

Attitudes towards domestic violence in Lebanon:

a qualitative study of primary care practitioners

Abstract

Background

Domestic violence (DV) is highly prevalent in the developing and developed world. Healthcare systems internationally are still not adequately addressing the needs of patients experiencing violence.

Aim

To explore physicians' attitudes about responding to DV, their perception of the physician's role, and the factors that influence their response.

Design and setting

Qualitative study using individual interviews among primary care practitioners working in Lebanon.

Method

Primary care clinicians practising for >5 years and with >100 patient consultations a week were interviewed. Physicians were asked about their practice when encountering women disclosing abuse, their opinion about the engagement of the health services with DV, their potential role, and the anticipated reaction of patients and society to this extended role.

Results

Physicians felt that they were well positioned to play a pivotal role in addressing DV; yet they had concerns related to personal safety, worry about losing patients, and opposing the norms of a largely conservative society. Several physicians justified DV or blamed the survivor rather than the perpetrator for triggering the violent behaviour. Moreover, religion was perceived as sanctioning DV.

Conclusion

Perceived cultural norms and religious beliefs seem to be major barriers to physicians responding to DV in Lebanon, and possibly in the Arab world more generally. Financial concerns also need to be addressed to encourage physicians to address DV.

Keywords

Arab world; attitude; domestic violence; Lebanon; primary health care.

INTRODUCTION

Domestic violence (DV) is a major public health concern and a frequently encountered clinical problem in primary healthcare settings. A World Health Organization (WHO) multi-country study has shown that the lifetime prevalence of DV ranges from 15% to 71%.^{1,2} Internationally, healthcare services are not sufficiently engaged with patients experiencing DV, with clinicians not asking about abuse, not responding appropriately when patients disclose, and not referring them to DV specialists services, where these exist, in line with current WHO guidelines.³ Barriers to inquiry about and management of DV include a belief that DV is irrelevant to health care, negative cultural social attitudes, institutional constraints, feeling powerless to offer a solution, lack of knowledge, training, resources, and time, fear of offending the woman and of opening up a 'Pandora's box'.⁴⁻⁸

In the Arab world, few studies have measured the prevalence of DV in healthcare settings. In Syria and Jordan, 15% and 87% of women, respectively, who attended a healthcare centre disclosed abuse by their husbands;^{9,10} while 35% of women users of primary care in Lebanon were found to be exposed to violence.¹¹ The attitudes of physicians towards DV in the Arab world, as revealed by a small number of studies, were controversial. Sixty per cent of 565 primary care physicians (PCPs) in Kuwait were ready to be involved in managing DV,

but the majority responded that there are 'good reasons to hit a wife'.¹² Seventy per cent of Sudanese physicians indicated they would not intervene with battered women beyond essential medical treatment,¹³ while some Palestinian physicians consider that only a small percentage of Palestinian wives are abused by their husbands and those most abused wives feel 'relieved after their husbands batter them'.¹⁴

In most Arab countries, family matters including DV continue to be handled by religious courts as civil legislation does not criminalise acts of violence within the family. In Lebanon, a law to this effect has been debated within a parliamentary committee since 2010. It is strongly opposed as it conflicts with much current legislation based on tradition. For example, article 503 defines rape as a forcible sexual act committed against someone other than a spouse.¹⁵

In view of the growing consensus internationally, as reflected in the WHO guidelines on intimate partner violence,¹⁶ that health services need to address the needs of their patients experiencing abuse, and the anticipated changes that would emerge in Lebanon if the DV law were approved, this study aimed to explore physicians' attitudes towards DV in Lebanon, their perception of their role in responding to DV in the context of healthcare services, the barriers to their involvement, and their attitude towards the proposed family violence law.

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How this fits in

Domestic violence is a major public health concern and clinical challenge, yet physicians in Lebanon (and internationally) are generally reluctant to ask about abuse and engage with the problem. Cultural beliefs and norms could be barriers to the involvement of physicians in cases of domestic violence and influences their level of engagement. Concern about potential threats to personal safety and income also inhibit physicians from engaging their patients experiencing domestic violence.

METHOD

This study involved one-to-one semi-structured interviews of primary care practitioners working in Lebanon.

