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# Perceived Impact of Intimate Partner Violence on Health-Related Quality of Life among Abused Jordanian Women

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ABSTRACT

***Background:*** Intimate partner violence (IPV) is a major public health problem that can affect women's physical, psychological, social, and economic well-being. Qualitative evidence on how abused women in Jordan perceive its impact on health-related quality of life (HRQoL) remains limited. in Jordan. ***Purpose*:** To explore the perceived impact of IPV on HRQoL among abused women in Jordan. ***Methods*:** A qualitative descriptive study was conducted among 15 abused women attending the Family Protection Department in Irbid, Jordan, between March and December 2023. Participants were selected purposively and interviewed face-to-face using a semi-structured guide. Interviews were audio-recorded, transcribed verbatim, and analyzed manually using Braun and Clarke's six-phase thematic analysis. ***Results***: Eight themes emerged. IPV was described as progressive, often beginning with verbal abuse and worsening over time. It negatively affected emotional well-being, relationships, self-worth, physical health, and financial stability. Social stigma reinforced silence and endurance, while support from other women helped reduce isolation. ***Conclusion*:** IPV profoundly compromised women's HRQoL across psychological, social, physical, and economic domains. ***Implications for Nursing*:** Nurses should adopt trauma-informed and survivor-centered approaches to assess and address these multidimensional consequences.

***Keywords:*** Intimate partner violence, Abused women, Health-related quality of life, Qualitative study, Jordan, Nursing.

**What does this paper add?**

1. It provides qualitative evidence from Jordan showing that IPV affects women's HRQoL across psychological, social, physical, and economic domains.
2. It shows that abuse is often experienced as a progressive process, commonly beginning with verbal abuse and worsening over time, while social stigma reinforces silence and endurance.
3. It identifies same-gender peer support as a potentially meaningful protective resource that may reduce isolation and support coping among abused women.

## Introduction

Intimate partner violence (IPV) is a major public health and social problem that threatens women's safety, dignity, and well-being. It includes physical,

psychological, sexual, and controlling behaviors perpetrated by a current or former intimate partner, and its effects extend far beyond immediate injury to women's emotional, social, and physical functioning (Alothman et al., 2024; World Health Organization, 2021). In Jordan and other Arab settings, IPV is shaped by gender inequality, family pressures, and socio-cultural norms that may discourage disclosure and delay help-seeking, thereby increasing women's vulnerability and prolonging exposure to abuse (Abuhammad, 2021; Elghossain et al., 2019).

Evidence from Jordan and the wider region shows that IPV is common and associated with substantial harm. Previous studies have shown that Jordanian abused women experience higher levels of depression, stress-related symptoms, and poorer overall functioning (Abuhammad et al., 2024; Al-Natour et al., 2020). IPV also affects women's quality of life across multiple domains, including physical health, emotional well-being, social functioning, and economic security. Women experiencing IPV may report chronic pain, sleep disturbance, fear, social withdrawal, and reduced autonomy, all of which can erode health-related quality of life (HRQoL) (Abuhammad et al., 2024; Mellar et al., 2024; Uvelli et al., 2024).

HRQoL is particularly relevant in nursing research, because it reflects how health problems affect daily functioning, role performance, and overall well-being. In the context of IPV, HRQoL provides a broader understanding of harm than physical injury alone, as it captures the cumulative effects of abuse on physical, psychological, and social health. Prior research has shown that IPV is associated with poorer HRQoL across these domains, and that abused women often present with a mixture of emotional distress, somatic complaints, and difficulties in social functioning (Abuhammad et al., 2024; Al-Natour et al., 2020; Alsaker et al., 2018). This relationship may also be understood through stress, trauma, and ecological perspectives, which suggest that chronic abuse undermines health not only through direct violence, but also through fear, isolation, and constrained access to resources (Bell et al., 2024; Postmus et al., 2020).

