and costs that professionals consider when they are asked to describe their approach toward wife abuse. For example, social exchange theory can be used to examine how professionals perceive the concept of equity, and the extent to which those perceptions predict or explain their attitudes toward wife abuse. Furthermore, resources theory can provide a basis for examining the relationship between the presence or absence of instrumental resources in the Palestinian Authority and the approach of professionals toward wife abuse. Notably, there is no law for prevention of wife abuse in the Palestinian Authority. Moreover, special services such as battered women's shelters and centers for treatment of violent men are lacking, and there are no special allowances to support battered women. In the same vein, it is possible to examine the impact of emotional resources (e.g., fear of revenge by the families of the victim and the perpetrator, anxiety, low self esteem), cognitive resources (e.g., lack of information about the problem of wife abuse, the impact of myths and stereotypes about men and women in general and violent and battered women in particular), and their relevance toward wife abuse. Other theories such as psychoanalytic theory and attribution theory can also be applied in future studies that aim to explore the attitudes of professionals toward wife abuse from a comprehensive, holistic perspective.

Above all, it should be emphasized that the present study examined the perceptions and approaches of Palestinian physicians toward wife abuse, but did not consider their actual responses to the problem. It is essential to examine these responses, mainly in terms of the way the physicians treat battered women under their care. For example, to what extent and how are the physicians involved in identifying and assessing battered women whom they encounter under their care? How do they behave toward those women and their husbands after they identify the wife as abused? To what extent do they show understanding and empathy toward the battered woman, and to what extent do they berate, belittle,

and preach to her? To what extent do they adopt an interdisciplinary approach such as involving social workers at the hospital or elsewhere, as well as police and other professionals in order to provide the most appropriate assistance to battered women and to respond to their need for protection and support? Clearly, examination of the perceptions and approaches of physicians toward wife abuse is essential for planning and implementation of training programs and guidance for physicians. However, without empirical evidence that indicates how they actually behave toward battered women and violent men, it will be difficult to provide them with the most effective guidance for intervention with battered wives and their husbands.

Limitations of the Study and Recommendations for Future Research

The importance of this study lies in its integration of two theoretical perspectives, which are applied toward examining the beliefs and approaches of Palestinian physicians toward wife abuse. Furthermore, it is important to note that the study used instruments that were developed in Western culture, and adapted them to the reality of Palestinian society. Nonetheless, several of its limitations need to be addressed.

As mentioned, a self-administered instrument package was utilized for data collection. Notably, self-report is subject to response biases and social desirability effects (Triposki et al., 1983). Although we attempted to ensure the confidentiality and anonymity of responses in addition to making sure that the participants answered the questionnaire independently, further efforts are required in order to minimize self-report bias. For example, reports by battered women who were treated by the physicians who participated in the study would provide an opportunity for cross-validation of the responses. Specifically, the reliability and validity of the results would be enhanced if

the battered women indicate how they perceive the physicians' approach toward them as well as the physicians' attitudes toward women in general and battered women in particular. Furthermore, reports by siblings and/or parents of the physicians concerning their exposure to different incidents of domestic violence (e.g., interparental violence, child abuse, and violence among siblings) would have contributed toward cross-validating responses and enhancing the reliability and validity of the results.

Participants in the study were asked to respond to questions about personal issues that are considered sensitive in Palestinian society - particularly questions about topics such as sex-role stereotypes, attitudes toward women, expectations of marriage, and violence in the family of origin. All of the instruments that measured these attitudes were developed with a clear recognition of the high potential for inaccurate reporting as well as the potential for a high rate of refusal to respond to certain items. Moreover, all of the instruments utilized in the study were developed in Western, post-industrialized societies and are not appropriate in the sociocultural context of Palestinian society, which is traditional in some aspects and transitional in others. As mentioned, attempts were made to maintain the original reliability and validity of the instruments by asking professional judges to adjust them to some cultural aspects of Palestinian society, as well as by conducting a pilot study. However, there is still no conclusive evidence that the original reliability and validity of the instruments was successfully maintained. Hence, further research should be based on more robust, complex, and conclusive methodological and statistical procedures.

