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RESEARCH ARTICLE

EVALUATION OF A SCHOOL OF MEDICAL STUDENTS' ATTITUDES TOWARDS VIOLENCE AGAINST WOMEN IN ISTANBUL

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ABSTRACT

Introduction: Violence against women has become an important public health and human rights issue. In this study, we aimed to determine and evaluate the attitudes of students in a medical school in Istanbul towards violence against women.

Material and Methods: This is a descriptive study. The population of the study consists of 1523 undergraduate students studying at the Faculty of Medicine of a university on the Anatolian side of Istanbul in the 2020-2021 academic year. The sample size was calculated as a minimum of 307 people with a 95% confidence interval and 5% margin of error and %50 prevalance (since the prevalence of medical students' attitudes towards violence against women is not known exactly, it was taken as 50%). This study was carried out with 504 participants in total. The research data were collected using a questionnaire designed to determine the sociodemographic characteristics of the participants and the "Attitudes towards Violence Scale (SITO)", which evaluates the attitudes of the participants towards violence.

Results: Among the participants %65.3 were female and 34.7% were male. While 41.9% of the participants in this study were preclinical medical students, 58.1% were clinical medical students. There is a statistical significant difference between the total scores of men and women from the SITO (Attitudes towards Violence Scale) scale ($p<0.001$). While the mean SITO(Attitudes towards Violence Scale) total score of preclinical medical students was 32.38±0.37, the mean SITO(Attitudes towards Violence Scale) total score of clinical medical students was 33±0.47. Considering the scores obtained from the all SITO(Attitudes towards Violence Scale) subscales, there was a significant difference between whether the students were preclinical or clinical and the scores they got from the SITO(Attitudes towards Violence Scale) emotional subscale ($p<0.05$). When the scale scores of the participants were examined according to the region they were born, a significant difference was observed between the participants in terms of the scores obtained from the SITO (Attitudes towards Violence Scale) economic subscale according to the region of birth ($p<0.05$).

Conclusion: Sex, class level, place of residence, region of birth, economic status of the students and their parents' work and education levels affect their attitudes towards violence against women

Key Words: Medical students, violence, attitudes

INTRODUCTION

Violence is a phenomenon that related to the thoughts and behaviors of the person, in which biological, cultural, social, political, economic, and psychological factors have important roles (1). World Health Organization has described violence as the

intentional use of physical force against someone or a group, that results in injury, psychological harm or death (2).

It is seen that people from all age groups are exposed to violence in society. Especially violence against women is still the most essential problem area all over the world (3). Violence against women, which is a serious public health problem, is one of the human rights that impresses the economic, social, educational and is universally practiced everywhere, in all ages and in all cultures around the world (4). Violence against women happens in every country of the world and is one of the most serious problems of today's population. Despite progress of the international legal norms and the creation of international legal and political structures that monitor various forms of violence, both in public and family, little progress has been made in decreasing the level of violence (5).

According to WHO data, although one out of every three women is subjected to physical or sexual violence, 38% of femicides are committed by spouses or partners (6). It is reported in the WHO 2002 report that violence is experienced mostly within the family and against women. It has been reported that 30% of women all over the world, including this country, and 37% of women in the Eastern Mediterranean Region have been exposed to physical and / or sexual violence by their spouse or partners at any time in their lives (7). General Principles reports of the European Union fundamental rights agency (FRA) showed that the amount of spousal abuse in European Community countries ranged from 13% to 32% in 2014 (8). The phenomenon of violence against women, which has been dealt with by various laws and sanctions in this country since 1980, has been handled with increasing attention until today. The Research on Domestic Violence Against Women in Turkey, conducted in 2008, is the first, largest and most comprehensive study conducted in the world and in this country on violence against women (9). Another study, which is a continuation of this research, was conducted in 2015. According to the Turkey Violence Against Women research prepared by the Ministry of Family and Social Policies in 2014, the rate of women who state that they have been subjected to physical violence at a certain time in their life is 36 percent (10). In this context, it can be said that almost 4 out of 10 women have been subjected to physical violence. This rate is thought to be even higher due to the shyness of women to describe the violence against them. Healthcare professionals are expected to be the key personnel in providing medical care, support, and counseling to the victims of violence.