Although the association between IPV and poor mental health is well recognized, the lived impact of IPV on women's day-to-day quality of life remains insufficiently explored in Jordan. Much of the existing literature has focused on prevalence, risk factors, or measurable psychological outcomes, while giving less attention to how abused women themselves understand and describe the effects of violence on their bodies, emotions, relationships, and daily functioning. This is an important gap, because women's own accounts can reveal dimensions of suffering and coping that are not fully captured by quantitative measures alone.

A qualitative approach is therefore valuable for examining how IPV unfolds within marriage, how it changes over time, and how it shapes women's sense of safety, self-worth, social connectedness, and physical well-being. Such insights are especially important for nursing practice, where effective assessment and intervention require not only identifying abuse, but also understanding its broader health consequences from the survivors' perspective. This is particularly relevant for women seeking formal support in Jordan, as they may represent a group with severe and prolonged exposure to abuse and complex support needs.

Given the aforementioned, discussion this qualitative study aimed to explore the perceived impact of IPV on HRQoL among abused women in Jordan. By centering women's lived experiences, the study seeks to generate contextually grounded knowledge that can inform trauma-informed nursing care and more integrated support responses for abused women.

## Methods

### Design

This study used a qualitative descriptive design with semi-structured interviews to explore the perceived impact of IPV on the HRQoL of abused women in Jordan. A qualitative approach was chosen to capture women's lived experiences and allow in-depth exploration of the emotional, social, physical, and economic consequences of IPV. The interview guide was informed by Bronfenbrenner's ecological systems theory and previous literature on IPV and HRQoL (Doyle et al., 2020). The reporting of this manuscript was guided by the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007).

### Setting and Participants

The study was conducted at the Family Protection Department (FPD) in Irbid City, Jordan, between March and December 2023. This qualitative inquiry was part of a larger study on IPV among abused women in Jordan;

however, the present paper reports only the qualitative findings. Participants were selected purposively from abused women attending the FPD, because purposive sampling is widely used in qualitative research to recruit information-rich participants who have direct experience of the phenomenon under investigation (Palinkas et al., 2015). Women attending the FPD were therefore considered especially suitable to provide detailed accounts of how IPV affected their HRQoL. Women were eligible if they were currently married, had experienced IPV, and were willing to share their experiences. Illiterate women were also eligible to participate in the interviews. Women were excluded if they were considered emotionally unstable due to acute or severe abuse, were attending the FPD for the first time, had recognized mental disorders, or had communication impairments that would limit participation in an in-depth interview.

Initial interviews were conducted with 10 participants, followed by preliminary thematic analysis. Further five interviews were then completed to confirm data saturation. No new codes emerged in the additional interviews, indicating that saturation had been achieved. In total, 15 abused women participated.

**Data Collection**

Data was collected through face-to-face semi-structured interviews conducted in a private room at the FPD by a trained research assistant under field supervision. Interviews were conducted by a female trained registered nurse with experience in qualitative interviewing who was external to the FPD clinical services; no therapeutic relationship existed between the interviewer and the participants. No prior relationship was established with participants before recruitment. No non-participants were present during the interviews, and field notes were taken after each interview. Before each interview, participants were informed about the study purpose, the voluntary nature of participation, and their right to refuse to answer any question or withdraw at any time. Verbal consent was obtained before data collection. To protect confidentiality, participants' names and addresses were not recorded, and only the research team had access to the data. No eligible participants withdrew after consenting to participate. Because interviews were conducted within the FPD setting, participants who became distressed could be referred immediately to available institutional support services.

The interview guide was developed by the researchers to explore women's experiences of IPV and its perceived effects on psychological well-being, physical health, social relationships, daily functioning, and financial life (Table 1). Open-ended questions and probes were used to encourage detailed accounts. The guide was reviewed by two experts in qualitative and health research and revised based on their feedback before use. Interviews were conducted in Arabic, audio-recorded, and lasted approximately from 40 to 60 minutes. After transcription, the audio files were destroyed.

