

ABUSED NURSES TAKE NO LEGAL STEPS - A DOMESTIC VIOLENCE STUDY CARRIED OUT IN EASTERN TURKEY

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SUMMARY

Background: Our aim was to evaluate domestic violence among nurses in eastern Turkey.

Subjects and methods: Ninety six (96) female nurses with an intimate partner were enrolled. Modified form of Abuse Assessment Screen Questionnaire was used.

Results: Twenty two (22.7%) of the participants reported domestic violence. None of them took legal steps. Most frequent domestic violence type was economic abuse (46%). Nurses, whose mothers were exposed to domestic violence, had significantly higher abuse rates. The abused group had also significantly higher smoking and miscarriage rates.

Conclusions: Nurses need to be well informed for taking legal steps in case of domestic violence. Family history, smoking status and abortion rates may be further research focus for risk factors of domestic violence. Legal interventions should be optimized in order to encourage the victims to take legal steps.

Key words: domestic violence - nurses- intimate partner violence - abortion - risk factors - legal

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INTRODUCTION

Nurses and midwives have known to be exposed to Domestic Violence (DV), mobbing, violence in their occupational settings but prevalence and risk factor information of DV is little (Paluzzi & Houde-Quimby 1996). Higher educational level of nurses may lead to expect lower rates of DV, but there is not sufficient data to support this idea. There are few studies about DV facing Turkish nurses. Therefore, it is essential to conduct descriptive studies.

It is estimated that one in every five women faces some form of violence lifelong (WHO 2005a). In World Conference on Human Rights, and the Declaration on the Elimination of Violence Against Women in the same year, civil society and governments have acknowledged that violence against women is a public policy and human rights concern (WHO 2005b). In Turkey, the Directorate General on the Status of Women that was established in early 1990s is coordinating the governmental efforts against Domestic violence. Several codes and regulations not only provide statutory protection for victims but also aim to prevent DV. For example, according to Code 4320, courts can provide protection for the abused women even if the women would be likely to suffer a backlash from their partners for reporting it. However, this is not always the case in everyday life. The victims usually do not take legal steps (Salaçin et al. 2009).

Not only in Turkey but also in other countries, the impact of DV on women's health is underestimated (WHO 2007). Researchers have consistently found high levels of depression, posttraumatic stress symptoms,

suicidality, and substance abuse among women victimized by physically abusive partners (Adams et al. 2008, Fikree & Bhatti 1999). Those results show the negative effect of DV on both psychological and physical health. Thus, governments must place more emphasis on women's mental health and its relationship to underlying gender discrimination and rights violations (Gülçür 2000). Some researches distinguish between domestic violence and domestic abuse but we will use the terms interchangeably in our paper.

National Plan suggests that nurses working at the primary level health institutions should incorporate the topic to the routine work (Combating Domestic Violence Against Women National Action Plan 2010). There is no doubt of importance of recognizing the DV in primary health settings. Nurses and primary health care practitioners are the critical staff for identifying DV. Systematic reviews and studies suggest that nurses should routinely ask all women about DV and screen for abuse (Moore et al. 1998, Taket et al. 2003).

Numerous data exist how nurses and other healthcare professionals can assess, empower, and become advocates for victimized women when the nurses are educated. For example, nurses in health centers do a 15 minute session on health promotion with all patients and the issue of domestic violence is included in Mozambique. Within the intervention, a core group of trainers has been established, consisting of doctors and nurses who have undergone intensive training in other countries as well (WHO 2007).

Several DV interventions were even initiated by nurses (Berlinger 1999). On the other hand, most of the

victims were far more likely to be seen in the health care system (Campbell 2004). In countries such as Turkey where there are fewer formal services (i.e. shelters) for abused women than are needed nurses are likely to play a particularly important role in providing support for abused women (“He Loves You, He Beats You” Family Violence in Turkey and Access to Protection 2011). Despite recent educational efforts that were mentioned above, healthcare providers in Turkey including nurses don’t know enough about domestic violence (Aksan et al. 2007, Education of the educators for domestic violence program reached up to 150 health professionals 2008). The transition from talking about nurses as caregivers to talking about nurses as violence victims is not easy at all. “The tailor cannot fix his own rip in a seam” is a popular Turkish idiom expresses that a professional may not deal with his problems himself or herself related with their professional area.

