Biomedical Research 2017; 28 (6): 2384-2390 *ISSN 0970-938X*
www.biomedres.info

Investigating the socio-demographic properties of women in shelters and the characteristics of violence that they are exposed.

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Abstract

Objectives: Domestic violence against women is a violation of basic human rights and freedom which is a major social problem in our country and worldwide. This cross-sectional, descriptive research aimed to investigate women's socio-demographic properties and characteristics of domestic violence they were exposed to, demonstration of inter-generational transfer of domestic violence by investigating the childhood trauma exposure and evaluating the problem solving techniques among women living in shelters.

Materials and methods: A 29-item questionnaire, the Childhood Traumas Questionnaire and the Problem Solving Inventory were performed face-to-face on 205 female residents of 22 women's shelters in Ankara, Istanbul and Izmir.

Results: In the outcomes, childhood trauma history rate of the women exposed to domestic violence was 73.6%. The rate of women witnessing inter-parental physical violence in childhood was 56.4%.

Conclusion: Prevention of violence against women can be achieved through comprehensive, multifaceted and integrated approaches requiring joint efforts by the government, policy-makers, social workers, religious scholars, educationalists, public health practitioners and family physicians. Family physicians, the first-line doctors and health care providers, should be skilled in detecting the risk factors of domestic violence, recognizing women at risk for partner violence, and providing appropriate health services and guidance for women experiencing domestic violence.

Keywords: Violence against women, Women's shelter, Family medicine.

Accepted on October 15, 2016

Introduction

Domestic violence against women is a violation of basic human rights and freedom which is a major social problem in our country as well as worldwide [1]. According to the announcement released by World Health Organization in 1996, violence against women involves any behavior that is sex-based, that probably hurts women physically, sexually and psychologically, and that causes pressure on women in social or private life, and restriction of women's freedom [2]. Domestic violence is generally used by men against women and children [1,3]. Violence can be physical, economic, sexual or psychological: Physical violence involves physical assaults and threats used to control another person [4]. Sexual violence involves any sexual gain including forcing a person with a high hand for sexual intercourse-whether completed or not-without their willingness, and using violence or ill treatment [4]. Psychological violence involves yelling at, insulting, swearing at, threatening, punishing, or oppressing a person [4]. Economic violence involves not fulfilling the economic needs of the family, preventing women from working, or not giving back women's bank cards [5,6]. According to various resources, frequency of domestic violence is 18-67% worldwide [7]. The present study aims to draw attention to the key role of the primary health care and an adopter of integrated approaches, i.e. the family practice, in identifying and intervening in each stage of the cycle of domestic violence, and to increase the consciousness of physicians about this problem.

Materials and Methods

This cross-sectional and descriptive research study was performed in secret through face-to-face interviews of about 30 minutes with 205 voluntary female residents of women's shelters in Ankara, Istanbul and Izmir between November 2014 and February 2015. The study was performed with the female residents of 13 women's shelters in Istanbul, 5 women's shelters in Ankara, and 2 women's shelters in Izmir. The reason why the current study was planned in these three cities is that most of the shelters in Turkey are in these cities, and that women from various regions stay in these shelters. We aimed to reflect the experiences and the perceptions of regional cultures in Turkey in this way. Firstly, a 29-item questionnaire by a group of researchers was performed on the respondents,

which investigates the socio-demographic properties and the characteristics of violence. Following the questionnaire, the 28-item Childhood Traumas Questionnaire in the 5-point Likert type and the 35-item Problem Solving Inventory in the 6-point Likert type were performed. The Childhood Traumas Questionnaire (CTQ-28) consists of questions to assess the emotional, physical and sexual abuse, and the physical and emotional negligence in childhood. According to the perspective of total scores and sub-group cut-off scores of CTQ-28 in Turkey; over 5 points for sexual and physical abuse, over 7 points for physical negligence and emotional abuse, over 12 points for emotional negligence, and over 35 points for the total score is regarded as the cutoff score [8].