**Table 1. Interview Questions**

| No. | Question | Probing question |
|---|---|---|
| 1. | How is IPV affecting your family's well-being? | • Tell me about your family life before IPV and after.<br>• Is IPV affecting your family? How?<br>• Describe your relationship with your husband, your parents, and your children.<br>• How was your married life before the violence started?<br>• How did you feel about the marriage before the violence? Then, after violence? |
| 2. | How is IPV affecting your health and well-being? | • Describe your health status before IPV and after.<br>• How IPV Affects Your Health and Well-being.<br>• Describe your sleep pattern, rest hours, and energy status.<br>• Do you have frequent pain or discomfort? Describe. How do you manage that situation?<br>• Describe your self-esteem, bodily image, memory, and concentration. |

| | | |
|---|---|---|
| 3. | How is IPV affecting your life in general: socially, financially, and in terms of job performance? | • Describe your social life. How did IPV impact your social life?<br>• How is your financial status? How has the IPV affected your financial status?<br>• How has IPV affected your job or your ability to find it?<br>• Have you informed your employer about your situation? Why or why not?<br>• Have you informed your co-workers about your situation? Why or why not?<br>• What support, if any, has someone at your workplace offered to you? How has the support affected you and your life on the job? |
| 4. | Do you have any other story that you would like to share with me/us? | |

**Data Analysis**

The interviews were transcribed verbatim and analyzed manually using Braun and Clarke's six-phase thematic analysis (Braun & Clarke, 2021). No qualitative data analysis software was used; coding was performed manually. The main researcher conducted the initial coding, and the developing codes, sub-themes, and themes were reviewed and discussed with the supervisory team until agreement was reached. The researchers first read the transcripts repeatedly to gain familiarity with the data. Initial codes were then generated, and similar codes were grouped into sub-themes and themes. These themes were reviewed, refined, and named to ensure that they accurately reflected participants' accounts and addressed the research aim. The research team consisted of nurses and academics with prior awareness of IPV as a significant women's health issue. Field notes and team discussions were used throughout the analysis to support reflexive interpretation and reduce the influence of prior assumptions.

**Trustworthiness**

Several steps were taken to enhance trustworthiness. Credibility was supported through the use of open-ended interviews, expert review of the interview guide, prolonged engagement with the transcripts, and iterative discussion of codes and themes with the supervisory team. Dependability was strengthened by following a systematic analytic process, documenting coding decisions through field notes, and conducting five additional interviews after the initial analysis to confirm thematic saturation. Confirmability was supported through reflexive team discussion, manual comparison of codes across transcripts, and efforts to ground interpretations in participants' own accounts and quotations. Transferability was enhanced by providing a clear description of the study context, participant selection, eligibility criteria, and participant characteristics, so that readers can judge the relevance of the findings to similar settings.

**Ethical Considerations**

Ethical approval was obtained from Universiti Sains Malaysia (USM/JEPeM/22060457), the Ministry of Health in Jordan (MOH/REC/2023/118), and the Public Security Directorate before data collection began. Participants were informed about the aims of the study, the confidential handling of the data, and their rights as participants. All interview materials were managed only by the researchers, and identifying information was kept separate from the study data. Transcripts and findings were not returned to participants for comment.

**Results**

**Participants' Characteristics**

Fifteen abused women participated in this study. The median age of participants was 40 years, the median husband's age was 43 years, and the median duration of marriage was 13 years. Ten participants were employed and five were unemployed. Most participants were economically disadvantaged, with 9 of 15 living below the Jordanian poverty threshold of 814 JD/month (Department of Statistics, 2024). Most marriages were family-arranged (Table 2). To protect anonymity in this service-based sample, quotations are identified by pseudonym, age, employment status, and marriage duration.