Health professionals, who are closely related to women's health, have very important responsibilities in terms of reducing the effects of violence on health, preventing its continuity, and taking protective measures. Family Health Centers (ASM), Community Health Centers (TSM) and hospitals operating under the Ministry of Health in this country provide services on violence against women. Physicians are health professionals who are responsible for evaluating the patient and his conditions in detail and doing everything for the benefit of the patient when faced (11). In the studies conducted, the majority of women who were exposed to domestic violence stated that when they applied to hospitals or other health institutions, they were asked whether they had been exposed to domestic violence or not, and that they wanted to be helped by revealing this situation (12). Since physicians can be appointed to critical positions most likely encountering domestic violence cases after graduation, this field is of vital importance in their medical school education to be given, so that they do not miss such events. Therefore, determining the attitudes of medical students towards domestic violence is important in terms of helping women who are exposed to violence and who are at risk of being exposed (13). A health worker's ability to properly address female abuse can be undermined by inadequate training and subsequent lack of knowledge and biased attitudes (14). It will also be beneficial for medical students to be aware of violence against women, to become more competent when they graduate or during their internship. In a study on violence against women among medical school students in Turkey, it has been stated that medical faculty students are disturbed by violence against women (15).

In this study, it was aimed to determine and evaluate the attitudes of students in a medical school in Istanbul towards violence against women.

MATERIAL AND METHODS

Type of Research

This study is a descriptive study.

Study Population

The population of this descriptive study consisted of 1523 undergraduate students studying at the Faculty

of Medicine of a public university on the Anatolian side of Istanbul in the 2020-2021 academic year. Time period of the research was April-May 2021. In calculating sample size, the population size being 1523 students, with a 95% confidence interval, 5% margin of error and %50 prevalance (since the prevalence of medical students' attitudes towards violence against women is not known exactly, it was taken as 50%) the minimum sample size was found as 307 individuals. Participants were stratified according to each grade level and selected in proportion to the number of students from each grade. This study was carried out with a total of 504 participants. Stratified selection was planned randomly; however, it could be applied haphazardly among the students who gave informed consent in the classroom. This could be a limitation of the study as to not representing the whole class. Inclusion criteria was being a medical student who studied at the concerned public university.

Measuring Tools

The research data were collected using a questionnaire designed to determine the sociodemographic characteristics of the participants and the "Attitudes towards Violence Scale (SITO)", which evaluates the attitudes of the participants towards violence.

Attitudes towards Violence Scale (SITO): The scale developed by Gömbül determines the attitude of the health professionals towards the violence perpetrated by the husband against the woman in the family (16). The purpose of using the scale in this study is to determine the students' attitudes towards violence perpetrated against women by anyone. In scale; There were a total of 19 attitude statements: 7 questions about economic violence, 6 questions about emotional, psychological and sexual violence, 3 questions about legitimating myths and 3 questions about cause explanatory myths. As economic violence it had been asked if the woman's opinion is important or not about the expenses of the house. Legitimating myts include questions about whether a man is justified in using violence in any matter. Explanatory myths questions as it is natural for a woman who does not obey her husband to be exposed to violence.

On a Likert-type scale; I strongly disagree is “1”, disagree is “2”, undecided is “3”, agree is “4” and completely agree is “5”. Six of the 19 questions were scored inversely. The average attitude score that can be obtained in the scale varies between 19 and 95. A high attitude score indicated an increase in traditionalism in the attitude of health professionals towards violence, while a low attitude score indicated a diversity from traditionalism indicating a contemporary/modern view. In the analyzes performed by Gömbül, the validity level of the scale was determined as 0.8233, the cronbach's alpha value, which is the internal consistency coefficient, was 0.8053 (17).