The Problem Solving Inventory aims to assess an individual's confidence in problem solving, personal control sense, and approach type. One person can get 32-192 points on the inventory [9]. Provided that one person gets higher points on the inventory, it means that the person perceives themselves as bad at problem solving skills. According to the analysis of the inventory, on the condition that one person gets higher points for the negative approach types, it means that the person has negative problem solving skills, on the other hand, higher points for the positive approach types indicate positive problem solving skills [10]. Women's total points and sub-dimensional points of the problem solving inventory are divided into three groups of high, moderate, and low. Higher sub-dimensional points show more frequent use of the mentioned approach type, on the other hand, lower sub-dimensional points show less frequent use of the mentioned approach type. In order to carry out the study, study permit was obtained by contacting the officials at the Ministry of Family and Social Policies. This study was performed after the decision numbered 184 of 12/11/2014 and the ethics committee approval of the Clinical Studies Ethics Committee, Yildirim Beyazit University Medical Faculty. Statistical analyses were made on the IBM SPSS for Windows Version 21.0 packaged software. Breakpoints were determined by dividing the minimum and the maximum score intervals on the problem solving inventory into 3 equal sets, "high, moderate, low". Significance level was taken as $p<0.05$.

Results

Mean age of 205 female residents of shelters was 31.7 ± 8.7, and their mean number of children was 2 ± 1.4. Table 1 presents the socio-demographic properties of the women. 55.1% (n=113) of them were smokers. The smokers' amount of smoking was 9.6 ± 9.5 (0.5-40) a packet/year. 51.7% (n=106) were living in a city, 39.5% (n=81) in a county, and 6.8% (n=14) in a village. The types of violence can be seen in Figure 1. 37.1% of the women were exposed to each of the four types of violence (Figure 2). 78.7% (n=157) of the women contacted the police/the gendarmerie for help before placement in a shelter, 13.5% (n=27) the official authorities (the district governor, the governor, the mukhtar, Center for Violence Research and Prevention [SONIM in Turkey], the courts, the judges, the ministries, the foundation of women's solidarity, etc), 4.5% (n=9) a health care official. 77.1% (n=158) of the women applied to a shelter due to violence by their spouses. 82.9% (n=170) of the violence-exposed women were exposed to violence by their spouses Socio-demographic properties of the violence-users are shown in Table 2.