**Table 2. Descriptive results of participants (N=15)**

| Participant Number | Participant Age (years) | Educational Level | Husband's Age (years) | Duration of marriage (years) | Family Income JD/month | Employment Status | Type of Marriage |
|---|---|---|---|---|---|---|---|
| 1 | 32 | Bachelor or above | 39 | 7 | 900 | Employed | Family arranged |
| 2 | 41 | Below high school | 43 | 18 | 300 | Unemployed | Family arranged |
| 3 | 26 | High school | 32 | 2 | 1500 | Employed | Family arranged |
| 4 | 35 | Below high school | 40 | 7 | 500 | Unemployed | Family arranged |
| 5 | 27 | Diploma | 30 | 1 | 450 | Unemployed | Family arranged |
| 6 | 40 | Diploma | 47 | 16 | 950 | Employed | Self-selected |
| 7 | 40 | High school | 43 | 19 | 870 | Employed | Family arranged |
| 8 | 39 | Bachelor or above | 44 | 18 | 1000 | Employed | Family arranged |
| 9 | 18 | Below high school | 26 | 2 | 450 | Unemployed | Self-selected |
| 10 | 44 | Bachelor or above | 48 | 13 | 600 | Unemployed | Family arranged |
| 11 | 42 | Bachelor or above | 43 | 11 | 1100 | Employed | Family arranged |
| 12 | 43 | Diploma | 49 | 13 | 1500 | Employed | Self-selected |
| 13 | 47 | Below high school | 64 | 27 | 730 | Unemployed | Family arranged |
| 14 | 35 | High school | 42 | 12 | 740 | Unemployed | Family arranged |
| 15 | 38 | Bachelor or above | 28 | 10 | 820 | Employed | Family arranged |

Note: JD = Jordanian Dinars.

The analysis generated eight themes and related sub-themes: violence increases with time, poor social functioning, psychological distress and mental well-being, poor self-esteem, decreased physical well-being, financial instability, social stigma, and same-gender peer support (Table 3). Poor social functioning refers mainly to behavioral withdrawal, strained relationships, and reduced participation in daily social life, whereas social stigma refers to perceived or anticipated devaluation, judgement, and fear of reputational harm.

**Table 3. Themes and sub-themes identified from the interviews (N=15)**

| Theme | Sub-themes |
|---|---|
| Violence increases with time. | 1. Harmony at the beginning of marriage<br>2. Often after the birth of children<br>3. Starting with verbal violence |
| Poor social functioning | 1. Strained Relationships and Increased Irritability<br>2. Socially isolated, reluctant to interact with anyone<br>3. Loss of Autonomy and Feeling Trapped in the Relationship |
| Psychological distress and mental well-being | 1. Depressive Symptoms and Emotional Exhaustion<br>2. Absence of Safety and Emotional Security in the Home<br>3. Anxiety, Tension, and Persistent Fear<br>4. Cognitive Impairment (Confusion, Poor Memory, Difficulty Concentrating) |
| Poor self-esteem | 1. Negative Body Image and Feeling Unattractive |

| | |
|---|---|
| | 2. Shame and Embarrassment in Social Interactions |
| Decreased physical well-being | 1. Chronic Physical Pain and Somatic Complaints<br>2. Sleep Disturbances and Night-time Fear<br>3. Fatigue and Overall Physical Exhaustion |
| Financial instability | 1. Economic Control and Restriction of Financial Autonomy<br>2. Overburdened by Household Financial Responsibilities |
| Social stigma | 1. Fear of Social Judgement and Cultural Stigma Around Divorce<br>2. Community Gossip, Exposure, and Fear of Reputation Damage |
| Same-gender peer support | 1. Emotional and Practical Support from Female Colleagues at Work |

**Violence Increases with Time**

Participants described IPV as a pattern that commonly developed gradually rather than appearing immediately after marriage. Women reported that the early period of marriage was often calm, but violence emerged and intensified over time, frequently beginning with verbal abuse and later progressing to physical abuse. One participant said, "At the beginning of the marriage, my life was peaceful and enjoyable. There was respect, comfort, and tranquility. After a while, the physical abuse started by my husband" (Participant 1). Another explained, "Initially, it was limited to verbal abuse, but it later progressed to physical abuse" (Participant 5).

