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Ability of Nursing Students to Recognize Signs of Violence Against Women

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PURPOSE: This study was conducted to evaluate the ability of nursing students in a Turkish school of health science to recognize signs of violence against women.
METHODS: This was a descriptive study. Data were collected via a personal information questionnaire and the Scale for Recognizing the Signs of Violence against Women by Nurses and Midwives. Two hundred fifty-nine students were included.
RESULTS: The students' total mean score on the Scale for Recognizing the Signs of Violence against Women by Nurses and Midwives was 17.79 ± 3.54.
CONCLUSION: In general, nursing students are unable to recognize signs of violence against women.
IMPLICATIONS FOR NURSING PRACTICE: The development and integration of courses on violence against women into the nursing curriculum are recommended. It is also recommended that the courses are offered every year of nursing education.
AMAÇ: Araştırma sağlık yüksekokulu hemşirelik bölümü öğrencilerin kadına yönelik şiddetin belirtilerini tanıma durumlarını belirlemek amacıyla yapıldı.
YÖNTEM: Araştırma tanımlayıcı tipte yapılmıştır. Veriler, kişisel bilgi formu ve "Hemşire ve Ebelerin Kadına Yönelik Şiddet Belirtilerini Tanımalarına İlişkin Ölçek" uygulanarak toplanmıştır. Araştırma 259 öğrenci ile yapılmıştır.
BULGULAR: Öğrencilerin genel olarak kadına yönelik şiddet belirtilerini tanımalarına ilişkin ölçek toplam puan ortalamaları 17.79 ± 3.54, olarak belirlenmiştir.
SONUÇLAR: Öğrencilerin genel olarak şiddet belirtilerini tanıma düzeyleri yetersiz bulunmuştur.
HEMŞİRELİK UYGULAMALARI İÇİN ÖNERİLER: Kadına yönelik şiddet belirtilerini tanımaya yönelik faktörler dikkate alınarak eğitim programlarının oluşturulması ve bu programların tüm eğitim yıllarına yayılacak şekilde müfredatın bir parçası haline getirilmesi önerilmektedir.

Violence is a salient and serious public health problem that is increasingly encountered in every aspect of life around the world (Güler, Tel, & Tuncay, 2005). Violence is defined as "the intentional use of physical force or power, threatened or actual, against another person that either results in or has a high likelihood of resulting in injury, death, or psychological harm" (Kızmaz, 2006; World Health Organization, 2002).

Aggressive and violent behavior has many causes (Gorman & Sultan, 2008). An ecological approach to abuse conceptualizes violence as a multifaceted phenomenon grounded in an interplay among personal, situational, and sociocultural factors (Heise, 1998). Sociocultural theories look at an aggressive individual's poor interpersonal skills (Gorman & Sultan, 2008). Exposure to aggression and violence as part of family life may also be a significant influential factor in subsequent aggressive behavior. Children who are exposed to violence may view violence as a normal way to deal with others. The cycle of family violence continues when children learn to use violence as a coping mechanism instead of socially acceptable appropriate coping behaviors. Poverty, deprivation, and hopelessness can also increase the risk of violent behavior (Gorman & Sultan, 2008).

Threats, repression, or arbitrary prevention of freedom may take place in private or public life (United Nations Declaration on the Elimination of Violence Against Women, 1993). Violence against women is a global issue. Violence has existed in every society in all eras and is closely associated with the process of social change (Akkurt, Sarı, &

Şahin, 2008; Eryılmaz, 2001; Polat, 2004). Violence against women is one of the most serious global health problems, along with human rights violations. The prevalence of violence and its role in the etiology of disease have been increasing in recent times. As shown in some studies, violence adversely affects physical and mental health, and constitutes an obstacle to the empowerment and influence of women in many areas (Giray et al., 2005; Öztürk & Sevil, 2005). Research has also demonstrated that domestic violence passes from generation to generation and psychologically affects not only the person subjected to the violence but also those who witness it (Vahip & Doğanavşargil, 2006).