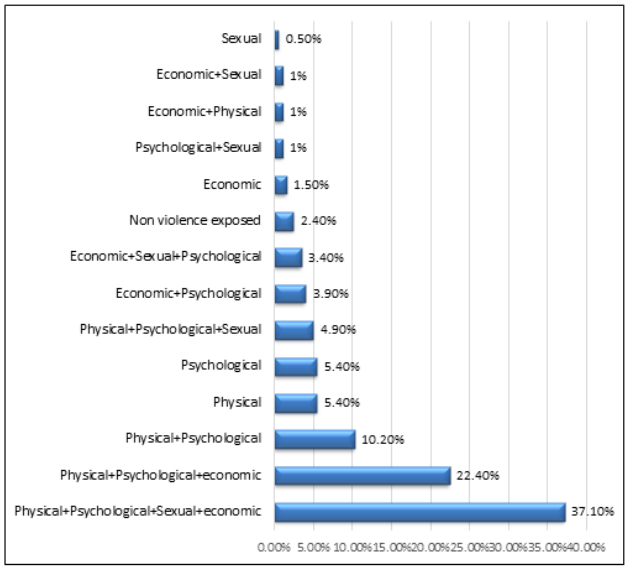

Figure 1. *Distribution of the types of violence that women were exposed to.*

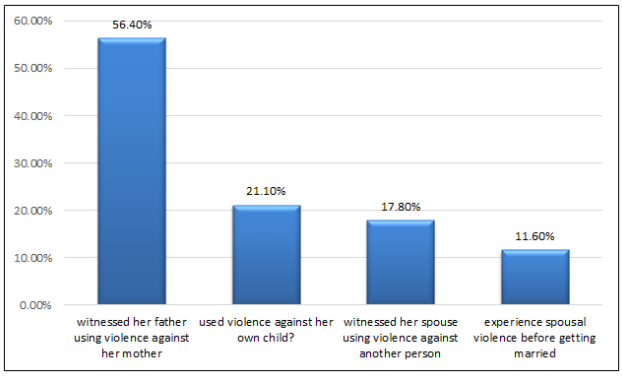

Figure 2. *Cycle of violence.*

Spouses of the violence-exposed women were older and of higher educational level than them ($p<0,001$). 24.8% (n=50) of the women learned where to apply from TV, 12.4% (n=25) from a violence-exposed friend. Mean first marriage age of the women was 19.1 ± 3.6 (11 minimum, 32 maximum). 36.6% (n=32) of them had a prearranged marriage, 17.8% (n=34) got married with a person they knew, but did not get their families' approval, 16.8% (n=32) got married with a person they knew, and got their families' approval, and 15.7% eloped. 82.2% (n=157) of the women had civil marriage, 10.5% (n=20) had religious marriage. 78.5% (n=150) of them got married once, 17.8% (n=34) twice, and 3.7% more than three times. As for the correlation between the first marriage age and the type of violence exposure, sexual-violence-exposed women had younger first marriage ages ($p<0.05$). 56.4% (n=114) of the women witnessed during childhood violence by their fathers

against their mothers, 21.1% (n=45) used violence against their own children (Figure 3). Psychological and sexual violence-exposed women had more children (p<0.001). 73.6% (n=148) of the violence-exposed women were exposed to a trauma in childhood (Figure 3).

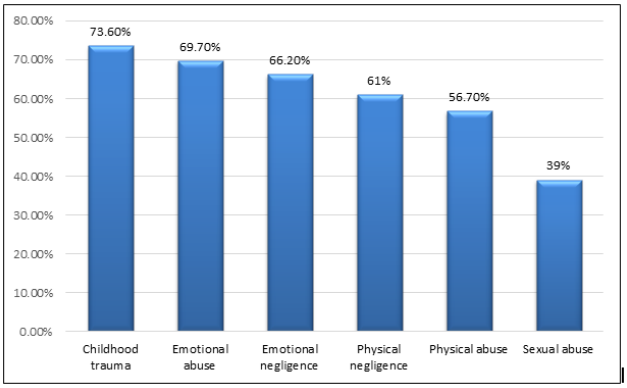

Figure 3. *Childhood trauma exposure, frequencies of abuses and negligence.*

Alcohol and drug users more frequently used psychological violence than non-users, and gamblers more frequently used sexual violence than non-gamblers (p<0.05). Alcohol and drug use showed no difference between the regions, whereas gambling rate was higher in the Marmara Region and in the Mediterranean Region (p<0.05). Literate women, primary school graduates, and secondary school graduates had a higher rate of smoking (p<0.001). As for the score distribution of the problem solving skills, monitoring was the most frequently used type of approach by women, and planfulness and reflective style were the least frequently used types of approaches by women. Also, 44.7% of the women perceived their problem solving skills as highly sufficient, and 2.5% of them as insufficient (Table 3). The sub-dimensional score averages of monitoring approach of the smoking women were higher. The reflective style scores of the women staying in a shelter for more than 12 months were higher. The total scores of the problem solving inventory of the women staying in a shelter for 6-12 months were lower. Planfulness scores of the women who eloped and who had a common-law marriage were higher. The older the women were, the lower the problem solving skills scores were, except for the avoidant style.