**Poor Social Functioning**

IPV substantially affected women's social and family functioning. Participants described strained relationships with children, relatives, and others, along with social withdrawal and reduced autonomy. One participant stated, "My relationships with my children, parents, and even neighbors have become strained due to the violence I engage in" (Participant 5). Another said, "I have distanced myself from my friends, because I no longer started feeling that I am not like them anymore" (Participant 6). These accounts suggest that IPV disrupted both interpersonal relationships and women's ability to participate comfortably in social life.

**Psychological Distress and Mental Well-Being**

Psychological suffering emerged as one of the most prominent themes. Women described depression, emotional exhaustion, hopelessness, fear, and ongoing anxiety. One participant shared, "I experienced feelings of depression, making it difficult to enjoy life" (Participant 6). Another stated, "All my hopes were shattered. I lost hope for the future" (Participant 12). Together, these narratives indicate that repeated IPV imposed a heavy and sustained psychological burden on participants.

**Poor Self-Esteem**

Participants also described marked damage to self-worth and self-image. Repeated humiliation and degrading comments made women feel unattractive, ashamed, and diminished. One participant stated, "I no longer like to see myself in the mirror" (Participant 12), while another explained, "I started seeing myself as unattractive… which gradually eroded my self-worth" (Participant 9). These accounts show how IPV affected not only emotional well-being, but also women's sense of personal value.

**Decreased Physical Well-Being**

Women linked IPV to multiple physical complaints, including pain, sleep disturbance, bruising, and persistent fatigue. One participant reported, "I experienced pain in my chest and body, difficulty breathing" (Participant 1). Another said, "I suffered from chronic insomnia due to constant worry" (Participant 2). These accounts indicate that IPV undermined daily functioning and physical well-being alongside its emotional effects.

**Financial Instability**

Financial instability emerged in a major part of participants' experiences. Women described both economic control by husbands and the burden of carrying household expenses with limited support. One participant said, "He started pressuring me to give him my entire salary. He left me with no money" (Participant 6). Another stated, "I assumed the responsibility for all

household expenses" (Participant 4). These narratives suggest that IPV operated not only through physical and emotional abuse, but also through economic deprivation and financial over-responsibility.

**Social Stigma**

Participants described social stigma as an important barrier to leaving abusive relationships. Divorce was perceived negatively, and women felt constrained by social expectations, fear of judgement, and pressure to endure abuse. One participant said, "Divorced women are indeed stigmatized" (Participant 5). Another explained, "The stigma hinders me from taking that step" (Participant 3). These accounts indicate that social norms reinforced silence and prolonged women's exposure to abuse.

**Same-Gender Peer Support**

Despite these difficulties, some participants identified support from other women, particularly female peers and colleagues, as a meaningful source of comfort and coping. One participant said, "I shared the depths of my problems. She provided me with immense emotional and moral support. She offered guidance on what to do and stood by me patiently" (Participant 4). Another explained, "They helped me see my strengths and encouraged me to deal with problems and handle situations. They guided me on how to manage my emotions when I'm upset and how to cope with the challenges" (Participant 1). These accounts suggest that same-gender peer support reduced isolation and provided both emotional validation and practical guidance.

**Summary**

Overall, the findings show that IPV was experienced as an escalating and multidimensional form of abuse that affected women's social relationships, mental well-being, self-esteem, physical health, and financial stability. At the same time, social stigma reinforced women's vulnerability, while peer support from other women offered a limited, but meaningful, source of resilience.