Retrospective self-reports about witnessing interparental violence during childhood are also subject to distortion. For example, it cannot be determined whether the reported behavior in childhood homes was actually abusive when evaluated or measured objectively. In addition, it cannot be determined whether the abusive behavior was defined by the participants as such at the time it was experienced or witnessed, or whether it was defined as such only in retrospect. Undoubtedly, concurrent cognitive labeling of the event may influence the degree

or nature of its impact on the individual's behavior. Thus, it would have been desirable to include reports from siblings about witnessing interparental violence, or to include reports from a sample of the physicians' parents concerning past and present styles of conflict management in the family. Furthermore, a longitudinal research design would contribute toward more conclusively establishing the relationship between witnessing interparental violence in childhood and modeling influences. This would involve identification of children whose parents were known to be physically and psychologically abusive to each other. The conflict tactics used by these children in a variety of settings (e.g., school, at play with siblings and peers, etc.) could then be observed and compared with those of children whose parents were not abusive to each other.

Additional limitations of the study are related to the sample and the sampling method. In light of the existing political situation in the region and particularly in the West Bank and Gaza, it was difficult to obtain a comprehensive sampling framework that encompassed physicians from every area of the Palestinian Authority. As a result, it was not possible to select a random sample of Palestinian physicians. Even if it had been possible to select a random sample, we would not have been able to reach the selected participants due to restrictions on travel in the Palestinian Authority. Nonetheless, we did reach a convenience sample, which was heterogeneous in terms of age, religion, area of residence, and years of work experience. Owing to the heterogeneous nature of the sample, it is assumed that the participants represented Palestinian physicians from various social strata. However, it is difficult to guarantee the generalizability of the findings to all Palestinian physicians. Therefore, future studies of Palestinian physicians should attempt to cover a large random sample that includes specialists in various fields (e.g., family practitioners, physicians in different hospital wards, emergency room physicians, physicians in private clinics, physicians in public and community clinics, gynecologists, dentists, etc.) from all areas of the Palestinian Authority.

Another drawback of the study relates to the correlational and stepwise statistical procedures that were employed to analyze the results. While such statistics are

relevant to the research questions examined, they provide only a limited understanding of the overall problem under investigation. Although the correlational and regression methods may be of some value in predicting and explaining beliefs about battered wives and husbands who batter, these statistical procedures do not offer insight into the causes of the physicians' approach toward and beliefs about various issues related to wife abuse. In order to fully understand the main causes of these approaches and beliefs, triangulation methods (which focus on unstructured interviews and observational methods) and statistical procedures that have been developed for these purposes must be utilized (see, for example, Courtright et al., 1979; Rogers-Millar & Millar, 1979).

Given the limitations of the study presented above, the following suggestions are presented for future research among Palestinian physicians as well as among other professionals. These suggestions include methodological considerations, which take into account approaches toward and beliefs about wife abuse and are based on the orientations and premises of this investigation:

1. The study should be replicated among a geographically proportional random sample, which includes a larger subsample of professionals from all areas of the Palestinian Authority, in order to allow for more convincing generalization of the findings.
2. The study should be replicated among a sample that provides a more proportional representation of different segments of Palestinian society, including specialists from different areas of medicine as well as other professionals. In this way, there will be a wider variety of possibilities for comparing different segments of professionals in terms of their approaches toward and beliefs about wife abuse, as well as other issues that are related to domestic violence.
3. The study should be replicated with an improved instrument package that is translated into Arabic and adjusted to Arab society. This should be done by using strong and robust statistical and methodological procedures,

in order to more effectively test the relationships between the different constructs of the study and the extent to which they explain issues that are related to domestic violence.

4. Future research should incorporate a wider range of constructs, as derived from the theoretical framework presented here as well as from other theories, in order to explain beliefs about wife abuse and other issues that are related to domestic violence.
5. Consistent with the current investigation, it is recommended that issues related to domestic violence in Arab societies be examined beyond the level of simple description. In essence, future studies should continue to utilize conceptual frameworks developed in Western societies in order to provide theoretical and empirical indications of how professionals respond to cases of wife abuse and the causes for those responses. Specifically, further research is required in order to ascertain the feasibility of incorporating different conceptual frameworks that explain issues related to domestic violence. Such studies would contribute toward broadening knowledge of these issues.
6. Further research is recommended, in order to provide a more comprehensive - albeit not necessarily more accurate - picture of family interaction. In this connection, more emphasis should be placed on the relationship between socialization patterns and violence in the family of origin, as well as on the relevance of those variables to professionals' approach toward and beliefs about wife abuse. The research data may be more valid and reliable if they are obtained from several family members.
7. Future research should consider the impact of personal, social, cultural, political, and environmental factors and conditions on professionals' beliefs about wife abuse and about other issues that are related to domestic violence.