Sample selection

All obstetricians, paediatricians, GPs, and family physicians (in Lebanon a GP practises medicine directly after 7 years of medical school, whereas family medicine is a 4-year specialty) registered in the Lebanese Order of Physicians (LOP) were included. The institution review board at the American University of Beirut proposed a minimum of 50 informants to be recruited. The research team decided to continue recruitment until data saturation, which was achieved after 67 interviews. Taking into consideration a likely 25% response rate, a total of 300 physicians were randomly selected from a list provided by LOP, stratified by a male:female ratio of 10:1, the sex distribution of the physicians in Lebanon according to LOP.

Inclusion criteria

Experienced physicians (≥ 5 years post-training) and those with intensive patient contact (≥ 100 consultations/week) were included to ensure that participating physicians' views were based on extensive experience. Since physicians in urban settings had more accurate records of their addresses and were more accessible, only physicians practising in three governorates (Beirut, Mount Lebanon, and South Lebanon) were interviewed. The three regions also reflect the diverse religious communities in Lebanon.

Recruitment

Physicians were initially contacted by telephone and the objectives of the study were explained. To encourage participation physicians were assured that the interview would not take more than 15 minutes and would not interfere with the workflow of

appointments. If they met the inclusion criteria, verbal consent was obtained to participate and audiorecord the interview; then an appointment for the interview in the clinic was set. On the day of the scheduled interview, physicians were contacted again to confirm the appointment. Those who cancelled were replaced by physicians from the same medical field, sex and geographical area whenever possible. Before starting the interview, the study objectives were restated and written consent was obtained.

Data collection

The face-to-face interviews were conducted by a university graduate with prior experience in conducting interviews using a semi-structured topic guide. The interviewer also worked in a local non-governmental organisation that assists DV survivors. The interview guide (Appendix 1) was developed in Arabic and pilot tested with four physicians. Physicians were asked open-ended questions that tackled broad themes about their practice when encountering patients disclosing violence, their opinion about involving health care in violence, the role they can potentially play in responding to violence, and reactions they would anticipate from patients and wider society. The questions about violence did not specify the family members perpetrating or experiencing the abuse. In this study only responses about DV were reported; that is, violence perpetrated by and experienced by adults in the family. All interviews were conducted in Arabic and audiorecorded. The interviews were transcribed and anonymised by referring to the participant with the following items (location, sex, age, and specialty). Transcription and coding of the interviews were conducted concurrently and interviews continued until data saturation occurred.

Data analysis

The transcripts were coded by the authors into various data driven headings. Reviewing the Excel sheet that summarised the headings and supporting quotes, the data were synthesised into themes, and searched for conflicting or contradictory data between informants. Any discrepancy was discussed until an agreement was reached. The themes were analysed according to the physician's specialty, sex, location of practice (governorate), and years in practice.

RESULTS

Sample characteristics

Three hundred physicians were initially

contacted: 137 satisfied the inclusion criteria and 92 consented to participate in the study. Reasons given for declining participation included insufficient time for interviews, unwillingness to participate in research in general, and no payment for the time spent during the interview. On the scheduled day of interview, 22 physicians cancelled the appointment.

Saturation of themes was achieved after 67 interviews. Mean age of the participants was 45 years (SD±9 years) and 15 were female. The distribution across the specialties and geographic areas is shown in Table 1. Mean duration of medical practice was 19 years (SD± 9 years). The average duration of the interview was 15 minutes.

All physicians said they had encountered cases of DV in their practice with a wide estimated prevalence ranging from 0.5% to 70% of female patients experiencing abuse from adult family members. Physicians with longer duration in practice and female physicians reported higher prevalence than their counterparts. There was minimal difference by geographic area (governorate) or by field of practice.

Experiences and opinions of physicians

Exploring physicians' experiences and opinions revealed six themes:

- DV as a non-medical issue;
- DV justification;
- role of physicians as a mediator for reconciliation;
- concerns regarding their personal safety;
- concerns of a negative impact on their clinical practice; and
- scepticism concerning support from the authorities.

DV as a non-medical issue. Many physicians considered DV either a social, behavioural, or psychological issue rather than a medical problem. *'It is not our business'*

they said and this viewpoint was backed up by some that if:

'... [it] were medical, it should have been taught in medical schools.' (South, male, 39 years old, general practice)

Several practitioners considered that DV:

'... becomes only medical when there are bruises or physical damage.' (Beirut, male, 42 years old, family medicine)

Responders considered that psychological violence was non-medical. The medical professionals *'won't interfere'* except to *'treat the damages'* (Beirut, male, 65 years old, paediatrics) and they:

'... have no right to intervene in such problems at all unless the patient or some family members asked them to interfere.' (Beirut, male, 42 years old, obstetrics/gynaecology)

DV justification. Several physicians commented that certain characteristics in a person invite aggression. Some women are said to have unbearable behaviour, are provocative, or:

'... are very edgy and attract violence.' (Mount Lebanon, male, 37 years old, general practice).