The independent variables of this study were sex, grade, region where they were born and region where they live currently, educational status of parents, family type, economic status (self-reported income) and employment status of parents.

The participants in this study were coded as preclinical and clinical medical students according to the phases they were in. Grade 1st, 2nd and 3rd were coded as preclinical medical students, and grade 4th, 5th and 6th were coded as clinical medical students.

Parents of the participants who worked in a private or public company were coded as being employed; those who did not have any job as unemployed, if they have worked before and retired; coded as retired.

Statistical Analysis

In this study, descriptive data were presented with means, standard deviation values and frequency tables. Mann Whitney-U test and Kruskal Wallis analysis of variance were used to compare non-normally distributed continuous variables. The conformity of the variables to the normal distribution was examined using visual (histogram) and analytical methods (Kolmogorov Smirnov/Shapiro-Wilk). In this study, $p<0.05$ was considered as statistically significant.

Ethical Considerations

Prior to the study, ethics committee approval and research permit were obtained from the Marmara University Faculty of Medicine Clinical Research Ethics Committee with 09.2021.429 protocol number on April 2, 2021. This study was conducted according to the Declaration of Helsinki and written informed consent was obtained from all participants.

RESULTS

Among the participants %65.3 were females and 34.7% were males. While 41.9% of the participants in this study were preclinical medical students, 58.1% were clinical medical students. While 82.5% of the

Table 1. The Distribution of Participants Acoording to Sociodemographic Characteristics

		n	%
Sex	Female	329	65.3%
	Male	175	34.7%
Grade	PreClinical	245	48.6%
	Clinical	259	51.4%
Where You Live in	Province	125	75.2%
	Non-province	379	24.8%
Region Where You Were Born	Marmara Region	260	48.4%
	Other	244	51.6%
Economical Status	Good	184	36.5%
	Moderate	300	59.5%
	Bad	20	4.0%
Family Type	Elementary Family	454	90.1%
	Extended Family	50	9,9%
Father's Employment	Not Working	21	4.3%
	Working	329	68%
	Retired	134	27.7%
Mother's Employment	Not Working	221	45.7%
	Working	187	38.6%
	Retired	76	15.7%
Mother's Education	Highschool and below	286	56.7%
	University and above	218	43.3%
Father's Education	Highschool and below	173	34.3%
	University and above	331	65.7%

participants lived in province, 17.5% lived in other places such as villages and districts. While the mothers of 46.0% of the participants were reported to be unemployed, 37.9% of them were reported to be employed, and 16.1% were reported to be retired. Distribution of the participants according to sociodemographic characteristics are shown in Table 1.

The fact that the mean score of the participants in this study was 32.6±6.7 and it was much lower than the SITO total score. The mean score of the females in the SITO scale was 31.05±0.39, while the mean of the total score of the males was 35.75±0.59. There was a statistically significant difference between the total scores of males and females from the SITO ($p<0.001$). While the mean SITO total score of preclinical medical students was 32.38±0.37, the mean SITO total score of clinical medical students was 33±0.47. There was no significant difference between the total scores of clinical and preclinical medical students from SITO ($p>0.05$). The regions where the participants were born were coded as Marmara and other regions. While 48.4% of the participants stated that they were born in the Marmara region, 51.6% answered other regions. When the scale scores were examined according to the region of birth, significant differences were observed between those born in the Marmara region and other regions, as far as the SITO total scores were concerned ($p<0.05$). There was a significant difference between the employment of the mothers of the participants in terms of SITO total scores ($p<0.05$). No significant difference was found between the educational status of the parents and the SITO total scores ($p>0.05$). Total SITO scores according to sociodemographic characteristics are shown in Table 2.

