Attitudes of health care professionals towards violence against women: Are mental health professionals more sensitive?

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SUMMARY

Objective: Mental health professionals have greater access to information about patients' personal lives compared to other areas of medicine. The purpose of our study was to evaluate the attitudes of mental health professionals and other healthcare professionals towards violence against women.

Method: A total of 160 healthcare professionals, including 80 mental health professionals, participated in the study. All participants completed a sociodemographic data form and the Violence Against Women Attitude Scale.

Results: The sociodemographic characteristics of the groups were similar ($p>0.05$). It was found that 63.8% of the participants had experienced violence at some point in their lives, with 45.2% experiencing violence from family members or spouses, 31.7% from their patients or patients' relatives, and 25% experiencing physical violence, 51.3% emotional violence, 3% sexual violence and 4% economic violence. No significant differences were found between the groups. It was also discovered that university graduates, single women, women without children, women living in urban areas, women who were not perpetrators of violence, and women who did not find the penalties adequate were more sensitive to violence against both the body and identity ($p<0.05$). Furthermore, women who had previously experienced emotional violence have been more sensitive to violence against identity ($p=0.019$).

Discussion: Establishing the attitudes of healthcare professionals, who serve as the primary defense against violence against women, and furnishing in-service training to equip them with the ability to guide victims of violence effectively is a vital action in the struggle against violence.

Key Words: Attitudes towards violence, violence against women, healthcare professionals, mental healthcare professionals

INTRODUCTION

The World Health Organization (WHO) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (1). Violence against women is a significant public health issue and a violation of human rights. According to the United Nations, violence against women includes "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty" (2). Globally, approximately 30% of women experience physical and/or sexual violence in their lifetimes (3). In Turkey, studies indicate that four out of ten women have experienced physical violence at some point (4).

Violence against women is recognized as an etiological risk factor for various physical and mental illnesses, leading to significant healthcare costs and work-related losses annually (5). Addressing and intervening in violence against women requires a multi-faceted approach, with the healthcare sector playing a vital role. Women who are physically and/or psychologically harmed should go to health institutions to be protected from the violence they are exposed to. Health institutions can be a starting point in providing comprehensive health services to women who are subjected to violence and in direct-

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ing them to other support services they may need. Health workers need to be aware of this issue to detect women who are subjected to violence early and provide the necessary support. Health services are of great importance in reducing the prevalence of violence against women and related mental and physical illnesses.

A significant portion of domestic violence cases remain hidden because they are not reported and cannot be evaluated by experts. In cases that are not hidden, the approach of healthcare professionals to the victim and their attitudes towards violence are very important for the problem to be recognized or resolved. A study found that spousal violence can be reduced by 75% if healthcare professionals recognize violence and intervene (6). The duties of people in these institutions include identifying domestic violence and its psychological, physical and sexual effects, conducting the necessary examinations and treatments, documenting these and delivering them to the necessary judicial authorities.

The fact that women who are victims of violence avoid sharing the violence they are subjected to due to shame, or fear of not being adequately protected and continuing to be subjec-ted to violence by their spouses plays a role in the secrecy of violence. In addition, health workers may ignore violence or hesitate to report it because they are afraid of the risk of legal sanctions due to any attempt at violence against them or a wrong decision they make (7,8).

For this reason, women who are victims of violence should be informed about their legal rights and the violence they experience, the measures to be taken for their safety should be explained, and if necessary, they should be provided with access to support services (9). Health workers should receive the necessary legal legislation training and be protected by administrators (10). The World Health Organization also recommends in its report that inappropriate and unequal gender attitudes should be addressed in the training programs of all health workers (11). Today, we can see that the doctor-patient relationship, the relationship between medicine and society, and many medical cases are being questioned in terms of our ethical values as well as the law, and our traditional values are being reanalyzed. It can be thought that mental health workers are more knowledgeable and sensitive about this issue because they can access information about their patients' private lives more easily compared to other fields of medicine, have the opportunity to meet with their patients for longer periods of time, and internalize the training they receive throughout their working lives and reflect it in their attitudes.

When the literature was reviewed, although studies were found on the attitudes and knowledge of health workers towards violence against women, no study comparing the attitudes between health workers in mental health and other disciplines was found. (12-14).

The aim of this study was to evaluate the attitudes of mental health workers (MHW) and other health workers (OHW) towards violence against women in a university hospital.