8. The study should be replicated among other significant people in the lives of the physicians (e.g., siblings, parents, etc.), who can serve as informants about the physicians' exposure to violence in their families of origin. Future studies should also be conducted among battered women and their families who have been under the care of the physicians, as well as among other professionals, in order to further enhance the validity and reliability of the data.
9. The study should be replicated, with more detailed demographic data and data on situational factors that relate to the professionals, their general training, and their specific training for work with abused wives and the wives' families of origin. Such data can be included in statistical and inferential procedures that aim to explain beliefs about wife abuse among professionals.
10. The above-mentioned recommendation to incorporate quantitative as well as qualitative designs in future research is strongly emphasized.

Implications for Theory Development

The present study offers some validation for the argument that beliefs and approaches toward battered wives are best explained by "multiple determinants". Notably, the research findings show that each of the two theoretical perspectives contribute, in one way or another, toward explaining the related domains mentioned above. In short, the study contributes toward the patriarchal and male dominance perspective as well as to social learning theory by showing that the basic propositions of each theory are related to the different domains of beliefs about wife abuse and approaches toward the problem. As such, the results of this investigation provide some support for Carlson's (1984) argument that "it is futile to attempt to demonstrate that one or two theories are 'correct' while the others are wrong, when there are factors at many levels that play a causal role in domestic violence" (p.571).

In order to further minimize the current inconsistency among theoretical and empirical explanations of issues related to domestic violence, as demonstrated by Dutton (1988) and Edleson et al. (1985), as well as by some results of this study, there is a crucial need to develop an integrated theory of domestic violence. A good basis for developing an integrated theory is provided by Hearn's (1958) theory building process in social work. In order to implement this process, scholars are expected to review and identify inadequacies in the present theories related to domestic violence. Appropriate constructs should be selected from these theories, and a conceptual framework for domestic violence should be developed. This framework, as suggested by Hearn, should emphasize the need for interdependent circular processes of domestic violence and its causes, as well as other related domains. This conceptual framework should be used to formulate and test hypotheses, which will ultimately provide the basis for developing an integrated theory of domestic violence. In order to facilitate the practical application of the integrated theory toward cases of domestic violence, Hearn proposes a concretizing process. Accordingly, the act of translating the integrated theory of domestic violence into practical operating terms should be an integral part of the theory-building process. Essentially, such translation means spelling out for the practitioner as specifically and concretely as possible the course of action that the theory suggests for dealing with cases of domestic violence.

The concretizing process should lead to the final phase of the theory-building process, in which the integrated theory of domestic violence meets its crucial test and achieves its ultimate fulfillment. Hearn calls this the practical test. Accordingly, if the new integrated theory of domestic violence has been soundly conceived, it will eventually - if not immediately - begin to influence and refine practice with cases of such violence. If, however, the theory is unsound, experience will reveal its weaknesses and eventually lead to its rejection and modification. Inevitably, in this stage of practical utilization, experience will reveal new gaps and inadequacies in the newly-developed theory. Such inadequacies may arise from faulty, incomplete, or inconsistent premises in the

basic value orientation toward domestic violence, or from an unfortunate choice of constructs and models from the different theories about issues related to domestic violence, as discussed earlier. Whatever the cause, Hearn suggests that if the existing theory is re-examined and found once again to be inadequate, then it will be necessary to begin the theory-building process anew.

The application of Hearn's theory-building process toward the development of an integrated theory of domestic violence is highly consistent with Edleson's et al. (1985) two directions for developing such a theory. Edleson et al. (1985) suggest that "from one direction, research questions and hypotheses based in theories from other fields of study should be explored. From the other direction, 'grounded theory' ... should be generated from empirical and clinical knowledge about [domestic violence]. Through the convergence of these two directions of study, a sound theoretical foundation for understanding [domestic violence] may be established" (p. 241, brackets added).

Finally, it should be emphasized that due to the scarcity of theoretical discussions and empirical investigations of domestic violence-related phenomena in different Arab societies, it is highly recommended that these theory-development procedures be applied toward establishing databases with relevant information on the phenomenon in an attempt to fill the gap.

Implications for Professional Training of Physicians

As mentioned, physicians can play a critical role in identifying battered women among the patients in their care, in addition to becoming actively involved in helping those women. Of course, the assistance required by these women may include protection for them and their children, support for them, and treatment of their violent husbands. The physicians can also play an active role - together with other professional staff at the hospital - in ensuring that the women receive

these types of assistance. In order to ensure the Palestinian physicians' involvement in this intervention process, they need to participate in activities such as workshops, seminars, and conferences, which will provide them with individual and group training, and enhance their involvement in identifying battered women and cooperating with other staff members in providing the women with the protection, support, and care they require.