This physician even stated that *'some persons are masochists and like to be beaten'*. A few physicians believed that violence is allowed by religion and that some religious doctrines allow hitting in certain contexts. Physicians were in favour of keeping DV management within the remit of religious authorities and opposed the proposed DV law that is being discussed in the Lebanese parliament:

'Domestic violence law is wrong and disagrees with our Islamic law and our

Table 1. Characteristics of the interviewed primary care practitioners (n = 67)

	N (%)	Beirut, n (%)	Mount Lebanon, n (%)	South Lebanon, n (%)	Bekaa, n (%)	North Lebanon, n (%)	Female, n (%)
Family medicine	8 (12)	4	2	1	0	1	2
GP	18 (27)	5	7	2	2	2	4
Obstetricians	16 (24)	7	2	1	4	2	4
Paediatrician	25 (37)	7	8	3	4	3	5
Total	67 (100)	23 (35)	19 (28)	7 (10)	10 (15)	8 (12)	15 (22)

traditions. In Europe it is different, a girl can denounce her father in case he hits her but this can't work over here.' (South, male, 39 years old, general practice)

Role of physician as a mediator of reconciliation. Physicians acknowledged their role in addressing DV, recognising their social status and the power they have over their patients as doctors. They are usually close to their patients and are involved frequently in their personal issues; patients will find themselves more comfortable discussing the situation with their doctors. Some proposed becoming mediators of reconciliation. They would try to connect the involved parties and discuss the issue with the husband, aiming to resolve the situation between the couples. Several physicians would ask the woman to tolerate the behaviour and be patient and give her hints on how to avoid DV. Some would prescribe tranquillisers and antidepressants:

'To calm her [the woman] down.' (Beirut, female, 36 years old, obstetrics/gynaecology)

This physician also stated that she:

'... had a woman who had an abortion because of severe physical violence. He [husband] told me he regretted what he did, but the woman wanted to get a divorce so I tried to calm her and I gave her tranquillisers.' (Beirut, female, 36 years old, obstetrics/gynaecology)

Concerns regarding their personal safety. Some physicians were worried about their personal safety:

'The aggressor is a violent person and I got actually beaten by people who came to my clinic to discuss violence.' (South, male, 55 years old, family medicine)

Several physicians expressed worry concerning the risk of getting entangled in religious discussions that might endanger their lives, especially as the religious laws govern family relations:

'We live in a religious community ... this is why I can't always discuss the issue especially with religious narrow-minded people.' (South, male, 55 years old, family medicine)

Some expressed the need to have a protective law:

'No one will protect me.' (Tripoli, male, 39 years old, paediatrics)

'I [would] feel secure if the law would protect me from any consequences of reporting or interfering.' (Mount Lebanon, female, 43 years old, family medicine)

Concerns of a negative impact on their practice. Some of the physicians anticipated that getting involved with DV may deter patients from coming to their clinics because it is such a stigmatising issue. Patients may feel embarrassed and get uncomfortable as:

'... people like to show the best of them so it may be embarrassing for them.' (Mount Lebanon, male, 37 years old, general practice)

Physicians also feared that they would be labelled for asking personal questions and getting involved in personal issues. The word would spread and then patients would not be daring enough to ask for their services.

In addition, attending to DV cases can be time consuming, which would affect a busy schedule in clinic. Some expressed their willingness to:

'... [give] time to interfere in the beginning but not to monitor and follow-up the cases.' (Mount Lebanon, male, 32 years old, paediatrics)

Yet, there were a few physicians who were ready to dedicate time and:

'... postpone a lot of things so that I would have time to discuss and follow-up a case.' (South, male, 55 years old, family medicine)

Scepticism concerning the support from the authorities. Physicians expressed their reluctance to report cases of DV, in case the proposed DV law that criminalises DV was approved. They believed it was a personal matter where there are *'[a] lot of tribes'* (Beirut, male, 42 years old, paediatrics), or because of lack of adequate response from the authorities:

'In Lebanon you cannot just bring authorities into family problems.' (Beirut, male, 52 years old, obstetrics/gynaecology)