Violence against women is a major focus of women's activism in Turkey because the frequency of violence against women is high. According to national statistics, approximately four of every ten married women in Turkey have experienced physical violence by a partner at least once in their lives, and 30% of women who reported partner abuse have been subject to both physical and sexual violence by their husbands or male partners (Diner & Toktaş, 2013; Jansen, Yüksel, & Çağatay, 2009). Globally, 50% of women suffer violence at the hands of their partners. It has been reported that a case of domestic violence occurs every 15 s in the United States, that two to four million women are beaten by their partners each year, with 2,000–4,000 dying as a result of their injuries, and that domestic violence is more common than any other type of crime (Tel, 2002). Studies carried out in Turkey also report significant levels of domestic violence against women. A study by Altınay and Arat (2007) of 1,800 women showed that one in every three women experienced domestic violence. According to a survey carried out in 2009 by the Turkish Prime Ministry-Directorate General on the Status of Women of 24,048 households in the country, 39% of women had been subjected to physical violence at some time in their lives, 15% to sexual violence, and 44% to emotional violence (T.C. Başbakanlık Kadının Statüsü Genel Müdürlüğü, 2012a).

In recent years, prevention of violence against women has become an issue of great importance in Turkey, with the Directorate General on the Status of Women launching the Combating Domestic Violence Against Women National Action Plan (2012–2015). The plan targets improvements in five main areas relating to gender equality and combating domestic violence against women: statutory regulation, raising social awareness and gender streamlining, empowerment of women and provision of protective services, provision of healthcare services, and interagency cooperation (T.C. Aile ve Sosyal Politikalar Bakanliği Kadının Statüsü Genel Müdürlüğü, 2012).

Healthcare professionals play important roles in contributing to the reduction in violence against women through identification of domestic violence, treatment, support, and rehabilitation. They also have important roles in the provision of prevention, protection, and early intervention services to help create a violence-free culture. Healthcare workers should be mindful of their own position on violence and strive to keep their professional lives unaffected by their attitudes. In accordance with professional and ethical codes of conduct, health professionals should recognize domestic violence victims, encourage them to voice their problems without feelings of guilt, ensure their privacy and safety, collect the relevant data, refer them to other professionals when necessary, and inform them about existing support structures (Kıyak & Akın, 2010; Tunçel, Dündar, & Peşken, 2007; Vahip & Doğanavşargil, 2006).

Healthcare professionals can provide multifaceted assistance to help battered women. However, the frequent failure by health professionals in recognizing cases of domestic violence, remaining indifferent, not regarding such cases as part of their professional responsibility, or not having enough knowledge hinder intervention (García-Moreno, 2002; Hague & Malos, 1998; Ramsey, Richardson, Carter, Davidson, & Feder, 2002; T.C. Başbakanlık Kadının Statüsü Genel Müdürlüğü, 2012b; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000; Wathen & MacMillan, 2003). Studies have emphasized that the provision of adequate training and support to healthcare workers can enhance their effectiveness in meeting the physical, emotional, and protective requirements of abused women (Kıyak, 2008; Williamson, 2000).

Nurses may be effective in the prevention of violence and future injuries by screening for and recognizing violence, educating women about domestic violence, and informing them about available support resources. However, most healthcare professionals do not have the training to attend to the needs of women subjected to violence or to undertake the responsibility for interviewing them. This study evaluated the ability of nursing students, as potential future health professionals, to recognize signs of violence against women.

Methods

Population and Sampling

This descriptive study was carried out at Mustafa Kemal University School of Health Sciences in Hatay, Turkey. The institution provides the only undergraduate program in Hatay that exclusively trains nursing students. The study population consisted of 298 students between years 1 and 4 who were enrolled in the School of Health Sciences during the 2012–2013 academic year. No selective sampling methods were used in the study, and all students who gave consent to participate were included. There were 39 students who were not accepted to participate in the study. The study was carried out with 259 students.

Data Collection Tools

Data were collected via a personal information questionnaire containing questions on sociodemographic characteristics of the participants. Additional data were collected

with the Scale for Recognizing the Signs of Violence against Women by Nurses and Midwives (SRSVAWNM).

Personal Information Questionnaire. A nine-item questionnaire was prepared following a review of relevant literature (Baysan-Arabacı & Karadağlı, 2006; Kıyak, 2008; Kıyak & Akın, 2010; Tanrıverdi & Şıpkın, 2008; Tunçel et al., 2007; Yayla, 2009). Questions included age, gender, family type, parental education levels, places resided in for the longest location period, knowledge about violence, and beliefs about intervening in cases of domestic violence.