The mean score of females for questions about emotional, psychological, and sexual violence was 14.88±0.97, while the mean score of males was 15.99±0.18. This difference between the scores obtained from the questions about emotional,

Table 2. Distribution of SITO* Total Score According to Sociodemographic Characteristics

		SITO* Total Score		
		Mean	Standard Deviation	P value
Sex	Female	31	5	<0.001
	Male	36	8	
Grade	PreClinical	33	7	0.946
	Clinical	32	6	
Where You Live in	Province	32	6	0.023
	Non-province	34	8	
Region Where You Were Born	Marmara Region	34	8	0.021
	Other	32	5	
Economical Status	Good	32	6	0.550
	Moderate	33	6	
	Bad	35	14	
Family Type	Elementary Family	33	7	0.439
	Extended Family	33	6	
Father's Employment	Not Working	34	4	0.120
	Working	33	7	
	Retired	32	5	
Mother's Employment	Not Working	34	8	0.008
	Working	32	5	
	Retired	32	5	
Mother's Education	Highschool and below	33	8	0.164
	University and above	32	5	
Father's Education	Highschool and below	33	7	0.509
	University and above	33	6	

*SITO; Attitudes towards Violence Scale.

psychological and sexual violence according to sex was found to be statistically significant (p<0.01). Considering the scores obtained from all subscales of SITO, there was a significant difference between the preclinical and clinical students and the scores they got from the SITO emotional subscale (p<0.05). According to the region where the participants were born, a statistically significant difference was found between those born in the Marmara region and those born in other regions in terms of the scores obtained from the SITO emotional subscale (p<0.05). There was no statistically significant difference between the education and employment of the participants' parents and the scores they got from the SITO emotional subscale (p>0.05). In Table 3, the sociodemographic characteristics and the mean and standard deviation values of the scores obtained from the emotional subscale are given.

According to this Table, the mean scores of females on questions about economic violence was 7.88±0.14, while the mean scores of males on questions about economic violence was 10±0.31. There was a statistically significant difference between the scores of females and males on questions about economic violence (p<0.001). When the scale scores of the participants were examined according to the region they were born, a statistically significant difference was observed between the Marmara region and other regions in terms of the scores obtained from the SITO economic subscale (p<0.05). There was no statistically significant difference between the economic status of the

Table 3. The Relationship Between Sociodemographic Variables and SITO* Emotional Subscale Scores

		SITO* Emotional Subscale Score		
		Mean	Standard deviation	P value
Sex	Female	15	2	<0.001
	Male	16	2	
Grade	PreClinical	15	2	0.019
	Clinical	15	2	
Where You Live in	Province	15	2	0.569
	Non-province	15	2	
Region Where You Were Born	Marmara Region	15	2	0.021
	Other	15	2	
Economical Status	Good	15	2	0.094
	Moderate	15	2	
	Bad	15	2	
Family Type	Elementary Family	15	2	0.726
	Extended Family	15	2	
Father's Employment	Not Working	16	2	0.102
	Working	15	2	
	Retired	15	2	
Mother's Employment	Not Working	15	2	0.175
	Working	15	2	
	Retired	15	2	
Mother's Education	Highschool and below	15	2	0.085
	University and above	15	2	
Father's Education	Highschool and below	15	2	0.803
	University and above	15	2	
*SITO; Attitudes towards Violence Scale.				

participants and the scores they got from the SITO economic subscale (p>0.05). In Table 4, the sociodemographic characteristics, and the mean and standard deviation values of the scores obtained from the SITO economic subscale are given.

A statistically significant difference was found between females and males according to the scores obtained from the questions about legitimating myths (p<0.001). A statistically significant difference was found between the family types of the participants and the scores they got from the subscale of legitimating myths (p<0.05). While there was a statistically significant relationship between the employment of the mothers of the participants and the scores obtained from the subscale related to legitimating myths (p<0.05), no statistically significant difference was found with the employment status and educational status of the fathers (p>0.05). In Table 5, the mean and standard deviation distributions of the scores obtained from the SITO subscale of legitimating myths according to sociodemographic characteristics are given.