Several prevalence studies have been conducted in Turkey (Akar et al. 2010, Baral et al. 1998, Tokuc et al. 2010). In Turkey, 26-58% of women have faced domestic violence (Domestic Violence Against Women in Turkey Study 2008). Several risk factors for DV have been suggested, such as prior history of DV, low social capital, and low educational level (WHO 2007, 2009). A recent report showed that women in ‘love’ marriages had almost twice the risk of DV than arranged marriages (a marriage type which mainly elders of the couple getting married make the selection of the persons to be wed) (Rocca et al. 2009). Nowadays, arranged marriage is not seen often but it still exist in Turkey especially in eastern part of the country where the study was conducted.

In our study we aimed to evaluate the prevalence of DV among nurses in eastern Turkey, determining whether interventions for DV is used by the nurses themselves and evaluate some of the possible risk factors regarding DV.

SUBJECTS AND METHODS

Subjects

This study was conducted in Sanliurfa, eastern Turkey with female nurses working in Harran University Teaching Hospital, aged between 22–48 years who had an intimate heterosexual partner. Nurses fulfilling those criteria were invited to participate in the study. 110 nurses participated in the study.

Methods

Participants were given written information about DV, types of DV, and how to take legal steps against DV by a leaflet that was published in public domain (Fighting against domestic violence 2007). According to the leaflet, economic abuse was defined as prevention of working, making money, buying, selling or seizure of revenues of someone. Taking legal steps was also defined in the leaflet. We used a structured questionnaire modified from the Abuse Assessment Screen

(AAS) questionnaire to determine violence among nurses. AAS gives a measure of current and past-year abuse, and of lifetime abuse. Any positive responses to current, past-year or lifetime abuse were regarded as abuse. The Likert type questionnaire was adapted and used in a Turkish setting before and it was revised to ensure that the translation was apprehensible (Yildizhan et al. 2009). Screening questions were: (1) Have you ever been emotionally or physically harmed by your partner or someone important to you? (2) Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone? If yes, by whom? (3) Within the past year, has anyone forced you to engage in sexual activities? (4) Are you afraid of your partner or someone important to you? (Yildizhan et al. 2009). It takes approx. 10 minutes to fill the questionnaire. The modified form of AAS and a sociodemographic chart were given to nurses with an envelope and they were asked to give their response in closed envelope. Sociodemographic form consisted of questions for marriage style, other types of violence past year, violence against her child/children, monthly sexual intercourse, sexual satisfaction, smoking status, miscarriage history, psychiatric treatment and taking legal steps against violence. Questions were as below: Please check your marriage style (Arranged marriage/dating/others), (If you have child/children) Do you think that you apply physical or verbal violence against your child/children?, Has your mother been exposed to violence?, Do you feel you are sexually satisfied?, Do you smoke?, Have you had any miscarriage?, Have you ever had psychiatric treatment?, (If you are exposed to violence) What was your reaction? No reaction? Resist? Inform your neighbors, relatives? Taking legal steps? (Taking legal steps was described in the information leaflet).

Procedure

One hundred and one (101) of the nurses returned the envelope. Four of them were blank. One report was excluded due to the insufficient data. The nine of the nurses who did not return their envelopes were accepted as blank envelopes. Women who reported a past and/or recent history of domestic violence formed the “abused” group, and women who had not reported domestic violence formed the “non-abused” group. Sociodemographic characteristics such as age, duration of marriage, education, employment status of the women and their partners, and sexual satisfaction were also recorded into the data sheet. “Sometimes” and “never” sexually satisfied participants were marked as sexually unsatisfied. The study was approved by the Ethics Committee of the Harran University and written informed consent was obtained from all participants.

Statistical Analysis

Statistical analysis was performed using SPSS 15.0 for Windows (SPSS, Chicago, IL, USA). Descriptive statistics were tabulated. The t test and χ^2 test were used, where appropriate, for comparing the non-abused