METHOD

Design of the Study

As indicated by the power analysis, this cross-sectional study encompassed a total of 160 individuals, comprising 80 mental health workers, including physicians, psychologists, and nurses employed at a university hospital, and 80 physicians and nurses engaged in other medical specialties. Since there was no similar study as a reference, considering that a low effect size could be obtained between the two study groups in line with the information and expectations obtained from the literature, as a result of the power analysis conducted, it was calculated that 80% power could be obtained at a 95% confidence level when at least 156 people were included in the study (at least 78 people for each group) for an effect size of $d = 0.4$.

The necessary permissions were obtained from the Pamukkale University Ethics Committee prior to the study with the ethics committee decision numbered 193035 dated 07.04.2022.

Data Collection Tools

Sociodemographic Data Form: A questionnaire form consisting of 11 questions investigating the sociodemographic characteristics of the participants, 4 questions investigating the characteristics of exposure to and perpetration of violence, and 7 questions regarding violence against women, was applied to the participants, developed by the authors.

Attitude Scale on Violence Against Women (ISKEBE Attitude Scale): It was developed by Yalçın Kanbay in 2016. It is a 5-point Likert-type measurement tool consisting of two factors and 30 items. The scale has two sub-dimensions: "attitudes towards the body (Sexual and physical violence)" and "attitudes towards identity (Psychological and economic violence)". Questions 5 and 24 on the scale are scored in reverse. Each question is scored between 1 and 5 in the scale. The lowest score that can be obtained from the first factor is 16, and the highest score is 80. The lowest possible score for the second factor is 14, and the highest is 70. The lowest possible score for the overall scale is 30, and the highest is 150. High scores indicate that the participant is against violence against women, while low scores indicate that the participant is not against violence against women. Kanbay determined the Cronbach α coefficient of the scale as 0.86. (15)

Statistical Analysis

SPSS 25.0 was used to evaluate the data. For descriptive statistics, number, percentage, arithmetic mean, standard deviation, median, and interquartile difference were given. According to the Kolmogrov-Smirnov analysis, it was seen that the data did not conform to normal distribution. Mann Whitney U test and Kruskal Wallis test were used to compare the measurement variables between groups. Relationships between continuous variables were examined with Spearman correlation analysis and differences between categorical variables were examined with Chi square analysis. Statistical significance level (p) <0.05 was accepted.

Table 1. Demographic and socioeconomic characteristics of the participants

Age (M–SD)	32,06 – 7,18		
Variables		**n**	**%**
Gender	Female	112	70,00
	Male	48	30,00
Occupation	Physician	97	60,62
	Nurse	58	36,25
	Psychologist	5	3,13
Status of being a mental health worker	Yes	80	50,00
	No	80	50,00
Educational status	Primary School	0	0,00
	High School	8	5,00
	University	152	95,00
Experience	Less than five years	77	48,13
	More than five years	83	51,88
Marital status	Married	73	45,63
	Single	87	54,37
Status of having children	Yes	50	31,25
	No	110	68,75
Longest place of residence	Rural	11	6,88
	Urban	149	93,13

M=mean, SD=Standard Deviation

RESULTS

160 people participated in the study. 70% of the participants were female (n=112). The mean age was 32.06 ± 7.18. Half of the participants were mental health workers and the other half were non-mental health workers. The sociodemographic characteristics of the participants are given in Table 1.

It was determined that 63.8% of the participants had encountered violence at some point in their lives; 45.2% by their family or spouse, 31.7% by their patients and relatives; 25% by physical, 51.3% by emotional, 3% by sexual, and 4% by economic violence. 23.2% of the participants stated that they had previously been a perpetrator of violence.

68.8% of the participants stated that having a female friend or relative who had experienced domestic partner violence helped them more easily identify women who had been subjected to violence in their professional lives. When faced with a case or suspicion of violence against women, 34.4% of the participants stated that they had difficulty or were inadequate during the examination and 26.3% during the reporting phase. Those who stated that there was a procedure for violence against women in the institution they worked at were 11.3%. It was determined that 88.1% of the participants reported a case or suspicion of violence against women. Of those who did not report, 36.8% stated that they did not have information about the legal processes and 36.8% stated that they were afraid that they would put the victim in a worse si-

