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The Physical and Psychosocial Health of Bedouin Arab Women of the Negev Area of Israel

The Impact of High Fertility and Pervasive Domestic Violence

JULIE CWIKEL
RACHEL LEV-WIESEL
ALEAN AL-KRENAWI
Ben Gurion University of the Negev

This study examined the self-reported health status of Bedouin Arab women in relation to two salient features of current Bedouin Arab social mores: the emphasis on maintaining a high rate of fertility and the social acceptance of domestic violence. A quota sample of 202 Bedouin Arab women ranging in age from 22 to 75 were personally interviewed. Forty-eight percent of the women reported a lifetime exposure to physical violence, and 30% reported domestic violence that was associated with symptoms of poor mental health status and gynecological problems. Domestic violence was associated with a large number of children, and there is some indication that the level of domestic violence decreases during pregnancy.

Keywords: *morbidity; polygamy; social change*

The Negev area comprises 58% of the territory of the State of Israel's pre-1967 borders, but only 10% of the population resides there. The Negev is characterized not only by a sparse population distribution but also by physical and psychological distance from the population centers of Israel. Furthermore, the socioeconomic status is lower, and there is a higher rate of unemployment in the Negev compared with the rest of Israel. There are approximately 180,000 women aged 18 and older living in the Negev, and of these, approximately one quarter (45,000) are Bedouin Arabs

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(Negev Development Authority, 1998). The Bedouin Arab population is a formerly nomadic, traditional society that is in the process of adaptation to the Western, democratic values of the Jewish Israeli majority.

In traditional societies, the role of women has typically been subordinate to men, and gender roles are strongly associated with women's biological imperative. However, in the throes of rapid social change, many of the cultural structures that protect women and maintain their health begin to erode. For example, Forman and colleagues (1990) demonstrated that the traditional period of a 40-day postpartum rest period has virtually been eliminated among the Negev Bedouin, with the result that women have less time to recuperate physically after childbirth. Furthermore, in periods of social transition, the pressures of change can be expressed in an increase in domestic violence that adversely affects the health of women who bear its brunt (Bui & Morash, 1999; Lev-Wiesel & Anson, in press).

The present article examines the self-reported health status of Bedouin women in relation to two salient features of current Bedouin social mores: the emphasis on maintaining a high rate of fertility and the social acceptance of domestic violence.

THE BEDOUIN ARAB SOCIETY

Bedouin Arabs are found throughout the Arab world. They are distinct because they inhabit desert lands, but this should not infer a unified racial, ethnic, or national group with a homogeneous style of life (Barakat, 1993). The society is "high-context culture" with an emphasis on affiliation, the collective over the individual, a slower pace of social change, and a greater sense of social stability compared to Western societies (Al-Krenawi, 1998; Barakat, 1993; Hall, 1976). In contrast to the Western liberal concept of individual autonomy, Bedouin Arab identity is inextricably linked with the collective identity of the family, extended family, and tribe (Al-Krenawi & Graham, 1999). Tribes remain important to the Bedouin Arab, particularly as a form of social support and group authority (Al-Krenawi, 1998). A hierarchical order is maintained within the family in which the dominance of male over female and older over younger is observed (Al-Krenawi, 1996).

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Today, the Bedouin Arabs of the Negev are undergoing rapid and dramatic urbanization, moving from a nomadic lifestyle that characterized the Bedouin until 1948, to settled towns and villages. Of the 120,000 Bedouin Arabs now living in the Negev, approximately 50% live in towns or villages recognized by the government, and 50% live in unrecognized villages that have no basic infrastructure or services (Ben Gurion University of the Negev, 1999). Furthermore, population growth has been exponential, from 17,800 in 1961 to 120,000 in 1999.

The Bedouin have one of the highest birth rates in the world. The rate of natural increase in Israel was 14.8 per 1,000 in 1995 and 1996, but among the Negev Bedouin, it was 44.1 (Central Bureau of Statistics, 1997). Arab society in Israel in general, and the Negev Bedouin in particular, are in the midst of a rapid cultural transformation whereby strong collective identity is giving rise to greater individualism and more personal choice (Ben-Ari & Azaiza, 1998).