Table 1. Some sociodemographic characteristics of the participants

Mean Age (years)	31.90±3.98	
Work Duration (years)	7.26±4.61	
Mean wage Turkish Liras/month (1TL= 0.657 \$)	1760.12±506.35	
Mean Marriage Duration (years)	9.25±2.67	
Marriage Style (%)		
Arranged Marriage	11.5	
Dating	83.5	
Other	5.2	
Median Child Number	2	
Median Sexual Intercourse (monthly)	5	
	Abused (N=22)	Non Abused (N=74)
Smoking status		
Smokers	57 (77%)	11 (50%)
Non-smokers	17 (23%)	11 (50%)
Medical Disease		
Medically ill	3 (14%)	12 (14%)
Medically not ill	19 (86%)	62 (86%)
Sexual Satisfaction		
Satisfied	12 (54%)	59 (80%)
Not-satisfied	10 (46%)	15 (20%)
Miscarriage History		
Positive	9 (41%)	11 (15%)
Negative	13 (59%)	63 (85%)
Psychiatric Treatment		
Positive	4 (18%)	8 (11%)
Negative	18 (82%)	66 (89%)
Nurses' mothers exposure to violence		
Exposed	14 (64%)	16 (22%)
Not exposed	8 (36%)	58 (78%)

group with the abused group. Spearman's and Kendall Tau's correlations test were used. $P < 0.05$ was accepted as significant.

RESULTS

Some of the sociodemographic characteristics of nurses are shown in Table 1.

Twenty two (22.7%) of the participants reported violence against herself. Verbal, physical, economic, and sexually abused numbers of nurses were; 4 (18%), 4 (18%), 10 (46%) and 4 (18%), respectively. 3 (14%) of them reported more than one type of violence. None of the abused nurses took legal steps. There was not any significant difference of DV among marriage styles ($\chi^2=1.329$, $p=0.515$). Among the nurses whose mothers were exposed to violence had significantly higher abuse rates ($p \leq 0.001$, $\chi^2=14.25$). In the abused group, smokers' rate was significantly higher ($p=0.014$, $\chi^2=5.996$). Abused group reported significantly more sexual dissatisfaction ($p=0.02$, $\chi^2=5.44$). Abused nurses also had significantly higher miscarriage rate ($p=0.047$, $\chi^2=3.956$). There was a significant correlation between violence and mother's violence exposure history, smoking habits and sexual satisfaction ($r_0=0.383$, $P \leq 0.001$, $N=97$; $r_0=0.250$, $P=0.014$, $N=97$; $r_0=-0.245$, $P=0.020$, $N=97$, respectively).

DISCUSSION

Our first finding is the DV rate among nurses. The proportion of ever-partnered women

who had ever experienced physical or sexual violence, or both, by an intimate partner in their lifetime, ranged from 15% to 71% (WHO 2005b). The 22.7% DV rate is a bit lower than other Turkey based studies which have shown from approx. 30% to nearly 50% DV rates, but still remains within the estimated margins of the world rate (Alper et al. 2005, Ergin et al. 2006, Karaoglu et al. 2006, Mayda & Akkup 2004, WHO 2005a). In a household held study from eastern part of Turkey, 52% of the participants were found to be exposed to at least one types of violence (Kocacik & Dogan 2006). Our finding is lower than the previous studies. The lower rate in this study may be due to the selected study population. Nurses have above the standards of general public educational levels. Cultural differences among populations populating different geographic areas, for one, may also be the issue here. Most of the other studies were community based or household held. On the other hand, the reasons behind the refusal of 9 (out of 110) subjects, who fully ignored the invitation to join the study, remain unclear. There exists a possibility that, in these particular cases, the lack of feedback information may be attributed to self-

defence mechanisms developed by these individuals in response to violence they might be subjected to. This possibility may also be valid for violence-negating responses that might be resulting fairly lower DV rates as compared to those obtained by other studies. Nearly one in four Turkish nurses in this study reported current or past verbal, physical, physical, economic, and /or sexual violence. Our study group is expected to be familiar with struggling DV (Domestic Violence Against Women in Turkey Study 2008). This may be due to lack of awareness. If nurses themselves are victims, it may impact how they respond to victims they encounter. Traumatized nurses may be reluctant to report DV of the patients. Further researchers are required to answer this question.

Economic abuse was the most frequent violence type (46%) while physical, verbal and sexual abuse were relatively low. Overall rates of economic abuse is unknown, but in a study conducted in abused people, 99% of the victims reported economic abuse as subtype (Adams et al. 2008). Economic abuse may be more disabling than other types of DV. A relative higher socioeconomic status of the participants might explain the lower rates of other DV types. In patriarchal societies such as Turkish society men are believed to hold the economic management in the family (Therborn 2004). This belief might lead to higher economic abuse rate.