Table 2. Participants' attitudes and characteristics towards violence

		Mental health workers		Other health workers		P
Variables		n	%	n	%	
Approach to violence if a relative has been subjected to violence	Increased anxiety	11	30,6%	25	69,4%	
	Avoidance	0	0,0%	1	100,0%	0.038
	Easier recognition	61	55,5%	49	44,5%	
	No change	8	61,5%	5	38,5%	
Difficult stages when faced with violence	Examination	27	49,1%	28	50,9%	
	Record	8	47,1%	9	52,9%	0,128
	Report	27	64,3%	15	35,7%	
	No difficulty	18	39,1%	28	60,9%	
Whether there is a violence procedure in the institution one works in	Yes	10	55,6%	8	44,4%	0,468
	No	17	58,6%	12	41,4%	
	Don t know	53	46,9%	60	53,1%	
Whether one reports when faced with violence	Yes	69	48,9%	72	51,1%	0,625
	No	11	57,9%	8	42,1%	
	Feeling that social services are uninterested	0	0,0%	2	100,0%	0,398
	Lack of knowledge of legal processes	4	57,1%	3	42,9%	
Reasons if not reported	Fear of making the victim worse off	5	71,4%	2	28,6%	
	Insufficient evidence	1	50,0%	1	50,0%	
	Fear for self	1	100,0%	0	0,0%	
Whether one finds the punishments given to the perpetrator sufficient	Yes	3	,0%	1	25,0%	0,620
	No	77	49,4%	79	50,6%	

tuation than she was now. It was determined that 98% of the participants did not find the punishments or sanctions given to those who perpetrated violence against women sufficient. It was determined that only 31.3% of the participants received training on violence against women. The groups were similar in terms of sociodemographic and violence views and experiences (p>0.05). Compared to the OHW, MHW stated that having a friend or relative who experienced domestic violence helped them to identify women who were subjected to violence in their professional lives more easily and statistically significantly (p=0.038, Table 2).

The mean scale score of ISKEBE 1 (attitude towards the body) was 78.80±2.69 for women and 78.10±4.50 for men (p=0.491). The mean scale score of ISKEBE 2 (attitude towards identity) was 63.99±6.86 for women and 60.10±10.00 for men (p=0.064).

There was no statistically significant difference between the MHW and OHW in terms of scale scores (p< 0.05, Table 3).

The ISKEBE 1 mean scale score was significantly higher among university graduates than high school graduates (p=0.032), among psychologists than nurses and doctors (p<0.001), among singles than married (p=0.025), among those without children (p=0.002), among those living in urban areas compared to those living in rural areas (0.007), among those who had not previously committed violence compared to those who had (p=0.004), 'among those who found the punishments or sanctions given to those who committed violence against women inadequate compared to those who did not(p=0.018), and they had a more sensitive attitude towards violence against women (Table 4).

The mean scale score of ISKEBE 2 was significantly higher in psychologists than in nurses and doctors (<0.001), in single individuals than in those who are married (p=0.009), in those without children than in those with children (p=0.002), in those living in urban areas than in rural areas (p=0.018), in those exposed to emotional violence than in those not exposed to emotional violence (p=0.019), and they had a more sensitive attitude towards violence against women (Table 5).

DISCUSSION

In our study comparing the attitudes of mental health workers and other health workers towards violence against women, it was determined that the attitudes of both groups towards violence were similar and negative. Studies on violence against

Table 3. ISKEBE scale scores of participants according to their status as mental health or other health workers

Variables	ISKEBE 1 scale (M–SD)	P	ISKEBE 2 scale (M–SD)	P
Mental health workers	78,63–3,27	0,290	62,90–7,46	0,904
Other health workers	78,56–3,42		62,75–8,74	

M=mean, SD=Standard Deviation

Table 4. Mean ISKEBE1 scores of participants according to demographic and socioeconomic characteristics

Variables		ISKEBE1 score (M–SD)		p
		M	SD	
Status of education*	Primary school	-	-	
	High school	77,00	4,00	
	University	78,68	3,29	0,032
Occupation*	Physician	78,98	3,31	
	Nurse	77,83	3,41	
	Psychologist	80,00	0,00	<0,001
Marital status**	Married	77,89	4,26	
	Single	79,18	2,15	0,025
Status of having children**	Yes	77,36	4,81	
	No	79,15	2,20	0,002
Residence**	Rural	77,00	3,41	
	Urban	78,71	3,32	0,007
Status of being a perpetrator of violence **	Yes	77,97	4,02	
	No	78,78	3,10	0,004
The status of thinking that sufficient punishment has been given **	Yes	73,00	7,39	
	No	78,74	3,09	0,018