While there was a statistically significant difference between sex and the scores obtained from the subscale of cause explanatory myths, no statistically significant difference was found with whether the students were clinical or preclinical (p>0.05). A statistically significant difference was found between the employment of the participants' parents and the scores they got from the subscale of cause explanatory myths (p<0.05). No statistically significant difference was found between the regions where the participants were born, and the scores obtained from the cause explanatory myths subscale

Table 4. The Relationship Between Sociodemographic Variables and Scores from The SITO* Economic Subscale

		SITO* Economic Subscale Score		
		Mean	Standard Deviation	P value
Sex	Female	8	3	<0.001
	Male	10	4	
Grade	PreClinical	8	3	0.608
	Clinical	9	4	
Where You Live in	Province	9	4	0.516
	Non-province	9	3	
Region Where You Were Born	Marmara Region	8	3	0.003
	Other	9	4	
Economical Status	Good	8	3	0.106
	Moderate	9	3	
	Bad	10	6	
Family Type	Elementary Family	9	3	0.521
	Extended Family	8	3	
Father's Employment	Not Working	8	2	0.582
	Working	9	4	
	Retired	8	2	
Mother's Employment	Not Working	9	4	0.038
	Working	8	2	
	Retired	8	2	
Mother's Education	Highschool and below	9	4	0.128
	University and above	9	3	
Father's Education	Highschool and below	9	4	0.291
	University and above	8	2	

*SITO; Attitudes towards Violence Scale.

(p>0.05). In Table 6, the mean and standard deviation distributions of the scores obtained from the SITO subscale for cause explanatory myths according to sociodemographic characteristics are given.

DISCUSSION

Violence against women is any kind of behavior that is sex-based, harms women, has the potential to result in physical, sexual or mental harm, is pressured in public or in private life, and causes restrictions on their freedoms (18). Although various studies are carried out to increase awareness of violence against women in the world and in this country, preventing violence against women is a concept that can be improved mainly by raising awareness and education. It is a concept that needs to be improved especially in the profession of medicine, since the target working group of doctors is the people in this society (19).

In this study, the median of the total score of the males' attitude towards violence scale (SITO) was found to be significantly higher than the median of the total score of the females(p<0.05). In a study conducted on nurses in which SITO was used, it was seen that males scored significantly higher, similar to this study (20). In Koştu's study of midwives' attitudes towards violence against women in the family and their professional roles in violence, the overall average score of 204 midwives' violence attitudes was found to be 37.29, and in Günal's study it was found to be 33.68 (18,21,22). The fact that Koştu's and Günal's general score on violence attitudes are lower than the scale mean, indicates that violence

Table 5. The Relationship Between Sociodemographic Variables and Scores from The SITO* Subscale of Legitimating Myths

		SITO* Legitimating Myths Subscale Score		
		Mean	Standard Deviation	P value
Sex	Female	3	1	<0.001
	Male	4	2	
Grade	PreClinical	4	1	0.232
	Clinical	4	2	
Where You Live in	Province	4	2	0.604
	Non-province	4	1	
Region Where You Were Born	Marmara Region	4	1	0.970
	Other	4	2	
Economical Status	Good	4	1	0.391
	Moderate	4	1	
	Bad	5	4	
Family Type	Elementary Family	4	2	0.035
	Extended Family	4	2	
Father's Employment	Not Working	3	1	0.593
	Working	4	2	
	Retired	4	2	
Mother's Employment	Not Working	4	2	0.049
	Working	4	1	
	Retired	3	1	
Mother's Education	Highschool and below	4	2	0.068
	University and above	4	1	
Father's Education	Highschool and below	4	2	0.754
	University and above	4	1	
*SITO; Attitudes towards Violence Scale.				

attitudes have a contemporary/modern tendency. Similar to this study, in a study conducted with medical students in India, female medical students demonstrated a significant advocacy against women and violence (14). In a study on violence against women among medical school students in Turkey, when the differences of opinion of male and female students on violence against women are evaluated and it was stated that in the vast majority of attitudes, male participants were significantly male dominated compared to females (15). In a study conducted in Mexico on the attitudes of physicians towards violence against women, it was stated that 63% had moderate knowledge on the subject, 21% had little knowledge and 16% had quite a lot of knowledge. In the same study, women were found to be more likely to have positive attitudes than men, and physicians with moderate or high knowledge were 3 times more likely to have positive attitudes than those with low knowledge (23).