SRSVAWNM. The SRSVAWNM developed by Baysan-Arabacı and Karadağlı (2006) consists of 31 items, which are answered as true or false. It consists of a physical symptoms subscale and an emotional symptoms subscale. Cronbach's alpha coefficient was used to test the reliability of the internal consistency of the scale. The total Cronbach's alpha reliability coefficient for the scale was 0.76. It was 0.56 for the physical symptoms subscale and 0.66 for the emotional symptoms subscale (Baysan-Arabacı & Karadağlı, 2006). The minimum and maximum total scale scores were 0 and 31, respectively. The minimum and maximum for physical symptoms was 0 and 13, respectively. For emotional symptoms, they were 0 and 18, respectively. High scores indicate high levels of knowledge. Scale from all received a score of 21–31 was considered good, 14–20 adequate, and 13 and under inadequate. The physical symptoms subscale consisted of 13 questions on physical symptoms indicating violence against women, such as scarring, bruising, swelling, and fractures. The emotional symptoms subscale consisted of 18 questions on violence against women. Emotional symptoms included insomnia, distractibility, and communication problems.

Nurses and midwives read the scale and then answered the questions. Before the application of the scale and during the assessment process, we consulted the researcher who developed and first implemented the scale, and decided that the scale was suitable for application among nursing students. In this study, the total Cronbach's alpha reliability coefficient was 0.79, physical symptoms 0.70, and emotional symptoms 0.56.

Data Collection

Data were collected between September 24, 2012 and October 5, 2012 from students who were attending classes at the Institute of Health who agreed to participate in the study (n = 259). After explaining the purpose and content of the study, we obtained informed consent from the students and distributed the data collection forms in the classroom. The forms were completed in 15–20 min.

Ethical Considerations

Written permission for the study was provided by the institution. Ethical clearance was sought from and granted by Çukurova University Faculty of Medicine Ethics Committee. Voluntary informed consent, in writing, was obtained from the students after they were informed about the research, assured that the data collected would only be used for scientific purposes, and invited to participate in the study.

Data Analysis

We evaluated the data using the SPSS 16 software (Ankara, Turkey). Frequency table of demographic characteristics of the participants has been presented. An independent sample t test, one-way analysis of variance, and Tukey's Honest Significant Difference (HSD) test were used for statistical evaluation of the data (Aktürk & Acemoğlu, 2010; Özdamar, 2004). Statistical significance was set at $p < .05$.

Results

The majority of the participating students were females (66.0%), and 40.5% were between 21 and 23 years ($\bar{X} = 20.07 \pm 1.84$). Thirty-four percent of the study sample consisted of first-year students, the majority (84.2%) of whom came from nuclear families. The commonest longest place of residence of the students was cities (46.3%). Most of the parents were primary school graduates (mothers 66.4% and fathers 53.3%). The majority of the students (61.0%) believed they had enough knowledge to deal with violence, and 88.4% of students felt it would be their professional responsibility to intervene if they encountered a woman subjected to domestic violence (Table 1).

The students' total mean SRSVAWNM score was 17.79 ± 3.54, with a mean physical symptoms subscale score of 7.46 ± 1.79 and an emotional symptoms subscale score of 10.33 ± 2.53. The mean scores of female students on the SRSVAWNM physical symptoms and emotional symptoms subscale were significantly higher than those of the male students ($p < .05$, Table 2). There was a statistically significant difference in the physical symptoms subscale scores of the students according to their age. The multiple comparison (Tukey's HSD) test results indicated that the difference stemmed from the 17–19 age bracket ($p < .05$, Table 2). There was a statistically significant difference in total mean SRSVAWNM scores and physical symptoms subscale scores based on the college year of the student. The multiple comparison test (Tukey's HSD) indicated that the difference in the physical symptoms subscale stemmed from year 1 students, and that the difference in the total SRSVAWNM score originated from year 1 and year 2 students ($p < .05$, Table 2). There was a significant difference in the total mean SRSVAWNM scores and emotional symptoms subscale scores between the students who believed they had sufficient knowledge in dealing with violence and those who did not think they had sufficient knowledge ($p < .05$, Table 2). Students who stated that it was their professional