Table 1. *Socio-demographic properties of the women who live in shelters (n=205).*

		Percentage (%)
Educational level	Illiterate	5.4
	Literate	6.3
	Primary school graduate	36.6
	Secondary school graduate	30.7
	High school graduate	17.6
	University graduate	3.4
Occupation	Housewife	54.1
	Worker	20.5
	Self-employed	12.2
	Private sector	8.3
	Student	4.4
Marital status	Single	8.3
	Married	38.5
	Divorced	22.0
	Spouse dead	2.4
	Separated	13.7
	Divorce suit continuing	15.1
Residence	Mediterranean	4.9
	Aegean	10.2
	Eastern-Southeastern Anatolia	7.3
	Central Anatolia	23.9
	Marmara	35.6
	Black Sea	1.5
Monthly household income	0	9.8
	<750	30.2
	750-1500	39.5
	1500-3000	9.8
	>3000	10.2
Lives with	Nuclear family	80.5
	Extended family	19.5
Smoking	No	44.9
	Yes	55.1

Table 2. *Socio-demographic properties of the violence-users.*

		Percentage (%)
Relationship with the violence-user	Brother	2.0
	Sister	0.5
	Mother	2.0
	Father	5.9
	Boyfriend	1.0
	ex-husband	2.4
	Husband	80.5
	Landlord	0.5
	Sibling	1.0
	My mother-in-law	0.5
	Son	0.5

	step-sibling	0.5
Educational level	Illiterate	6.6
	Literate	5.1
	Primary school graduate	48.5
	Secondary school graduate	34.3
	High school graduate	4.0
	University graduate	1.5
Occupation	Civil servant	1.5
	Worker	26.3
	Farmer	2.0
	Retired	2.0
	Unemployed	25.3
	Private sector	5.6
	Self-employed	36.9
Bad habits	Alcohol user	47.5
	Drug user	24.7
	Gambler	11.3

Table 3. *Problem solving inventory score distribution.*

	Groups	Percentage (%)
Impulsive style	High	24.1
	Moderate	55.3
	Low	20.6
Reflective style	High	74.9
	Moderate	18.6
	Low	6.5
Avoidant style	High	50.8
	Moderate	33.7
	Low	15.6
Monitoring	High	82.4
	Moderate	10.4
	Low	7.3
Problem-solving confidence	High	46.5
	Moderate	40.4
	Low	13.1
Planfulness	High	66.8
	Moderate	26.6
	Low	6.5
Problem solving inventory	High	44.7
	Moderate	52.8
	Low	2.5

Discussion

In this cross-sectional and descriptive research study, we investigated the types of violence that female residents were exposed to in women's shelters in Ankara, Istanbul and Izmir, the socio-demographic properties of the women and of the violence-users of them, the risk factors leading to violence, and the inter-generational transfer of violence exposure. We examined the authorities that women applied to for help following violence exposure, and the correlation between the violence exposure and the women's problem solving methods. According to the country-wide field research by the TR Prime Ministry Turkish Institution of Family Research in the early 1990s, the frequency of physical violence against women was 16,5%, and the verbal violence was 12.3% [11]. According to another study, the percentage of women that expressed they were exposed to physical violence by their spouses at least once was 35% in the Turkish sample, and 40% in the Eastern sample [12]. According to a study in a shelter, 21% of women were exposed to both physical and psychological violence, and 19% of them experienced physical, psychological and sexual violence together [13]. According to a research in a psychiatry clinic, the percentage of women that were exposed to physical violence by their spouses was 57% [14]. Distribution of the violence types that women were exposed to according to our study is 88.3% psychological, 81% physical, 70.2% economic and 47.8% sexual. The reason why these percentages are higher than those of other studies might be that our study was performed in shelters without social pressure and anxiety, and that the women had told some other officials about their violence exposure. It is thought that due to the fact that especially sexual violence exposure is in privacy in our society, it is largely secreted.