Gender differences in Bedouin Arab society are strongly defined. The social structure is patriarchal; men are the leaders and the authorities in the home, economy, and in politics (Al-Krenawi, 1996). Women are expected to be wives and mothers and maintain the household. In the former nomadic lifestyle, women had a significant economic role, with responsibility for herding and handicrafts (Elsana-Alhjooj, 2000). Now, a good wife and mother is expected to remain in the home, not to leave except for everyday chores, and to sacrifice her own needs for the sake of the family (Mass & Al-Krenawi, 1994). A woman's social status is based on her marriage and her ability to have and rear children, especially boys. When asked how many children a man has, the response invariably refers only to sons; daughters are not included in the count (Al-Abbadi, 1973). Thus, even Bedouin women with higher education feel that they are judged by their reproductive capacity and may feel that they need to have children, especially male children, to maintain their social status.

As one Arab scholar observed, Muslim patriarchy considers female sexuality as extremely powerful but subversive to the social order (Mernissi, 1975). Women are taught from childhood that their sexuality is the inalienable and permanent property of the *Hamula* (extended family) rather than their own (Al-Krenawi & Graham, 1998). "Sexual purity and lineage honor are seen as

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inseparable" (Haj, 1992, p. 764, cited in Al-Krenawi & Graham, 2003), and a woman's sexual identity is of concern to all. A woman who is perceived to have strayed from the strict norms of sexual conduct, even if she is a victim of sexual abuse as a child, may be ostracized and even murdered to preserve family honor (Shalhoub-Kevorkian, 1999). Accordingly, women's sexual integrity is maintained by ubiquitous forms of family and community surveillance and control. Dating is prohibited, romantic love is rare, and most marriages are arranged by family members to promote inter- and intrafamily ties (Al-Krenawi & Graham, 1999).

WIFE ABUSE IN THE ARAB MUSLIM FAMILY

As mentioned previously, physical abuse is used in the Muslim sociopolitical context to control and subordinate women and is not therefore considered grounds for breaking up the family unit. Consistent with this view is the finding of Haj-Yahia (1998a, 1998b) with regard to patriarchal and male dominance among the Palestinian Arabs and attitudes of engaged Arab men toward abuse and violence. The author points out that one third of the Palestinian Arab women who participated in one study believed there is no excuse for a man to beat his wife, yet a substantial percentage justified wife beating when a woman is sexually unfaithful or when a woman challenges her husband's manhood (Haj-Yahia, 1998a). Another study of engaged Arab men revealed that lack of communication skills, traditional expectations for woman's role after marriage, negative attitudes toward women, and having experienced abuse as a child predicted the view that abusive husbands should not be held accountable for their behavior (Haj-Yahia, 1998b).

Understanding the problem of violence requires attention to the cultural context in which it occurs (Hassouneh-Phillips, 2001). Bui and Morash (1999) suggested that class, culture, and gender may simultaneously affect the degree to which women suffer violence from their husbands. One finding worthy of note, obtained from research carried out on several non-Western cultures, suggests that women's economic contributions to the family may not reduce the husband's dominant position in the family hierarchy or the degree of violence experienced by these women (Bui & Morash, 1999; Shalhoub-Kevorkian, 1997).

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Shalhoub-Kevorkian (1997), in her discussion of wife abuse among Palestinian Arab families, suggested that culture, tradition, politics, and power structures affect social perceptions and policies toward wife abuse. The view that Arab women are the property of men whom they need for protection (Ahmed, 1992; Barakat, 1985) is a social perception associated with male control and the subordination of women (Adelman, 2000; Ali & Toner, 2001; Hassouneh-Philips, 2001).

Despite work on Arab culture and domestic violence, there are no published studies on the extent of domestic violence among Bedouin Arab women and its association with other variables, such as the high fertility rate, or its effect on women's health. In this article, we present the first combined examination of these phenomena in this population that has heretofore been somewhat neglected by social scientists and epidemiologists.

METHOD

The research is based in part on the groundbreaking survey conducted by the Commonwealth Club in the United States (Leiman, 1998). This survey is considered the first comprehensive national survey of American women's health. It shattered the myth of women as generally healthy and showed that often women's health is ignored and neglected. In this survey, more than 2,500 women were interviewed as well as 1,000 men as a comparison group. The survey showed for the first time the extent to which women are not receiving routine preventive services (e.g., Pap smears, clinical breast exams, mammograms, and physical checkups) in the United States.