In this study, it was shown that those living in province scored significantly higher scores and took a more traditional approach. This may be because families living in metropolitan cities might have migrated and they might still have traces of the culture they live in. In this study it was also observed that the unemployed parents of the participants were also associated with exhibiting a more traditional attitude. In this study, a significant relationship was found between the mother's education level and the score obtained from the subscale of cause explanatory myths, and it was observed that students with a

Table 6. The Relationship Between Sociodemographic Variables and Scores Obtained from The SITO* Subscale of Cause Explanatory Myths

		SITO* Cause Explanatory Myths Subscale Score		
		Mean	Standard Deviation	P value
Sex	Female	5	2	<0.001
	Male	6	2	
Grade	PreClinical	5	2	0.065
	Clinical	5	2	
Where You Live in	Province	5	2	0.021
	Non-province	5	2	
Region Where You Were Born	Marmara Region	5	2	0.052
	Other	5	2	
Economical Status	Good	5	2	0.681
	Moderate	5	2	
	Bad	6	4	
Family Type	Elementary Family	5	2	0.549
	Extended Family	5	2	
Father's Employment	Not Working	6	2	0.046
	Working	5	2	
	Retired	5	2	
Mother's Employment	Not Working	5	2	0.006
	Working	5	2	
	Retired	5	2	
Mother's Education	Highschool and below	5	2	0.001
	University and above	5	2	
Father's Education	Highschool and below	5	2	0.564
	University and above	5	2	

*SITO; Attitudes towards Violence Scale.

mother's education level of high school and below displayed a more traditional attitude ($p<0.05$). It is an expected situation that violence can be normalized with the decrease in the level of education in individuals. However, according to a study conducted with first-emergency aid students, it was found that students with a high school education level and above also showed a traditional approach to violence against women ($p<0.05$) (24). The fact that there are still students with traditional attitudes at the university education level reveals the necessity of providing students with professional knowledge and skills, as well as raising awareness about violence against women.

Physicians are involved in every stage of preventive medicine practices against violence against women. They take part in primary prevention by providing training and creating supportive services for women, in secondary prevention by providing early intervention to violence, and in tertiary prevention by providing rehabilitation services in the possible effects of violence. It is thought that medical students should receive education on these issues and provide the necessary emotional and social support to women who are exposed to violence by seeking solutions. In addition, it may be suggested to include questions about the important signs of violence in case diagnosis or anamnesis forms in order to notify the necessary institutions when healthcare professionals come across a case of violence.

Limitation of the Study

This study has some limitations. Because it is a descriptive study, the causal relationships between the variables could not be determined. During the pandemic period, the Center for Socio-Political Field Research reported that violence against women increased by 27.8% during this period, according to the results of a survey study in which 1873 women participated (25). The fact that this study was conducted during the pandemic and there were periods of increased domestic violence may be a confounder. Also, the fact that a study was conducted at a single medical school may not allow us to generalize about all medical students in Istanbul. Further research should be conducted on violence against women in medical faculties, and awareness should be raised by developing suggestions for them.

CONCLUSION

Violence against women is a very important problem for physicians. It is necessary to raise awareness of physicians in their training on what to do when faced with violence against women. Violence against women has been accepted as a serious and priority health problem due to the serious harm it causes to women's health, and it is called a "silent epidemic" in some sources (26). This participants' total mean score was much lower than SITO total score but, although in this study medical students revealed relatively contemporary/modern attitudes for violence against women, they should be supported with trainings for the diagnosis and treatment of violence against women. Furthermore, qualitative studies can be recommended to enlighten physicians' awareness and attitudes for violence against women.

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