**Discussion**

This study explored the perceived impact of IPV on HRQoL among abused women in Jordan. The findings show that IPV was experienced as a progressive and multidimensional form of abuse that affected women's psychological, social, physical, and economic well-being. Women described violence as often escalating over time, commonly beginning with verbal abuse and later becoming physical. They also reported substantial psychological distress, impaired social functioning, diminished self-esteem, physical exhaustion, financial instability, and social stigma, while support from other women emerged as a limited, but meaningful, protective factor. Overall, these findings suggest that the burden of IPV extends far beyond isolated acts of violence and instead shapes women's daily functioning and well-being across multiple domains. Viewed through an ecological lens, these effects operated across interconnected individual, relational, and social levels, rather than as isolated consequences of physical assault alone.

A key finding was that IPV was commonly described as increasing with time. Participants' accounts suggest that abuse may begin in less visible forms, particularly verbal degradation and emotional mistreatment, before progressing to more severe physical violence. This pattern is important, because it shows how violence may become normalized within marriage, especially when early abusive behaviors are minimized or tolerated. Such escalation is consistent with literature showing that coercion, intimidation, and emotional abuse frequently precede or accompany more severe IPV and may gradually weaken women's capacity to resist or seek help. In the present study, this progression appeared to shape the later deterioration in women's mental, social, and physical well-being.

The findings also indicate that IPV seriously disrupted women's social functioning. Participants described strained relationships with children, parents, neighbors, and colleagues, as well as social withdrawal and reduced participation in normal social life. These accounts suggest that the effects of IPV are not confined to the intimate relationship itself, but spill into the wider family and social environment. Similar patterns have been reported in previous studies, where abused women experienced poorer social functioning, strained interpersonal relationships, and reduced engagement in social roles (Abuhammad et al., 2024; Al-Natour et al., 2020; Bell et al., 2024; McCaw et al., 2007; Nawaz et al., 2022). For nursing in Jordan, this matters, because social withdrawal may reduce disclosure, weaken informal support, and make it harder for women to engage with follow-up care and referral pathways.

Psychological distress was one of the most

prominent consequences of IPV in this study. Women described depression, hopelessness, fear, anxiety, and emotional exhaustion, indicating that abuse affected not only their mood, but also their overall sense of safety and emotional stability. These findings are consistent with previous evidence showing that IPV is strongly associated with depression, anxiety, and compromised mental well-being among women (Indu et al., 2021; Innab et al., 2024). They also align with broader evidence that abused women often experience poorer mental HRQoL and ongoing emotional suffering (Abuhammad et al., 2024; Alsaker et al., 2018). Compared with general expectations of women's well-being in Jordan, the women in this study described markedly compromised emotional and social functioning, underscoring the need for routine mental health assessment in nursing encounters.

Poor self-esteem was another important finding. Participants described feeling unattractive, ashamed, and diminished by repeated humiliation and degrading treatment. This suggests that IPV damages not only women's emotional state, but also their sense of personal worth and identity. Previous studies have similarly reported lower self-esteem among abused women, especially when abuse is prolonged and accompanied by emotional degradation and limited social support (Innab et al., 2024; Sumiarti & Puspitawati, 2017). This finding is clinically important, because low self-esteem may make it harder for women to seek help, assert boundaries, or imagine alternatives to abusive relationships.

The women also described clear deterioration in physical well-being, including pain, bruising, sleep disturbance, fatigue, and other somatic complaints. These findings highlight that IPV is not only a psychological or social issue, but also a substantial physical health problem. Previous research has similarly shown that abused women often report chronic pain, insomnia, poor physical functioning, and reduced overall health status (Bell et al., 2024; Uvelli et al., 2024). In the present study, physical suffering appeared closely connected to chronic stress, fear, and ongoing exposure to abuse. This supports the view that the physical burden of IPV may arise through multiple pathways, including direct injury, persistent hypervigilance, and prolonged emotional strain.