The following are several recommendations for training and supervision of physicians, as well as some recommendations for overcoming obstacles that prevent physicians from fulfilling their professional obligations toward battered women, children of battered women, and abusive husbands. These recommendations are primarily based on the findings of our study among Palestinian physicians. To some extent, the recommendations are also based on the experience of physicians in other countries as presented in the professional literature.

First, although the Palestinian physicians' definitions of wife abuse reflected their considerable awareness of the problem and of various patterns of violence against women, their responses also included indications that they are not always willing to consider acts of violence as wife abuse (e.g., when the woman is perceived by the physicians as provoking her husband). Therefore, there is a need to challenge the perceptions and debunk the misconceptions that cause physicians to refrain from referring to certain violent acts as abuse - for regardless of the context, violence has to be acknowledged for what it is.

Second, although the responses of the physicians indicate their awareness of some of the causes of wife abuse, some of them mentioned causes that have not been empirically or clinically confirmed in the literature. It is therefore important to enhance the Palestinian physicians' awareness of the true causes of and risk factors for wife abuse, with special emphasis on causes and risk factors that have already been empirically and clinically established (e.g., from the ecological perspective). Concomitantly, there is a need to shatter myths and contravene

erroneous perceptions that the physicians may have regarding causes of wife abuse that have not been confirmed in the literature (e.g., alcoholism, “causes” attributed to the wife’s personality, or “causes” attributed to marital relations as mentioned by the physicians).

Third, there is a need to change erroneous perceptions that were revealed among the Palestinian physicians (see Table 1). For example, they should be made more aware of the real high rates of wife abuse in Palestinian society, and should realize that the problem exists at all levels of the society. Moreover, the physicians should be made aware that women can become victims of violence by their husbands regardless of their personality (because battering is related to the husband and not to the wife, and because the wife’s psychological situation is the result of battering and not the cause of it). In addition, there is a need to change the physicians’ perception that women benefit from battering, and they feel relieved after their husbands batter them. Concomitantly, physicians should be made aware of the severe consequences of wife abuse (physical consequences such as wounds, cuts, fractures, bleeding, etc as well as psychological consequences such as anxiety, fear, low self esteem, anger, grief, hopelessness and helplessness, depression, contemplation of suicide, stress, PTSD, impaired psychosocial functioning, and deterioration of her motherhood).

Fourth, there is a need to explain to the physicians that wife abuse is unjustified, irrespective of its severity, of the wife’s behavior, and of any other situation as mentioned earlier (see Tables 2 and 3). At the same time, there is a need to explain to the Palestinian physicians that wife abuse is by no means the responsibility of the battered wife. Rather, it is the exclusive responsibility of the perpetrator husband.

Fifth, even though the Palestinian physicians clearly indicated that they are willing to help battered women, it is important to note the priorities they mentioned for helping battered women. The physicians’ responses indicate that they tend to attribute high priority to preserving the family at almost price, and

that they tend to prefer intervention by relatives and community members who are not professionally qualified to work with battered women. Indeed, Palestinian physicians should also be encouraged to invest efforts in enlisting assistance from relatives of the battered wife and/or from relatives of the perpetrator husband or from people in the general social network of the couple who can provide protection and support for the woman and her children and pressure the husband to seek treatment. Nonetheless, they should be made aware that intervention by nonprofessionals may harm the woman, and prevent her from receiving the protection and support she needs. Our experience has shown that nonprofessionals from the social network of the husband and/or the wife usually blame the battered woman (and support the perpetrator husband). In the same vein, they tend toward preserving the marital relationship and family at any expense - even at the expense of the woman's safety and well-being - and they tend to preach to the woman rather than calm her down and offer her support and encouragement.

Sixth, the findings of our study revealed that the physicians' perceptions of wife abuse are largely explained by their patriarchal perspectives as well as by their exposure to violence in their own families of origin. It is therefore recommended to train doctors to make efforts to change their patriarchal ideology, with special emphasis on changing their negative and conservative attitudes toward women, as well as changing their nonegalitarian expectations of marriage and sex-role stereotypes. In addition, the physicians should be given an opportunity to have a corrective experience, in which they become aware of the psychological and cognitive consequences of their exposure to family violence. It is assumed that this experience will substantially reduce the physicians' tendency to justify wife abuse, as well as their tendency to blame the battered woman for violence against her. The experience will also enhance their sensitivity toward the suffering of battered women, and make them more willing to become involved in identifying, assessing, and helping battered women.