This survey, with minor revisions, was repeated with a national sample in Israel by the Brookdale Institute in 1998 (Gross & Brammli-Greenberg, 2000). However, the national sample included only about 80 women from the Negev, a number too small to draw meaningful conclusions about the status of women's health in the Negev in comparison to the rest of the country. The Center for Women's Health Studies and Promotion of Ben Gurion University of the Negev repeated and extended this survey in the Negev via a telephone interview of more than 500 women (Cwikel, 2000). The reason that a larger Negev sample was needed is due to the heterogeneity of the population. For

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example, in the city of Beer-Sheva, the largest city in the Negev, 29% of the population are new immigrants from the former Soviet Union (Negev Development Authority, 1998).

The Negev has some 50,000 Bedouin women, many of whom do not have phones and therefore were not included in the National telephone survey. Only 3 Bedouin women were included in the random sample of women in the Negev (despite Arabic-speaking interviewers) due to the lack of telephones in the community and women's reluctance to speak on the phone. It was therefore decided to conduct a separate survey of Bedouin women using personal interviews.

RESPONDENTS

There is no way to draw a random sample of Bedouin women, because there is no completely accurate list of Bedouin residents of the Negev, so a quota sample of the population was constructed based on the best estimate available from the Israel Population Register (Central Bureau of Statistics, 1997). In this fashion, we devised a sample based on the well-known differentiation between settled towns and unrecognized settlements (50% and 50%) and the age structure for women. Furthermore, we decided to collect data in the one central place that Bedouin women visit frequently, the Soroka University Medical Center that serves all of the Negev population. All data were collected in face-to-face interviews with a trusted Arab public health nurse who approached women who were visiting other hospitalized family members. Because the public health nurse was well trusted, she did not have any refusals. Problems were encountered in finding women who fit the oldest age category. A formal human subjects' authorization (Helsinki Committee) was obtained to conduct the study in the hospital.

A total of 202 interviews were completed. Participants' average age was 34.5 years (*SD* = 12.8), with a range from 22 to 75. All were married or widowed, and all but 3 were mothers. The average number of children was 5.85 (*SD* = 3.50), with a range of 1 child to 16 children. More than one third (35.6%) of the women were married in polygamous families. Regarding education level, 49.5% of the sample had no formal education, 31.1% graduated primary school or less, 8.9% had an incomplete high school education, and

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TABLE 1
Number of Children and Pregnancy Status According to Respondents' Age Group

Age	*Percentage in the Sample (N = 200)*[a]	*Were Pregnant During the Last Year (%)*	*Mean Number of Children (SD)*
22 to 25	33.5 (67)	86.4	2.62 (1.31)
26 to 30	17.5 (35)	71.4	5.37 (2.02)
31 to 40	25.5 (51)	60.8	7.14 (2.51)
41 to 50	9.5 (19)	5.9	9.63 (3.96)
51 to 60	8.5 (17)	0.0	9.59 (2.18)
61 and older	5.5 (11)	0	8.64 (3.41)
Total	200	62.3 (114)	5.85 (3.50)

a. Data were missing on 2 respondents on age.

10.5% had a high school diploma or higher education. Table 1 shows the number of children and pregnancies according to participants' age group.

MEASURES

The questionnaire was based on the Hebrew version of the Commonwealth Fund's Survey of Women's Health (Gross & Brammli-Greenberg, 2000). The Hebrew version was translated and back-translated to check the validity of the wording. It was adapted to meet the needs of Bedouin women by a steering committee of researchers and health care practitioners who are either themselves from the Bedouin population or who have worked extensively with this group. Specific measures included questions about lifetime exposure to physical violence and a 5-item scale on domestic violence in the past year used in the Commonwealth Fund survey (Leiman, 1998) (Cronbach's alpha, $\alpha = .98$); a 4-item self-esteem questionnaire derived from the Rosenberg Self-Esteem Scale (Rosenberg, 1979) ($\alpha = .82$); a 2-item hopelessness-helplessness scale (Everson et al., 1996) ($\alpha = .58$); a single question on social support; and a 6-item depression scale derived from the CES-D (Center for Epidemiological Studies–Depression) Scale (Radloff, 1977) and validated in the shortened version by Sherbourne, Dwight-Johnson, and Klap (2001) ($\alpha = .7028$). Among women under age 55, fertility was assessed by the questions: Is the respondent currently pregnant, or was she pregnant in the past year? Did she give birth in the past year? Due to the exploratory nature of this research and the relatively small sample size,

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results with significance levels between $p = .05$ and $p = .10$ are included in the report.