Financial instability emerged as another major theme. Women described economic control, deprivation of access to their own income, and the burden of carrying household expenses with little support. These accounts show that IPV may operate through economic abuse as well as through physical and emotional violence. Economic dependence can limit women's options for leaving abusive relationships, while financial over-responsibility can deepen exhaustion and hopelessness. In this sense, financial instability should be understood as a core dimension of women's lived experience of IPV rather than as a secondary consequence.

Social stigma further intensified women's suffering. Participants described fear of divorce stigma, gossip, and negative community judgement, as well as pressure to remain silent and endure abuse. This finding is especially important in the Jordanian context, where family reputation and social expectations may strongly shape women's decisions. Stigma appears to function as both a social barrier and a psychological burden: it discourages disclosure, reinforces shame, and may prolong women's exposure to abuse even when they recognize its harm. These findings highlight the importance of culturally sensitive responses that address not only the violence itself, but also the surrounding norms that sustain silence and endurance.

Despite these harms, same-gender peer support emerged as a meaningful protective factor. Some women described female colleagues or friends as sources of emotional validation, practical advice, and encouragement. Although such support did not remove the violence, it appeared to reduce isolation and help women cope more effectively. No participant explicitly described female peers as minimizing or normalizing abuse; rather, peer support was framed as helpful, but limited. This finding is in line with previous research suggesting that support from informal and formal networks can improve safety and well-being among the abused women, while group-based interventions may help interrupt isolation and strengthen coping and recovery (Crespo et al., 2021; Gharaibeh, 2022).

Taken together, the findings show that IPV profoundly compromises women's HRQoL across emotional, social, physical, and economic domains. For nursing practice, this means that responses to abused women should extend beyond immediate safety concerns to include routine assessment of psychological distress, social isolation, sleep problems, chronic pain, and financial vulnerability. In Jordanian practice

settings, this could include integrating brief IPV and HRQoL screening questions into nursing assessment, providing trauma-informed communication training for frontline staff, and strengthening referral pathways linking protection, mental health, and social support services. The need for such expanded nursing roles is consistent with regional calls for advanced and context-responsive nursing practice (Gharaibeh, 2022).

This study should be interpreted in light of some limitations. Participants were recruited from women already attending institutional support services, and their experiences may therefore reflect relatively severe or prolonged IPV. However, this should also be understood in the context of IPV as a pattern that is often recurrent, cumulative, and progressive, with many women seeking formal support only after abuse has intensified or persisted over time (Hulley et al., 2023; World Health Organization, 2021). In addition, the findings are context-specific and may not represent all abused women in Jordan. Nevertheless, this context makes the findings highly relevant for nursing and support services working with abused women in Jordan.

**Conclusion and Implications for Nursing**

IPV substantially diminished the HRQoL of abused women in Jordan across psychological, social, physical, and economic domains. Women's accounts showed that IPV was often progressive, isolating, and deeply harmful to daily functioning and well-being. Same-gender peer support emerged as a potentially important protective resource.

For nursing practice, these findings underline the importance of recognizing IPV as a complex health issue with wide-ranging consequences. Nurses and other frontline professionals should adopt trauma-informed and survivor-centered approaches that include attention to mental distress, physical complaints, social isolation, and financial vulnerability. More integrated referral and support pathways, together with brief screening and assessment of HRQoL in routine care, are needed to address the broader impact of IPV on women's lives. Similar approaches have shown promise in developed-country settings; for example, the United Kingdom's Identification and Referral to Improve Safety program improved healthcare identification of IPV and referral to specialist support, highlighting the value of structured training and referral systems (Bradbury-Jones et al., 2021).

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**Conflict of Interests**

The authors declare no conflict of interests.

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**Author Contributions**

Study Design: **KA, ENZ, NMS**. Data Collection: **KA, HD**. Data Analysis: **KA, ENZ**. Study Supervision: **HD, ENZ, NMS**. Manuscript Writing: **KA, HD, ENZ**. Critical Revision for Important Intellectual Content: **HD, ENZ, NMS**.

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