The Approach of Palestinian Physicians Toward Wife Abuse

Notwithstanding these recommendations, there are numerous barriers and factors that prevent Palestinian physicians from providing assistance to battered women. These include: sociocultural factors (e.g., societal tolerance of violence); personal factors (e.g., idealized concepts of family life, sex bias, privacy concerns, sense of powerlessness, hostility toward women, personal history of abuse, etc.); professional barriers and factors (e.g., time constraints, inadequate skills, professional relationship with the abuser, etc.), and institutional and legal barriers and factors (e.g., fear of legal reprisal, limited institutional resources, inadequate or unclear policies, etc.).

It should be mentioned that a report submitted to the Ford Foundation (Haj-Yahia, 1998c), and a social policy proposal that we just completed writing for the Bisan Center, provide a comprehensive discussion and recommendations for contending with these barriers and factors. Therefore we briefly mentioned the barriers and factors, in order to emphasize their role in reducing chances that Palestinian physicians will become involved in dealing with cases of wife abuse. For a more comprehensive discussion of how the Palestinian Authority can deal more effectively with this severe problem, we refer the readers to the above-mentioned reports.

Table 1: General Approach Toward Abused Wives and Abusive Husbands (Percentages, Mean, and Standard Deviation) (N=396)

Physicians' Approach toward Abused Wives	A	U	D	Mean	s.d.
1. A very small percentage of Palestinian wives are abused by their husbands.	44	26	30	1.87	.05
2. Wives are abused because of the abnormal way they treat their husbands.	29	37	34	2.06	.79
3. Most abused wives feel relieved after their husbands batter them.	10	35	55	2.45	.67
4. The percentage of lower-class abused wives is far higher than in the higher classes.	43	36	21	1.78	.77
5. If the wife truly believed in God, she would never have been abused by her husband.	48	31	21	1.73	.79
6. The percentage of educated women who are abused is far less than that of uneducated women.	49	26	25	1.76	.83
7. Even in an abused wife gets a divorce and remarries, she will be abused by her second husband.	10	37	53	2.44	.66
8. If the abused wife understood her husband's life conditions, he certainly would not have abused her.	38	37	25	1.88	.79
9. If the woman had supported her husband when he was going through hard times, he certainly would not have abused her.	43	39	18	1.75	.74
10. If the wife had really wanted her husband to stop attacking her, she would simply have divorced him.	15	41	44	2.29	.71
11. Most abused wives deserve to be treated violently by their husbands.	16	38	46	2.31	.73
Physicians' Approach toward Abusive Husbands					
1. If the husband truly believes in God, he will never abuse his wife.	63	25	12	1.49	.70
2. Abusive husbands usually behave violently in other places as well (e.g., on the street and at work).	29	38	33	2.04	.79
3. Drinking alcohol causes husbands to abuse their wives.	63	27	10	1.47	.67
4. Abusive husbands are usually failures, and cannot deal with difficult situations in their lives.	34	42	24	1.90	.76
5. Abusive husbands are mentally ill.	23	48	29	2.05	.72
6. Abusive husbands usually don't love their wives.	15	48	37	2.22	.69
7. Most husbands who abuse their wives also abuse their children.	37	35	28	1.92	.81

Abbreviations: A=Agree, U=Undecided; D=Disagree, s.d.=standard deviation

Table 2: Extent of Support for Minor Violence (e.g. Slapping) and Severe Violence (e.g., Hitting with a Belt, a Stick, or a Shoe) Against the Wife in Different Situations (N=396)