Therefore, there was explicit avoidance of contact with authorities *'unless the case is brutal'* (Beirut, male, 66 years old, paediatrics) and some considered:

'Calling the police would make a scandal and I would be causing the family more problems.' (Bekaa, male, 37 years old, general practice)

Many physicians favoured that the patients themselves or a forensic doctor report the incidents to the authorities, especially in the absence of clear guidelines of what to do and who to contact, along with general scepticism about implementation of the currently debated DV law if it was approved by the parliament:

'It is a nice law but it will never be applied just like the law which forbids smoking or the driving laws; none of these laws is applied.' (South, male, 34 years old, general practice)

DISCUSSION

This is the first qualitative study in the Arab world that reports the attitudes and concerns of physicians towards involvement of the health care services in the management of DV.

This study reveals that religion, cultural beliefs, fear of losing patients, and personal safety were key barriers to physicians responding to their patients experiencing DV in Lebanon, which may also be the case in other parts of the Arab world.

The participants were concerned about opposing perceived societal norms, running the risk of being stigmatised and being ostracised for opposing the teachings of religion with regard to DV which potentially would turn patients away from their practices or clinics. This fear of losing patients (and income) if the physician started addressing DV in clinical practice has not been reported previously. In countries like Lebanon, where the patient pays the physician directly and payment is made most often by the man, who is usually the financial supporter of the household, this concern may be justifiable and has to be addressed. A few physicians were willing to take on, and some actually were practising, the role of mediator between perpetrator and victim of violence, in an attempt at reconciliation. Although mediation's safety and effectiveness is contestable,²² it may be one possible alternative solution to survivors in conservative societies like the Arab world, where divorce is considered taboo and helpful resources are scarce.

Strengths and limitations

This study has several limitations as participation was limited to primary care physicians in urban settings and their

opinions may not reflect those of doctors practising in rural areas. Moreover, physicians who agreed to participate without payment could be more engaged with DV, interested in the topic or more knowledgeable about DV. Another limitation is the brevity of the interviews. The interviews explored the general attitude or opinion of the physicians concerning the majority of cases and did not go into depth about the cases they have encountered. The interviewer's work experience in DV organisations and her commitment to improving outcomes for women experiencing abuse may have skewed informants' responses towards a positive depiction of the physicians' role in relation to DV. On the other hand, the narrative that emerged from the interviews covered a wide range of views. It is also recognised that the transcripts were analysed by female family physicians interested in increasing the engagement of physicians in the management of DV survivors. Researchers from a different disciplinary background could have identified different themes.

Comparison with existing literature

When asked for their opinions concerning wife abuse and their proposed interventions to the problem in general, the physicians in this study perceived DV a social rather than a medical issue and did not consider intervening in it as part of their professional responsibilities. Almost all physicians preferred their role in DV management to be limited to treating medical symptoms or physical injury. The attitude of physicians towards involvement in DV is quite varied among different countries. While physicians in US, Canada, Australia, and UK¹⁷⁻²⁰ consider DV to be a healthcare issue and welcome the involvement of physicians in the management of DV, physicians in conservative countries like Lebanon (such as, Sudan, Pakistan, and Jordan^{9,13,21}), still consider DV as not directly concerning health care, other than treating injuries.

Physicians in the current study recognised that they are well positioned to potentially play a pivotal role in addressing DV and are perceived as community leaders. Women also perceived physicians' involvement in DV as a socially accepted way to break the silence.^{22,23} Physicians proposed mediation, and some were actually mediating between conflicting couples. This could be reflecting a common behaviour observed among the Lebanese people where individuals would interfere to resolve conflicts or arguments they are witnessing. However, the mediation performed by the physicians in the current

study leaned toward blaming the victim, justifying violence, and prescribing tranquilisers to survivors, which posed a risk of further victimising the survivor.

As for the perceived barriers preventing engagement in DV management, many of the ones highlighted by the participating physicians have previously been reported in the international literature, including powerlessness to offer a solution, lack of training, lack of time, decreased knowledge of existing resources, and fear of offending the woman.⁴⁻⁸ Concern about personal safety has also been mentioned,^{7,24} but may loom larger in countries like Lebanon, where DV is not criminalised and the authorities are not perceived to be protective. There were barriers identified by participating physicians that are more specific to this region, and could be applicable to other areas, namely the religiously-based beliefs of the physicians and a medical education and healthcare system that do not include DV in its scope.