RESULTS

To examine the extent of domestic violence among Bedouin Arab women and its association with high fertility and physical and mental health problems, four analyses were conducted: (a) analysis of bivariate relationships between study variables, (b) chi-square analysis to compare differences in health problems according to age and fertility, (c) analysis of frequency of types of domestic violence comparing nonpregnant versus pregnant women, and (d) reported spousal violence and specific demographic factors, such as type of settlement and income level.

There was a tendency that approached statistical significance for less domestic violence to be reported as women got older; 33.5% of those younger than age 40 reported domestic violence compared to 21.3% of those older than age 40 ($x^2 = 2.6$, $p = .07$). Furthermore, there was a positive correlation between the number of children and the level of domestic violence after controlling for age (partial correlation = .15, $p < .05$). Significant positive partial correlations were found between being subjected to spousal violence and the following health problems after controlling for age: gynecological problems (.29, $p < .000$), poor self-esteem (.17, $p < .05$), reporting any illness (.15, $p < .05$), symptoms of hopelessness and/or helplessness (.27, $p < .000$), low social support (.16, $p < .05$), and symptoms of depression (.40, $p < .000$). Domestic violence was more commonly reported in recognized towns and settlements than in unrecognized ones (36.6% vs. 24.8%, $x^2 = 3.35$, $p < .05$) and also among women with more education. Women without any formal education reported any type of domestic violence at the lowest rate (22%); 38% of women with up to a primary school education and 41% of those with a high school education or greater reported significantly higher levels ($x^2 = 7.1$, $p < .05$). Because there is a correlation between type of settlement and education of women, we calculated partial correlations between education and reporting different types of domestic violence (scores ranged from 0 to 5). After controlling for education, there was no significant correlation between type of settlement and domestic violence (partial correlation = .06, $p = .39$), but the correlation

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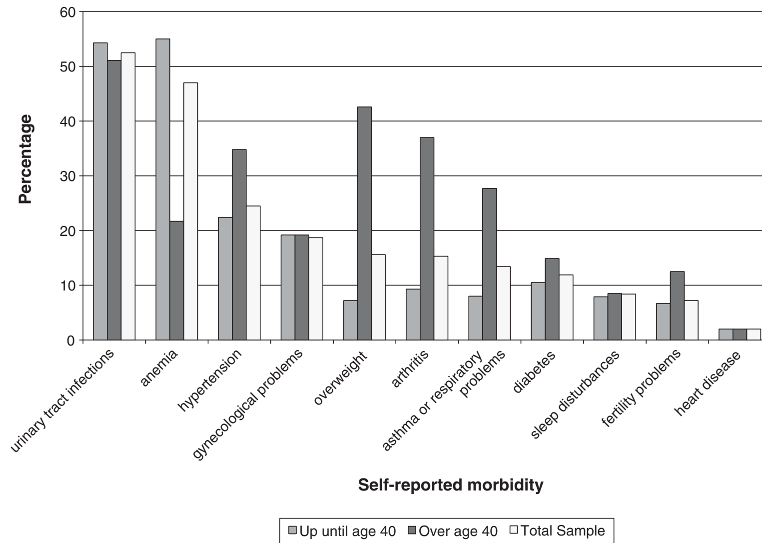

Figure 1: Morbidity by Age/Fertility

remains significant between education and domestic violence even after controlling for type of settlement (partial correlation = .14, $p < .05$). No correlation was found between polygamous marriage and spousal violence or with being born into a polygamous family. Reporting spousal violence was related to whether the husband was unemployed. Spousal violence was more common among women whose husbands were unemployed, compared with those women whose husbands worked (41.7% vs. 28.6%, $x^2 = 3.36$, one-sided significance $p > .05$).