Situations	Minor Violence		Severe Violence	
	Mean	s.d.	Mean	s.d.
1. The wife threatens her husband with a knife.	3.12	1.33	3.58	1.37
2. The wife beats her children.	3.49	1.18	3.90	1.17
3. The husband finds his wife in bed with another man.	3.08	1.56	3.32	1.63
4. The wife screams angrily and in a hysterical manner.	3.38	1.17	3.87	1.24
5. The husband has been told (after getting married) that his wife had an affair before their marriage.	3.68	1.23	3.97	1.19
6. The husband has been told that his wife is currently having an affair.	3.06	1.44	3.37	1.49
7. During a heated argument, the wife initiated an attack against her husband.	3.24	1.24	3.75	1.19
8. The wife keeps criticizing her husband and accusing him of being a failure.	3.34	1.05	3.76	1.12
9. The wife returns home drunk.	3.04	1.48	3.32	1.54
10. The husband suspects his wife is having an affair.	3.38	1.18	3.73	1.14
11. The wife insults her husband in front of others.	3.60	1.16	3.91	1.16
12. The wife neglects the home while spending most of her time visiting relatives.	3.10	1.37	3.58	1.40
13. The wife insults her husband while both of them are alone at home.	3.20	1.21	3.69	1.27
14. The wife insults her husband in front of their children.	3.20	1.30	3.59	1.37
15. The wife does not fulfill the requests of her husband.	3.39	1.21	3.68	1.21
16. The wife neglects cleaning the house for weeks.	3.54	1.09	3.76	1.19
17. The wife doesn't prepare food for her husband and children, despite the fact that she doesn't work outside the home.	3.66	1.06	3.83	1.10
18. The wife irritates her husband by giving him an endless list of requests.	3.58	1.07	3.80	1.17
19. The wife doesn't respect her parents-in-law.	3.43	1.22	3.78	1.17
20. The wife squanders money.	3.58	1.11	3.71	1.16
21. The wife doesn't respect her husband's way of thinking and scorns him in front of his family and friends.	3.24	1.30	3.50	1.31
22. The wife responds to her husband disrespectfully.	3.34	1.14	3.69	1.19
23. The wife irritates and provokes her husband by constantly putting him down.	3.43	1.17	3.69	1.14
24. The wife keeps interfering in her husband's social life.	3.64	1.12	3.88	1.12
25. The wife refuses to have sex with her husband.	3.73	1.33	3.96	1.21

s.d.=Standard Deviation

The responses ranged from 1=Strongly Agree to 5=Strongly Disagree

**Table 3: Beliefs about Wife Beating
(Percentages, Mean, and Standard Deviation) (N=396)**

Beliefs about Wife Beating	SA	AG	UD	DA	SD	Mean	s.d.
1. A husband has the right to beat his wife if she breaks agreements between them.	3	21	22	32	22	3.50	1.13
2. A husband has the right to beat his wife if she makes fun of his manhood.	15	32	22	21	10	2.79	1.22
3. A wife deserves to be beaten if she keeps reminding her husband of his weak points.	10	25	28	26	11	3.03	1.17
4. A wife who lies to her husband deserves to be beaten.	6	20	33	30	11	3.20	1.09
5. A sexually unfaithful wife deserves to be killed.	20	16	16	26	22	3.15	1.45
6. It would do some wives good to be beaten by their husbands.	11	19	26	24	20	3.23	1.28
7. Occasional violence by a husband toward his wife can help maintain the marriage.	8	18	25	33	16	3.30	1.19
8. A wife who constantly refuses to have sex with her husband is asking to be beaten.	10	21	23	29	17	3.24	1.26
9. There is no excuse for a man to beat his wife.	16	18	28	24	14	3.02	1.28
10. Episodes of wife-beating are the wife's fault.	6	20	30	29	15	3.27	1.14
11. Sometimes the wife's provocative words cause her husband to beat her.	7	20	20	28	15	3.25	1.15
12. A husband has the right to beat his wife if she doesn't respect his parents.	9	21	23	30	17	3.24	1.23
13. A husband has the right to beat his wife if she doesn't respect his relatives.	8	20	23	36	13	3.29	1.19
14. A wife who insults her husband and is disrespectful toward him in front of his friends deserves to be beaten.	8	31	24	25	12	3.01	1.18
15. A woman who constantly disobeys her husband is asking to be beaten.	11	27	25	22	15	3.04	1.25
16. When a woman is beaten, it is caused by her behavior during the weeks beforehand.	8	24	29	24	15	3.13	1.19
17. Battered wives are responsible for their abuse because they intended it to happen.	6	15	31	28	20	3.43	1.15
18. Men are incapable of controlling themselves, and therefore they beat their wives.	9	24	27	24	16	3.13	1.22
19. Women are usually beaten because they keep talking nonsense.	7	21	32	26	15	3.21	1.13
20. If the wife had known her boundaries, her husband wouldn't have beaten her.	18	23	28	22	9	2.81	1.23
21. In most cases, battered women are responsible for being beaten.	7	19	30	31	13	3.25	1.10
22. Battered wives are responsible for being abused because they should have foreseen that it would happen.	10	20	36	22	12	3.07	1.16
23. Battered wives try to get their partners to beat them in order to gain attention from others.	7	17	27	31	18	3.35	1.18
24. Most wives secretly desire to be beaten by their husbands.	4	18	21	29	28	3.59	1.20
25. Wives try to get their husbands to beat them in order to gain sympathy from others.	7	14	24	28	27	3.56	1.21
26. Women feel pain and no pleasure when they are beaten by their husbands.	34	28	19	13	6	2.29	1.24
27. Husbands who beat their wives should be arrested.	7	20	30	27	16	3.28	1.17