Our second finding is the higher abuse rate in those, whose mothers were exposed to DV. World Health Organization states history of violence in family as an individual risk factor for DV. Our finding is consistent with previous reports (WHO 2005b). The correlation between mother's violence history and DV ($r_0=0.383$) may be useful for screening people who are prone to DV.

Our third finding is the higher smoking rate in the abused group. Substance abuse and other psychological problems are already known to be higher in abused people (Kyriacou et al., 1999). Smoking can be regarded as an indirect effect of DV on health.

Our fourth finding is higher sexual dissatisfaction rate in the abused group. Yildizhan et al. (2009) has found similar results in infertiles. Possible reason for dissatisfaction is victims may not feel comfortable towards the abuser in sexual activity. Sexual dissatisfaction is more related with sexual abuse, however, regardless the type of DV it has an impact of sexual life (Finkelhor et al. 1990).

Our fifth finding is the higher miscarriage rate in the abused group that may be another impact of DV on reproductive health. The relation between miscarriage and DV is not clear; however the psychological stress on the abused pregnant women may induce abortion (Markert et al. 1997). On the other hand, one study from Turkey found more unplanned pregnancies in DV population (Sahin & Sahin 2003). The studies are underpinning the negative impact of DV on sexual health in general.

Our sixth finding is no difference of DV between marriage styles. Generally, in public it is believed that women who had arranged marriage will be more vulnerable to the DV. Not only in our study but also in the previous findings no result was found to confirm that belief (Karataş et al. 2008).

The major finding of our study is none of the victims took legal steps. The Directorate General on the Status of Women publishes fact sheets how to report DV and ministry of health has courses for DV intervention (Fighting against domestic violence 2007). However, a woman's judgment about the costs and benefits of legal intervention is shaped by her perceptions of the institutional reactions (Anderson 2001). Mostly, people who report a sexual assault to the police may undergo a forensic medical examination without their health needs being addressed (WHO 2011). The stigmatization of the women who applies to law and relative weak legal protection mechanisms may be related with this issue and may lead to the "justifiable pessimism" of victims (Okello & Hovil 2007). As mentioned before, Turkey has taken critical legislative steps, but is failing to take all necessary measures to safeguard the rights of women from violations by third parties ("He Loves You, He Beats You" Family Violence in Turkey and Access to Protection 2011). For example, the European Court of Human Rights decided in one such case, *Opuz v. Turkey*, which directly emphasized the failure of the Turkish state to take reasonable measures to prevent domestic violence perpetrated against the applicant, Nahide Opuz, and the murder of her mother (Londono 2009). Why victims avoided seeking legal steps might be related with the general view to DV as well. Mostly, domestic violence is regarded as a private or family problem that should be resolved in the family in Turkey (Altınay 2007). Therefore, victims did not talk to an authorized person. On the other hand, if Turkish nurses who are themselves victims of violence are unlikely to take legal steps to protect themselves, they might be also unlikely to recommend this option to abused women who seek health care services. Steps must be taken to increase abused Turkish women's protection under the law, and to train nurses to respond to violence and refer women to appropriate services.

Our study has several limitations. The sample size was small and highly selective (health professionals) and modified form of AAS was used. However, the modified form was tested and used in a Turkish setting before (Yildizhan et al. 2009). In addition, despite revealing a statistically higher share of the abused among smoking and miscarrying women the data still do not allow for jumping into conclusion that positive family history, smoking status and miscarriage rates may be associated with present abuse, since a number of cofactors not well-controlled within this study frame, do not allow for the establishment of causal relationships, but rather for the assumptions that definitely call for further research. Limitations stemming from restricted possibilities of study outcome extrapolation to other

cultures and communities should also be kept in mind as well. To the best of our knowledge, this is the first study investigating DV among nurses in Turkey.

Positive family history, smoking status and miscarriage rates may be associated with present abuse. In conclusion, legal interventions should be optimized in order to encourage the victims to take legal steps against DV in Turkey.

CONCLUSIONS

Nurses need to be well informed for taking legal steps in case of domestic violence. Positive family history, smoking status and abortion rates may be associated with present abuse and as such, should be of interest for future research on risk factors of domestic violence. Legal interventions should be optimized in order to encourage the victims to take legal steps.

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