Of the respondents, 14.5% (26) were pregnant at the time of the interview, 62.2% (115 of 185) reported being pregnant in the past year, and 55% (99 of 185) had given birth in the past year. Figure 1 shows the percentage distributions of participants' health problems according to age and fertility. Respondents were divided into two groups, younger than 40 and older than 40, based on the fertility rate (see Table 1). The results indicate that more than 50% of the women suffered from urinary tract infections and close to 20% reported gynecological problems regardless of age. Women younger than 40 were found to suffer more from anemia than women older than 40 ($x^2 = 16.2$, $p = .000$), whereas the latter suffered more from hypertension ($x^2 = 3.05$, $p = .08$), being over-

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TABLE 2
Frequency Distribution (%) of Types of Spousal Violence Suffered in the Past Year During Pregnancy Versus Nonpregnancy (*N* = 185)

Type of Violence	*Percentage of Women* (n)	*Women Who Were Pregnant at the Time Percentage* (n)	*Women Who Were Not Pregnant at the Time Percentage* (n)
Cursed	29.6 (53)	53 (28)	47 (25)
Threatened	20 (36)	27.7 (10)	72.3 (26)
Beaten	17.8 (32)	44 (14)	56 (18)
Forced sex against will	6.7 (12)	42 (5)	58 (7)
Other types of violence	14.4 (26)	42 (11)	58 (15)
Any type of domestic violence	32.4 (60)	50 (30)	50 (30)

weight ($x^2 = 34.6$, $p = .000$), arthritis ($x^2 = 20.8$, $p = .000$), and asthma or respiratory problems ($x^2 = 10.8$, $p = .005$).

Lifetime exposure to physical violence was 48.3%, and 100% of the victims knew the attacker. Of those who were victims of violence by a known attacker, 62% reported seeking help, but only 8% went to formal agencies (medical, legal, or police); the rest sought help within informal family networks. Analysis of frequency of domestic violence indicated that 30.7% (62) of the participants reported some type in the past year, and having been subject to violence in the past significantly increased the risk of spousal abuse compared with those who did not report abuse earlier in their lives (45.4% vs. 16.3%, $x^2 = 19.9$, $p = .000$).

Table 2 shows the percentage of nonpregnant versus pregnant women who were subjected to one of the following types of spousal violence in the past year: curse, threat, battering, forced sex, or other types of violence, such as kicking or burns. If a woman reported some type of violence, she was asked whether she was pregnant at the time it occurred. If there was no relationship between pregnancy and family violence, we would expect approximately the same proportion of women to say that they were pregnant when victimized as reported being pregnant (62.2%) in the sample during the past year ($n = 185$) because these were different questions. To find out how much violence during pregnancy would be expected if violence was randomly distributed, we calculated the difference between the expected (62.2%) level being pregnant in the total sample and the observed level of being pregnant among the group that had experienced spousal

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violence (50.0%). The results indicate that during pregnancy women suffer somewhat less from all types of spousal violence, as only 50% of those who reported any type of domestic violence were also pregnant at the time.

DISCUSSION

The present study examined the relationship between the following variables: fertility rate, exposure to physical violence, experiences of domestic violence, and heath problems among Bedouin Arab Israeli women. The results indicated that Bedouin Arab wives have a very high rate of fertility until they reach 40 years of age and that high fertility is associated with greater reported domestic violence. In addition, these women have a high rate of many health problems such as anemia and repeated urinary tract infections. The results also indicated that during pregnancy, women are somewhat less likely to report being abused.

Among Jewish respondents in the comparable survey, only 9.7% reported experiencing some type of domestic violence in the past year; the most common type was being cursed. The rate of domestic violence was 6.2% among those without a history of prior victimization and 21% among those with such a history. Having a history of prior victimization increased the risk of domestic violence among Bedouin women by a similar proportion. However, by comparison, the frequency as well as the types of domestic violence Bedouin Arab wives endure is significantly greater. Keeping in mind that this was reported in a personal interview, we could assume that the rate might be an underestimate due to response bias. This suggests that the ubiquitous physical abuse is not as a result of a crime but occurs in the framework of culturally engrained family violence, initially by fathers and older brothers and subsequently by spouses. Furthermore, domestic violence often happened when the woman was pregnant, although nonpregnant women experienced more domestic violence than pregnant women. The high fertility rate of the sample contributes to this finding. Thirty percent of the women in the Bedouin sample reported experiencing some type of domestic violence in the last year. Reporting domestic violence in the past year was positively related to symptoms of depression, low self-esteem, hopelessness and/or helplessness, low social support,

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overall morbidity, and a high rate of reported gynecological problems.