According to various studies women who were not literate, whose spouses were unemployed, who had economic problems, and who had a wide age gap (5-9 years) between their spouses and them were exposed to violence more [15,16]. In another study, even if the household income of a woman was high, she was at risk for violence because she did not have her own income [17]. Similarly, according to our study, the bigger the difference in the age and the educational level between spouses are, the bigger the risk for violence against women is. As for the distribution of monthly household incomes in our study, while it is not statistically significant, the lower the educational level and the income level is, the bigger the risk of women for economic violence exposure. As for the occupational status of the women in our study, 54.1% of them were housewives. While individuals from each type of occupation might be inclined to use violence, it can be stated that an employment with a regular income decreases the risk for using violence. While it is thought that education protects women from violence exposure, this is not thought to be completely represented in statistics due to the fact that women of high educational level produce solutions different from applying to shelters when they are exposed to violence [1].

According to a study, half of the women whose spouses were illiterate were exposed to violence at least once, but 18% of the women whose spouses were of higher educational level experienced violence. The result that one of six men of higher educational level used physical violence against their spouses is as remarkable as this difference of percentage [12]. According to our study, 3 (1.5%) of the violence-users were university graduates. According to the results of many studies, lower educational level of both women and men increases the violence against women [15,18]. These results clearly illustrate the importance of education for preventing violence in society.

While some studies found extended families to be associated with domestic violence [11,19-22]; according to other studies similar to ours, nuclear family form does not prevent domestic violence [17]. It was seen in literature that domestic-violence-exposed women experienced violence by family members other than spouses [23,24]. According to our study in agreement with literature, the fact that 29.8% of the women stated that they were exposed to violence by more than one person shows how big the women's problem is. According to other studies in parallel with the results of our study, it is emphasized that bad habits such as alcohol and drug use, and gambling cause violence, and increase violence [22,25,26]. It is understood from our study that alcohol and drug users use psychological violence more, and gamblers use sexual violence more. While alcohol and drug use do not vary according to the residence areas, the percentage of gambling is higher in the Marmara and the Mediterranean Regions.

According to a study, the spousal-violence-exposed were more frequent smokers. The spousal-violence-exposed were more frequent smokers during pregnancy [27]. As for the results of our study, 55.1% of the women were smokers. According to the results of many studies, witnessing or experiencing violence during childhood made men more likely to use violence, and women more likely to be exposed to violence [12,28-30]. According to a study, children who witnessed domestic violence had higher trauma symptom scores, and they were more furious [31]. Some researches indicate that 25%-75% of the spousal-physical-violence-exposed women had childhood histories of physical or sexual abuse [32]. According to our study, 73.6% of the women were exposed to trauma(s) during childhood. 56.4% of the women witnessed violence against their mothers by their fathers. Women might use violence due to being exposed to it. As a result, the children of violence-exposed mothers experience more abuse and negligence by both parents [11,21]. According to a study at a women's shelter, almost all of the violence-exposed women were also exposed to violence during childhood, and they used violence against their own children [1]. According to our study, 21.1% of them stated that they used violence against their own children. 29.6% of the childhood-trauma-exposed women, and 8% of the non-exposed used violence against their own children. Rate of violence use of the spousal psychological-economic-and-sexual-violence-exposed women against their children was high. The bigger the number of children was, the more severe the psychological and sexual violence by spouses were. Thus, it can be assumed that sexual violence leads to unwanted pregnancy.

Some studies in literature suggest that the fact that women are deprived of immediate environment support due to marriages without family approval or a civil marriage might increase the violence against them [12,22], whereas according to other studies similar to ours, the type of marriage (prearranged marriage, elopement, etc) has nothing to do with violence exposure [1,17]. According to studies, women might be frequently exposed to violence during honeymoon or engagement [33]. Similarly, according to our study, the percentage of the women who were exposed to spousal violence before marriage during engagement or flirtation was 11.6%, and the percentage of witnessing violence by spouse against a person was 17.8%. 71.4% of the women who got married two times, and 66,7% of the women who got married three or more times were exposed to violence during their previous marriages. The reason for this might be that they regarded violence as their destiny, and that they had no choice other than submitting.