Table 3 (continued)

Beliefs about Wife Beating	SA	AG	UD	DA	SD	Mean	s.d.
28. If a wife tells me that her husband abuses her, I prefer not to intervene.	9	24	35	22	10	3.01	1.12
29. If I heard a husband beating his wife, I would call the police.	6	21	25	32	16	3.31	1.16
30. The Palestinian Authority should give wife abuse very high priority over many other social problems.	20	36	21	16	7	2.53	1.19
31. Social agencies should do more to help battered women.	25	30	24	11	10	2.50	1.26
32. Women should be protected by law against beating.	24	35	21	14	6	2.45	1.21
33. If a woman tells me that her husband beats her, I will help her in any way I can.	14	34	32	12	8	2.67	1.13
34. If a woman is battered, her family should give the problem high priority as a family problem.	24	30	18	18	10	2.60	1.32
35. I believe that the hospital I work at should offer the best services and assistance to battered women.	13	35	25	15	12	2.80	1.21
36. I think that if I try to help a battered woman it will make things worse.	10	20	38	20	12	3.05	1.14
37. I think that any woman who is beaten by her husband should get a divorce.	7	15	25	32	21	3.47	1.19
38. I would advise any abused woman to leave her husband and move in with her family of origin.	8	18	25	33	16	3.31	1.18

SA=Strongly Agree; AG=Agree; UD=Undecided; DA=Disagree; SD=Strongly Disagree; s.d.=Standard Deviation.

**Table 4: Zero-Order Correlations
among All Independent and Dependent Variables (N=396)**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	Mean	s.d.
1 AGE	-	-.09	-.01	.32 ^d	.20 ^c	-.09	.11	.11	.01	.03	.03	.02	.08	.11	.19 ^b	.13 ^a	.15 ^a	-.17 ^b	39.20	8.40
2 REL	-	-	-.15 ^b	.06	.03	.01	.16 ^b	.17 ^b	.09	.03	.09	.04	.12	.10	.13 ^a	.11	.16 ^b	.08	.93	.25
3 PLA	-	-	-	.05	.06	.05	.05	.11	.06	.01	.06	.02	.02	.09	.13 ^a	.04	.03	.04	.60	.49
4 GEN	-	-	-	-	.13 ^a	.08	.13 ^a	.23 ^d	.07	.08	.17 ^a	.06	.04	.10	.15 ^a	.15 ^a	.20 ^b	-.12 ^a	.74	.44
5 SRS	-	-	-	-	-	.16 ^a	.28 ^d	.33 ^d	.07	.07	.09	.02	.02	.03	.31 ^d	.32 ^d	.17 ^b	-.28 ^d	60.26	12.85
6 WSI	-	-	-	-	-	-	.33 ^d	.26 ^d	.02	.03	.04	.06	.02	.08	.16 ^b	.17 ^b	.04	-.20 ^b	30.21	9.06
7 ATW	-	-	-	-	-	-	-	.48 ^d	.16 ^b	.06	.10	.03	.21 ^b	.19 ^a	.31 ^d	.43 ^d	.05	-.12 ^a	31.86	7.50
8 MRE	-	-	-	-	-	-	-	-	-.13 ^a	.08	.01	.12	.24 ^c	.29 ^d	.42 ^d	.40 ^d	.17 ^b	-.29 ^d	49.80	8.51
9 FTM	-	-	-	-	-	-	-	-	-	.53 ^a	.65 ^d	.37 ^d	.33 ^d	.37 ^d	.20 ^c	.18 ^b	.09	-.10	23.51	9.95
10 MTF	-	-	-	-	-	-	-	-	-	-	.62 ^d	.42 ^d	.21 ^b	.23 ^b	.02	.01	.03	-.01	19.31	6.66
11 FTP	-	-	-	-	-	-	-	-	-	-	-	.56 ^d	.36 ^d	.37 ^d	.07	.09	.18 ^b	-.14 ^a	23.67	8.51
12 MTP	-	-	-	-	-	-	-	-	-	-	-	-	.27 ^d	.32 ^d	.19 ^b	.12 ^a	.09	.02	24.00	8.55
13 APM	-	-	-	-	-	-	-	-	-	-	-	-	-	.75 ^d	.33 ^d	.24 ^c	.11	.08	98.64	20.74
14 APS	-	-	-	-	-	-	-	-	-	-	-	-	-	-	.30 ^d	.17 ^a	.08	.08	108.35	24.31
15 JWB	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	.80 ^d	.35 ^d	-.24 ^d	44.07	10.73
16 BBW	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	.31 ^d	-.16 ^d	43.11	10.12
17 WBV	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-.43 ^d	17.56	3.93
18 HBW	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	33.17	8.51