As noted, there was some indication that during pregnancy the level of violence decreases. This may be explained by the husband's concern for the fetus and/or the well-being of the mother-to-be. Yet, in view of the high rate of fertility on one hand and prevalence of health problems on the other, pregnancy might be considered one way of escaping or at least reducing spousal violence because it has cultural legitimization. Moreover, giving birth means being hospitalized for at least 3 full days, which enables women to rest and often receive better treatment. Pregnancy may therefore contain a secondary latent benefit for Bedouin women by buffering spousal violence.

Surprisingly, inconsistent with previous findings indicating that polygamous wives suffer higher levels of violence perpetrated by their spouses (Al-Krenawi & Lev-Wiesel, 2002), no correlation between polygamy and domestic violence was found in this study. This may be due to the small number of polygamous wives who participated in the current study sample. It should also be noted that the study conducted by Al-Krenawi and Lev-Wiesel (2002) included Bedouin women who were senior (first) wives in polygamous marriages, which may partly explain the inconsistent findings. What is common between this sample and others is that domestic violence is more common among unemployed husbands than among employed men (see, e.g., Catalano, Dooley, Novaco, Wilson, & Hough, 1993; Kyriacou et al., 1999).

What is notable is that the rate of domestic violence appears to be somewhat higher among women who have acquired some education, the majority of whom are living in settled, urban communities compared to unrecognized settlements where the lifestyle is more traditional. On acquiring education, women may be more likely to challenge their husbands' authority, more likely to report violence, or both. In settled townships, it is possible that women feel more restrained by being kept inside their homes; with education, they see options for changing traditional balance of authority in the marriage and the strains that result from these attempted changes are expressed in an increase in domestic violence.

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STUDY LIMITATIONS

These data are the first known to us that examine the reported rate of domestic violence among Bedouin Arab women living in the Negev. They share with other surveys the high likelihood of underreporting about these sensitive topics (e.g., Grynbaum, Biderman, Levy, & Petasne-Weinstock, 2001). An alternative method would to be prospectively record data on violence against women within the framework of a primary care or well-baby clinic, where most women come for medical or prenatal care. This would also offer validation about the suggested relationship between violence and pregnancy in this population. There are also cases of violence against women that might have been detected among Jewish Israeli women that, due to language and cultural barriers, are not reported in this study. For example, a health educator from Soroka Medical Center in Beer-Sheva (serving all of the Negev region) reported an excess of cases of Bedouin women with extensive burns that are not explainable by accidents with cooking fires, but no one is willing to complain to the police (personal communication, E. Shani, 2002).

PRACTICAL IMPLICATIONS

Domestic violence is pervasive in cultures around the world. Violence adversely affects every aspect of the lives of abused women and often spills over to harm children physically and psychologically in these households. Physical aggression and psychological abuse toward wives are both an intensely private affair and a major issue in public health and social welfare. The intrusion of various agencies and institutions—whether police, social services, religious authorities, or medical personnel—into what victims and perpetrators alike view as a private matter highlights the extremely delicate nature of the problem and the need to handle it with cultural sensitivity and skill to be effective in bringing about change.

Despite the critical contribution of personal factors to spousal violence, the influences of culture and society cannot be ignored (Dutton, 1996; Loseke, 1992; Kazarian & Kazarian, 1998). In a number of recent studies, the problem of wife abuse has been examined from a cultural perspective (e.g., Bui & Morash, 1999; Haj-Yahia, 1996; Mehrotra, 1999; Rhee, 1997; Shalhoub-Kevorkian,

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1997). Mehrotra (1999) has pointed out that because culture influences human behavior, it is essential to include the experiences of diverse groups of women in any analysis of domestic violence and wife abuse. Bronfenbrenner (1986), Carlson (1984), and Dutton (1995) have emphasized that the key to understanding marital abuse is the concept of nested cultural, social, and psychological factors. These interactive factors exert both direct and indirect influences on the abuser's reactions to the victim's response and on the continuation of violent behavior. According to this view, culturally ascribed expectations of male and female behavior are a major determinant of wife abuse. Gender roles are manifested across a wide spectrum of historically constructed social contexts (i.e., dating, marriage, family life, and religion). In a male-dominated society, these contexts serve to reinforce the social expectation that males have (and possess the means to maintain) control over all aspects of social and economic life, including the lives of women. Hence, within this type of social context, wife abuse is, in part, an outcome and reflection of cultural norms. In this sense, the phenomenon of wife abuse may reflect both the general cultural characteristics of a particular society and individual factors (Loseke, 1992). It is unclear how pervasive cultural norms that support wife abuse may or may not change when the culture is exposed to contrasting social norms that do not sanction wife abuse and even consider it grounds for severe legal intervention.