*Kruskal Wallis, **Mann Whitney U, M=mean, SD=Standard Deviation

women have determined that exposure to violence affects individuals' attitudes and behaviors regarding this issue. Studies have determined that when faced with domestic violence, men tend to respond to violence with violence, while women tend to accept violence (16,17). Therefore, it has been stated that personal experiences affect attitudes towards violence (18). In our study, it was found that 63.8% of the participants had been exposed to violence at some point in their lives. As a result of a study evaluating the violence experiences of midwives, physicians and nurses working in family health centers and their attitudes and behaviors towards violence against women, it was determined that 51.8% of the health personnel participating in the study had been exposed to violence at least once in their lives (19). In a study evaluating the knowledge, attitudes and behaviors of female health personnel about violence against women, the rate of exposure to violence was determined as 69.8% (13). These findings are similar to our study. Unlike our study, another study found that the rate of participants who stated that they had been exposed to violence before was 26.7% (20). This difference was attributed to the high sociocultural levels of the participants and the fact that the majority were single.

Healthcare workers are in a risky occupational group in terms of exposure to violence (21). This risk is present in many occupational groups in the work sector, as is the case in the health sector (22). In our study, it was determined that 45.2% of the participants were exposed to violence by their family and spouse, and 31.7% by patients and relatives. Similarly, in a study, it was determined that 21.2% of women and 40.9% of men were exposed to violence by their fathers, 16.2% of women and 3.2% of men were exposed to violence by their spouses, and 39.3% of all participants were exposed to violence by relatives of patients (19). Similar to the literature, when the type of violence that the participants were exposed to in our study was examined, it was seen that emotional violence was the most common, followed by physical violence. In our study, the status of having the role of perpetrator of violence was found to be 23.3%. In one study, this low rate is parallel to our study because violent behavior affects attitudes towards violence against women (20).

Table 5. Mean ISKEBE2 scores of participants according to demographic and socioeconomic characteristics

Variables		ISKEBE2 score (M–SD)		P
		M	SD	
Occupation*	Physician	64,44	7,68	<0,001
	Nurse	59,60	8,07	
	Psychologist	68,80	2,17	
Marital status**	Married	61,10	8,88	0,009
	Single	64,28	7,11	
Status of having children**	Yes	59,80	9,44	0,002
	No	64,20	7,03	
Longest place of residence**	Rural	58,09	9,29	0,018
	Urban	63,17	7,93	
Exposure to emotional violence**	Yes	63,85	8,24	0,019
	No	61,74	7,85	

*Kruskal Wallis, **Mann Whitney U, M=mean, SD=Standard Deviation

In our study, 68.8% of the participants stated that having a female friend or relative who had experienced domestic violence helped them to more easily recognize women who were subjected to violence in their professional lives. In a study, 72.6% of the health workers who participated in the study stated that having a female relative who had experienced violence from their spouse would affect their professional lives (14). In the same study, 43.6% of the workers stated that this situation would allow them to more easily recognize women who were subjected to violence. This difference may be due to the fact that the study was conducted only with family health center workers and the samples were different.

In a study similar to our study, it was determined that 80.9% of women and 83.9% of men would report a case or suspicion of violence against women (19). Again, in the same study, 47.4% of the participants stated that they were afraid of making the victim worse and 13.7% hesitated to report because they did not have information about the legal process. These findings indicate that training should be provided to fill the gap in knowledge about legal processes and to disseminate information in order to prevent violence against women.

The finding that only one-third of healthcare professionals received sufficient training on violence in our study is similar to the literature (23-25). It is known that healthcare professionals can have various difficulties in determining and managing violence, especially since their student years (26). It was determined that their ability to respond to these cases and to direct them consciously improved after the training to be provided (27).

In this study, the ISKEBE 1 and 2 scale scores of the two groups were found to be similar and high. Both healthcare professional groups adopted an attitude against violence against women. It was observed that the literature mostly focused on nurses, and although no exactly similar study could be found, the fact that the violence attitude scale scores were found to be similar in healthcare professionals in a study is consistent with this study (20).

In a study comparing mental health workers and other health workers in the literature, no statistically significant difference was found between the two groups in terms of emotional empathy (28). One of the striking findings of our study is that the similar attitudes of mental health workers and other health workers are indirectly measured, although not directly, by empathy ability.

On the other hand, the fact that healthcare professionals have similar and negative attitudes towards violence is a pleasing finding that is consistent with the literature (29,30). Considering that our country is one of the countries with the highest number of cases of violence against women, the fact that our healthcare professionals have a high level of awareness and a contemporary approach allows us to look with hope to a solution to this problem.