Abbreviations: AGE=Age; REL=Religion (1=Muslim, 0=Christian); PLA=Place of Residence (1=Urban Areas, 0=Rural Areas and Refugee Camps); GEN=Gender (1=Male, 0=Female); SRS=Sex-Role Stereotypes; WSI=Attitudes Toward Women's Social Integration; ATW=Attitudes Toward Women; MRE=Marital Role Expectations; FTM=Father-To-Mother Violence; MTF=Mother-to-Father Violence; FTP=Father-To-Participant Violence; MTP=Mother-To-Participant Violence; APM=Approval of Minor Violence; APS=Approval of Severe Violence; JWB=Justifying Wife Beating; BBW=Blaming Battered Women; WBV=Women Benefit from Violence; HBW=Helping Battered Women; s.d.=Standard Deviation.

Table 5: Regressions of Approving Minor and Severe Wife Abuse, and of Justifying Wife-Beating on Sociodemographic Characteristics, Witnessing and Experiencing Family Violence, Attitudes toward Women, and Marital Role Expectations

Predictors	Approval of Minor Wife Abuse			Approval of Severe Wife Abuse			Justifying Wife Beating		
	B	β	t-value	B	β	t-value	B	β	t-value
Age	.17	.07	.93	.10	.03	.44	.11	.08	1.26
Religion	9.41	.12	1.59	2.86	.03	.43	.40	.01	.15
Place of residence	-1.54	-.05	-.70	-3.75	-.11	-1.48	-1.67	-.11	-1.66
Gender	6.22	.13	1.57	10.26	.18 ^a	2.29	.14	.01	.09
Witnessing interparental violence	.21	.14	1.47	.41	.25 ^a	2.47	.12	.17 ^a	1.99
Experiencing parental violence	.32	.23 ^a	2.35	.30	.18	1.78	.03	.03	.35
Attitudes toward women	.54	.20 ^a	2.19	.28	.18 ^a	2.01	.02	.22 ^d	4.19
Marital role expectations	.31	.21 ^a	2.50	.852	.31 ^c	3.49	.44	.36 ^d	4.86
R ² adjusted, df, and F	.36	8, 326	12.95 ^d	.44	8, 323	29.29 ^d	.32	8, 321	10.64 ^d
Constant: B and Standard Error	126.88		16.73	119.98		19.32	7.34		

Religion: 1=Muslim, 0=Christian; Place of Residence: 1=Urban Areas, 0=Rural Areas and Refugee Camps; Gender: 1=Male, 0=Female; a: p<.05; b: p<.01; c: p<.001; d: p<.0001.

Table 6: Regressions of Blaming Women for Being Beaten, the Belief that Women Benefit from Beating, and Willingness to Help Battered Women on Sociodemographic Characteristics, Witnessing and Experiencing Family Violence, Attitudes toward Women, and Marital Role Expectations

Predictors	Blaming Women for Being Beaten			Women Benefit from Beating			Helping Battered Women		
	B	β	t-value	B	β	t-value	B	β	t-value
Age	.07	.06	.83	.05	.11	1.63	-.05	-.07	-.01
Religion	3.58	.09	1.35	2.39	.15 ^a	2.32	-1.07	-.05	-.69
Place of residence	-.93	-.06	-.99	-.23	-.04	-.57	.43	.05	.71
Gender	.34	.02	.23	1.52	.17 ^a	2.45	-.45	-.03	-.48
Witnessing interparental violence	.08	.11	1.36	.03	.10	1.23	-.03	-.08	-.91
Experiencing parental violence	.04	.05	.61	.05	.19 ^a	2.20	-.06	-.14	-1.62
Attitudes toward women	.29	.21 ^b	2.69	.17	.30 ^d	3.84	-.18	-.19 ^a	-1.97
Marital role expectations	.25	.22 ^b	2.91	.10	.21 ^b	2.70	-.18	.25 ^c	-3.26
R ² adjusted, df, and F	.31	8, 324	9.98 ^d	.27	8, 320	8.93 ^d	.28	8, 322	9.04 ^d
Constant: B and Standard Error	21.13		7.01	11.99		2.88	47.40		4.37

For values of Religion, Place of Residence, and Gender, see Table 5.

a: $p < .05$; b: $p < .01$; c: $p < .001$; d: $p < .0001$.