Similar to findings in Bangladesh, Tanzania, Palestine, and Japan,^{14,15,25-27} some physicians in Lebanon justified violence and blamed the survivor rather than the perpetrator for triggering the violent behaviour. This could reflect the impact of a patriarchal culture and traditions on the attitudes of physicians. Many participants further argued that their opinion is based on religious doctrines that advocate male supremacy and women's obedience, reciting verses or passages from religious texts to bolster their arguments. In their view, DV management should be confined to religious leaders. Such a position needs to be challenged as it poses a major barrier to combating DV on the basis of human rights and sexual equality.

A study in a rural Bangladeshi community found that religious beliefs were put forward to justify lack of action against DV *'the wife is a property owned by the husband and if she takes her husband's beating, she will go to heaven'*.²⁶ Although not studied in the field of DV, religious beliefs affect physicians' practices with regards to abortion and the field of terminal care where religious physicians were less likely to withdraw life support.^{28,29} Similarly, addressing DV

in families with strong religious beliefs could challenge their ideas and beliefs.³⁰ A different approach, not explicitly based on human rights or sexual equality, may need to be improvised in these situations, for example, highlighting the health impact of violence. Cultural barriers to reducing DV are not exclusive to religious cultures. In the 2014 Crime Survey for England and Wales, 10% of men and women thought that it is 'mostly or sometimes' acceptable to hit or slap their partner in response to them having an affair.³¹

This study's finding that gynaecologists and/or obstetricians irrespective of their sex were least willing to help and more inclined to blame the survivors, is not consistent with Roelens and colleagues' study where the majority of gynaecologists and/or obstetricians disagreed with the question 'Do you agree that women may harass their spouses so badly/to the extent that is conceivable for husbands to lose their temper?'.³² This surprising finding, although based on interviews with a small sample of physicians need to be further elucidated.

Implications for research and practice

As in other parts of the world, integration of DV into the undergraduate and postgraduate medical curriculum is a priority, to give physicians competence in addressing the issue as part of their clinical practice. These findings can also inform the training of primary care physicians in Lebanon and perhaps other Arab countries, helping doctors consider how their personal religious and cultural beliefs influence their response to DV. These beliefs may constitute barriers to a safe and appropriate response. These findings also raise the issue of the role of religion or, at least, how religious positions on DV are perceived by doctors. One way to explore this further in societies where religion has a strong influence on social norms, would be discussions between medical and religious leaders to reach a consensus about a role for doctors in supporting women who are experiencing abuse, consistent with human rights and international guidelines.

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American University of Beirut Institutional Review Board (reference FAM. JU.06).

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Competing interests

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Appendix A. Interview guide

The main questions are in bold. The remaining statements are probing questions and reminders for the interviewer.

1. **Demographics: age; place of work; sex; specialty; years in practice; average number of consultations per day; percent of adult patients (male/female adults, paediatric)**
2. **What percentage of your patients do you think is subject to violence? In your opinion, how would a victim of violence commonly present?**
3. **When was the last time you encountered a patient subject to violence from a family member? Would you like to talk about it?**
4. **How often do you discuss violence with your patient or their family? When?** Do you have ample time? Do you feel comfortable discussing the topic of violence in the family with patients or their parents? Is asking patients/parents about violence an invasion to their privacy? Is it demeaning to patients/parents to question them about it? Would it make patients/parents very angry? Are there specific signs you look for before asking about violence in the family?
5. **What are the measures you take when a patient discloses violence?** What are the services that should be offered to violence victims? Do you think you are not in a position to interfere with how a couple chooses to resolve conflicts? Why?
6. **Where do you make referrals for violence victims?** Where to? If not, why? Can social workers' personnel help in managing patients subject to violence at home? How? Do you have access to medical social workers to assist in the management of patients subject to violence? Where? If not, why? Do you have access to mental health services should your patients need referrals? Who are they? If not, why?
7. **Are there specific characteristics that predispose a person to be abused? To become abuser?** If yes, what are they? Are people only victims if they choose to be? Are victims getting something out of the abusive relationship?
8. **Would you consider violence a medical issue?** What would be the role of the healthcare system? Are children adversely affected by violence occurring in their homes? Would it be inappropriate to ask parents about violence in the family in the paediatric setting?
9. **What training is needed for physicians so that they can help victims of violence?** Should residents be taught about domestic violence during residency training? What should be included in the training?
10. **Are you aware of the family violence law?** What do you think of it? Would you be willing to assist survivors of violence if the law got approved? If yes how, if no why not?