Table 1. Sociodemographic Characteristics of Students

Personal information	No	%
Gender		
Female	171	66.0
Male	88	34.0
Age (years)		
17–19	105	40.5
20–23	108	41.7
24 and over	46	17.8
Academic year		
Year 1	88	34.0
Year 2	68	26.3
Year 3	52	20.1
Year 4	51	19.7
Place of longest residential location		
Village	52	20.1
Small town	9	3.5
County	78	30.1
City	120	46.3
Familial type		
Nuclear	218	84.2
Extended	34	13.1
Broken	7	2.7
Maternal education levels		
Illiterate	37	14.3
Elementary	172	66.4
Middle school	15	5.8
High school	32	12.4
University	3	1.2
Paternal education levels		
Illiterate	13	5.0
Elementary	138	53.3
Middle school	23	8.9
High school	52	20.1
University	33	12.7
Perception of own adequacy in addressing violence		
Sufficient	158	61.0
Insufficient	101	39.0
Belief that intervention upon encountering a woman being subjected to violence is a part of one's professional responsibility		
Yes	229	88.4
No	30	11.6
Total	259	100.0

responsibility to intervene when faced with a woman subjected to domestic violence had significantly higher mean SRSVAWNM totals and physical and emotional symptoms subscale scores than those who did not think it was their professional responsibility ($p < .05$, Table 2).

Discussion

The majority of the students who participated in this study believed that they had a professional responsibility to intervene if they encountered a woman subjected to violence (Table 1). This is consistent with other studies on nurses and midwives (Haggblom & Möller, 2005; Kıyak & Akın, 2010; Woodtli, 2001; Yayla, 2009). In a study by Tunçel et al. (2007), nearly half of the students stated that women who presented to the hospital with physical injuries should be asked whether they had been subjected to domestic violence. Perceived professional responsibility to address violence against women is a positive and important indication of students' ability to undertake nursing practices following graduation.

The students' mean total SRSVAWNM score was 17.79 ± 3.54, with a mean physical symptoms subscale score of 7.46 ± 1.79 and an emotional symptoms subscale score of 10.33 ± 2.53. Other studies reported that nurses, midwives, and physicians obtained higher mean scores than students (Baysan-Arabacı & Karadağlı, 2006; Yayla, 2009). The evaluation of students' scores shows that although they scored better in recognizing physical symptoms than in recognizing emotional symptoms of violence, overall they are less than proficient in recognizing symptoms of violence. The results of several studies indicated that nurses, midwives, and physicians are more adept at recognizing physical symptoms than emotional symptoms (Baysan-Arabacı & Karadağlı, 2006; Yayla, 2009). For health workers to create a safe environment free from violence, they need to be effective in detecting and preventing violence. Therefore, it is imperative that they recognize the symptoms of violence against women. According to one study, a well-planned educational program up to graduation is the only way to achieve this goal (McGibbon & McPherson, 2006). In a study carried out by Yazıcı and Mamuk (2010), the majority of healthcare workers said they required training to detect violence against women. The results of the present study demonstrate the necessity for such training.

In the current study, the total mean SRSVAWNM scores of the female students, as well as their mean emotional and physical symptoms subscale scores, were significantly higher than those of male students ($p < .05$, Table 2). In a study on medical and nursing students, Majumdar (2004) reported that female students are more sensitive than male students in addressing violence against women. Female students likely see violence against women as women's issue, and are therefore more sensitive than male students are to the problem.

In the present study, the difference in the physical symptoms subscale scores of the students by age was statistically significant. The multiple comparison (Tukey's HSD) demonstrated that the difference originated from the 17- to 19-year-old age group ($p < .05$, Table 2). In contrast, Kıyak (2008) reported no significant association between age and recognizing signs of violence. The current study found a statistically significant difference in the total mean SRSVAWNM scores and physical symptoms subscale scores of the students based on education year. The multiple comparison test (Tukey's HSD) revealed that the difference in the physical symptoms subscale stemmed from year 1 students, and that the difference in the total SRSVAWNM score stemmed from year 1 and year 2 students ($p < .05$, Table 2). The scores increased in accordance with the age of the student and the academic year of the student. We believe that additional years of advanced academic training increased students' awareness of the issue and contributed

Table 2. Mean SRSVAWNM Scores of Students According to Demographic Characteristics