To develop effective social interventions, it is important to acknowledge that domestic violence is an entrenched cultural norm and widespread behavior and that this culture is subject to the pressures of being a minority within the dominant society. We need answers to such questions as: What circumstances reinforce the behavior of wife abuse as a buffer in times of social difficulties? Does the culture justify wife abuse as the way to vent feelings of frustration, reactions to discrimination, and difficulties suffered when trying to negotiate a world where one's language, customs, or values are not understood? Or does the culture adapt so that as men's physical and social control over women become less strict and the intercouple balance more egalitarian, the norms that sanction wife abuse become less pervasive? The results presented in this article suggest that women were better protected from spousal abuse in traditional living arrangements than in urban settlements.

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Given the current security situation in the Middle East, it is interesting to speculate on how severe military tension is expressed in domestic conflict. Although the Bedouin Arabs in the Negev do not reside in areas where bombings have taken place, they have extensive ties of family and commerce in the Palestinian Authority and certainly hear about the conflict through the media. It should be noted that some of the men are married to wives who originate from the Gaza Strip and the West Bank areas. The most likely effect is an indirect one, because in times of high military expenditure, fewer public resources are available to address inequalities in public services in the Bedouin sector. Clearly, in times of economic hardship, the most vulnerable segments of the population are most likely to be affected, and we found unemployment associated with an increased risk of domestic violence in this sample. The impact of the security situation on domestic conflicts deserves further research in both this population and the larger Israeli society.

In addition, although battered women's shelters, legal services, and counseling and treatment services exist in the Jewish sector, there are few services available for Bedouin women who are victims of spousal abuse. Aside from social welfare offices, there are no special services in the Negev designed to deal with problems of family violence. Recently, the Ministry of Health designated a Bedouin woman social worker as the professional to deal with cases of domestic violence. If a woman complains and decides to go to a shelter (there are two that accept Arab-speaking women in the whole of Israel), she is often required to forfeit her children, who will be taken from her by the husband and the *hamula*. There have been some reported cases of Bedouin women who have taken this drastic step and were later found murdered (personal communication, R. Liran, 2000). Due to the involvement of the extended family in the conflict, services that exist for the Jewish sector have refused to handle cases from the Bedouin community after staff members received death threats for helping a woman escape an abusive situation. Even when a Muslim woman seeks a divorce due to extreme physical violence against her, she essentially withdraws from social integration and retreats into the world of her housework and children to avoid causing animosity against her (Al-Krenawi & Graham, 1998; Cohen & Savaya, 1997).

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In conclusion, given the adverse health effects we have observed among women who suffer from domestic violence, the high reported rate of domestic violence among the Negev Bedouin requires social intervention. However, due to the cultural sensitivity of the issue, this type of entrenched domestic violence requires developing new approaches to changing social opinion about the desirability of this type of marital interaction. Practitioners should develop social interventions with the collaboration of community opinion leaders to reduce the rates of domestic violence. Lowering the rate of violence against wives may also have the ripple effect of reducing violence against children.

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Julie Cwikel, Ph.D., is a University of Michigan trained social epidemiologist, founder, and director of Ben Gurion University's Center for Women's Health Studies and Promotion and teaches courses on gender, women's health, multiculturalism and epidemiology. Her main foci in research are using epidemiological methods in research on immigrant and minority populations, women's health issues, and environmental hazards.

Rachel Lev-Wiesel, Ph.D., is a senior lecturer at the Spitzer Department of Social Work, Ben-Gurion University, Israel. Her main research interests are trauma and stress, domestic violence, and the use of drawings for analysis and therapy purposes. Several of her papers focus on specific issues within minority communities, such as circumcision of female Bedouin girls and marital quality among Druze, Muslim, and Christian Arabs.

Alean Al-Krenawi, Ph.D., is a senior lecturer at the Spitzer Department of Social Work, Ben-Gurion University, Israel, and the director of Ben-Gurion University's Center for Bedouin Studies and Development. His research interests are mainly multicultural social work practice and mental health in the Arab world.

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