The fact that ISKEBE 1 (Attitude towards the body) scores are higher in university graduates is an expected finding that is consistent with the literature (20,29,31). It is known that educated people move away from traditional attitudes; they are more contemporary and have higher self-esteem (32). The fact that people who have not previously been perpetrators of violence and do not find punishments sufficient are more sensitive to violence against the body may be due to the fact that they have not normalized violence (29,33).

While there are studies that are consistent with the finding that single healthcare professionals have more sensitive attitudes towards both the body and identity, there are also studies that contradict this finding (20,29,34). In one study, no relationship was found between attitudes towards violence and marital status (19). This situation can be explained by the fact that married women are more tolerant and accepting of violence due to the traditional structure of our country (35). The fact that people with children are more sensitive to violence may be related to the fact that having children makes people more sensitive and empathetic (36, 37).

The fact that ISKEBE scores and attitudes towards violence generally do not create a significant difference depending on the violence experienced before is a finding that has been determined in the rele-

vant literature (19,31,33). It is noteworthy that ISKEBE 2 (identity-related) scores were higher in people who had previously been exposed to emotional violence. The reason for this may be that our sample generally consists of an educated and sensitive group.

The finding that psychologists are more sensitive than nurses in this study is important and has not been encountered in the literature. The reason for this can be explained by the fact that psychologists are more conscious of this issue due to their mental health training. In another study, no significant relationship was found between professions and attitudes (19).

The fact that 11.9% of healthcare professionals who encountered violence in our study did not report it is an important finding. The literature emphasizes that healthcare professionals should take the time to understand their obligations in the country they are in and to know the legislation, case laws, statutes and guidelines affecting these issues (38). Healthcare professionals often face ethical dilemmas regarding the situations in which they should report. While legal regulations in our country, on the one hand, prohibit the disclosure of personal data and consider acting contrary to this as a crime within the scope of Articles 134-137 of the Turkish Penal Code, and on the other hand, grant healthcare professionals the right to withdraw from testifying with Article 46 of the Criminal Procedure Law, the opposite of these two regulations, Articles 279-280 of the Turkish Penal Code, impose an obligation to report a crime under the threat of punishment. On the one hand, the need to clarify the crime and restore the disrupted public order, and on the other hand, the right to demand respect for individuals' private life compete, causing healthcare professionals to face ethical dilemmas regarding how to act in which situations (39). In addition, the expression "symptom" must be encountered in order for the obligation to report to arise in our country's laws may leave healthcare professionals in a dilemma, considering that the findings detected by the physician may have evidentiary value. Indeed, whether the obligation to report arises with the patient's statement has also been a subject of debate among lawyers. According to some authors, what is meant by symptom is any trace or artifact that reveals the suspicion that a crime has been committed, remains from the incident and represents the incident (40). It has also been stated in the literature that symptom should be understood as a trace or sign that objectively creates a legitimate and reasonable suspicion that a crime has been committed; simple suspicion, delusion or abstract assumption that is not supported by concrete information or trace cannot be accepted as a symptom (39).

According to some authors, if the crime is learned from the evidence of the statement rather than the "symptom", no obligation will arise. Accepting otherwise would lead to an unbearable expansion of the scope of the crime (41,42). However, according to some authors, the expression 'indication' in the way the law is written is not used to prevent the use of document and statement evidence as the basis for the obligation to report the crime, but to indicate that it is not necessary to seek definitive evidence that the crime has been committed (39,43,44). As can be seen, there is a need for clearer legal regulations.

Among the limitations of our study is that participation in the study was not random but voluntary. However, this also ensures that the volunteers provide their opinions anonymously, thus ensuring that the data is reliable. Another strength of this study may be that it is the first study in the literature that compares other health professionals and mental health professionals on violence against women and that it will contribute to the literature since it includes physicians and psychologists.

Health institutions and health professionals, which are one of the first points to which women who experience violence apply, play a key role in resolving this issue. It is very important for health professionals to be conscious, understanding, and to first recognize and then take part in guiding women victims correctly.

As a result, recognizing violence and managing it well is of great importance for healthy individuals and society. Health professionals have also undertaken a great task in this regard, for this reason they need to be educated and sensitive, and they

need to remember to bring violence to mind, especially in people who apply with psychiatric complaints or trauma. Due to the relationship between a person's attitude towards violence and the perception or application of violence, it is important for health professionals to determine their attitudes towards violence and to provide in-service training in order to protect their victims. More studies should be conducted on the subject, and different solutions and new legal regulations compatible with Turkish culture should be produced.

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