Demographic characteristics	SRSVAWNM Physical $\bar{X} \pm SD$	Emotional $\bar{X} \pm SD$	Total $\bar{X} \pm SD$
Gender			
Female	7.659 ±9 1.89	10.57 ± 2.61	18.22 ± 3.68
Male	7.09 ± 1.52	9.87 ± 2.30	16.96 ± 3.09
	t = 2.316[a]	t = 2.115[a]	t = 2.752[a]
	p = .016	p = .035	p = .006
Age			
17–19	7.04 ± 1.89	10.65 ± 2.64	17.70 ± 3.79
20–23	7.70 ± 1.66	10.00 ± 2.32	17.70 ± 3.23
24 and above	7.84 ± 1.71	10.39 ± 2.67	18.23 ± 3.67
	F = 4.982[b]	F = 1.816[b]	F = 0.430[b]
	p = .008	p = .165	p = .651
Academic year			
Year 1	6.63 ± 1.81	10.09 ± 2.64	16.72 ± 3.72
Year 2	7.38 ± 1.64	10.80 ± 2.65	18.19 ± 3.60
Year 3	8.07 ± 1.41	10.36 ± 2.18	18.44 ± 2.71
Year 3	8.37 ± 1.67	10.09 ± 2.48	18.47 ± 3.52
	F = 14.649[b]	F = 1.220[b]	F = 4.310[b]
	p = .000	p = .303	p = .005
Self-assessed level of knowledge toward addressing violence			
Sufficient	7.39 ± 1.83	10.78 ± 2.50	18.35 ± 3.41
Insufficient	7.57 ± 1.73	10.05 ± 2.52	17.44 ± 3.58
	t = –0.794[a]	t = –2.285[a]	t = –2.038[a]
	p = .428	p = .023	p = .043
Belief that intervention upon encountering a woman being subjected to violence is a part of one's professional responsibility			
Yes	7.55 ± 1.79	10.48 ± 2.48	18.04 ± 3.47
No	6.73 ± 1.81	9.16 ± 2.66	15.90 ± 3.48
	t = 2.389[a]	t = 2.722[a]	t = 3.180[a]
	p = .018	p = .005	p = .002

[a]Independent sample t test.
[b]One-way analysis of variance.
SRSVAWNM, Scale for Recognizing the Signs of Violence against Women by Nurses and Midwives; *SD*, standard deviation.

to an increased ability to recognize signs of violence against women.

There was a significant difference in the total mean SRSVAWNM scores and emotional symptoms subscale scores between the students who believed they had sufficient knowledge for dealing with violence and those who did not think they had sufficient knowledge ($p < .05$, Table 2). In Baysan-Arabacı and Karadağlı's (2006) study, nurses' and midwives' levels of self-perceived proficiency were associated with the ability to recognize symptoms of violence against women, and the findings were statistically significant. Haggblom and Möller (2005) reported that nurses who received on-the-job training were more successful in violence intervention. The results of our study are consistent with the findings of existing studies. The results also suggest that students accurately assess their awareness of their levels of knowledge.

Students who stated that it was their professional responsibility to intervene when faced with a woman subjected to domestic violence had significantly higher mean SRSVAWNM totals, as well as physical and emotional symptoms subscale scores, than those who did not think it was their professional responsibility ($p < .05$, Table 2). Kıyak and Akın (2010) also reported that total and physical symptoms subscale scores of nurses and midwives who viewed intervening in cases of domestic violence as their professional responsibility were higher than the scores of those who did not hold this view, with the difference statistically significant. Hyman, Guruge, Stewart, and Ahmad (2000) reported that the level of knowledge of health professionals is important in the early diagnosis of violence. It may be that a sense of professional responsibility and empathy generates interest in the subject, and therefore enhances enthusiasm for more information and the provision of care.

Conclusion

The current study suggests that the ability of students to recognize signs of violence against women is inadequate. The variables associated with this outcome were students' gender, age, year of undergraduate enrollment, perceived proficiency in intervening with domestic violence situations, and their belief that such intervention is part of their professional responsibilities. Based on these results, we recommend the development of courses on violence and integration of these courses into the nursing curriculum to aid detection of signs of violence against women. We also recommend an evaluation of the content and methodology

of undergraduate and continuing education courses on violence against women. In addition, violence is a complex issue and should be addressed with a multidisciplinary approach, and for solution structuring of policies and legislation at the national level is recommended.

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