Women with traumatic and physical abuse experiences and women with traditional gender roles use avoidance coping more than problem focused coping [34,35]. Women with social support are inclined to use less avoidance coping [17,35]. This result may indicate that women who give up seeking social support use emotion focused coping instead. Depressive symptoms and intense stress restrict the mobility of women and prevent them from seeking support. Childhood-violence-exposed women apply directly to passive methods due to previous experiences of this despair. In contrast, less or no violence-exposed women use more actively the active coping strategies and problem solving skills, and can get out of violence exposure or stressful experiences more easily [17]. According to our study, although the older the women were, the more sufficient they felt to solve problems, they used avoidant style more. This result indicates that as violence exposure continues, women gradually accept their fates. Similarly, illiterate or literate but non-graduate women used avoidant style more. Low educated women find it more difficult to create a new life independent from their spouses. Women who stayed in a shelter for 6-12 months regarded themselves as insufficient to use problem solving skills. Women who stayed in a shelter for more than 12 months used reflective style less. In agreement with the other study results [1,36], according to our study, women mostly hear about the women's shelters from the police. Even though the responsibility of the law enforcers is now appreciated and these officials are trained in our country, it is critical to do these studies faster.

According to a study at the primary healthcare units, 92.4% of the women stated that during the polyclinic interviews family physicians did not ask them about domestic violence exposure. 67.3% of the women stated that they would want to tell the family physicians about it provided that they were exposed to domestic violence [37]. According to our study, only 1.5% of the women told the family physicians about their violence

experiences. If the family physicians identify the risk factors of the violence against women early, and if they question them about violence exposure, then more women will be expected to tell their family physicians about their violence experiences. According to a retrospective study in 1976, when the data were analysed about the female patients who applied to emergency service due to a traumatic experience, it was found that 5,6% of them had stated that they were exposed to violence by their spouses. In 1977, in the direction of a planned retrospective study, nurses were trained, and then every woman who applied due to a trauma was asked about spousal violence. 30% of them stated that they were exposed to violence by their spouses [38]. Similarly, according to a study at an emergency service, as a result of the interviews between nurses and women, defining the violence against women was clarified more [39]. These studies show that if there are no policies and practices which aim to identify the domestic-violence-exposed women, many cases will escape the attention without being detected and treated [11]. According to our study, 2.5% of the violence-exposed women applied to an emergency physician.

It is easier for patients to reach the primary healthcare, and to have a close relationship with a physician or a primary healthcare official, and the violence-exposed generally ask for the help of primary healthcare officials instead of legal experts or psychiatric care officials. Family physicians see their patients at every stage of the life cycle of a family. So, they have the opportunity to intervene in the intergenerational and cyclical nature of violence [40]. In order to identify the domestic violence against women early, the women at the age of 15 and above who apply to a healthcare institution should be regularly questioned about domestic violence exposure. Identifying domestic violence early makes it possible to provide the violence-exposed women with the support they need, and the non-violence-exposed women with critical information. Even if a woman does not or does not want to respond to questions about domestic violence at the time of speaking, when she sees that the healthcare official is concerned with violence, she will be encouraged to ask for help once she feels ready [4].

Conclusion

When it is considered that most of the research population learn by the way of media where to apply following violence exposure, the importance of media is obvious for informing and supporting women. Due to the fact that most of women apply to the police for help following violence exposure, the importance of careful training of the law enforcers such as the police and gendarmerie is obvious. Projects should be launched against alcohol use, drug use, and gambling. University years during the early adolescence and the early adulthood have risk for violence use and sexual assault against partners. Thus, the youth should be targeted for numerous prevention programmes [41]. Physicians and healthcare specialists play a critical role in intervening in the violence cycle. Studies show that the spousal-violence-exposed are not adequately identified by the healthcare institutions [42,43]. Physicians are recommended to continuously obtain domestic violence data from the appliers, and if they experienced violence, to provide them with emotional support, information about social services, and psychological treatment [11]. It can be a good policy for preventing violence to provide women with employment to strengthen their status, with educational opportunities, and security.

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