TURKISH JOURNAL OF APPLIED SOCIAL WORK

Volume: 4 Number: 2 Year: 2021

p-ISSN: 2651 - 4923

e-ISSN: 2667 - 6915

TURKISH JOURNAL OF APPLIED SOCIAL WORK

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Turkish Journal of Applied Social Work is an international refereed journal. The journal started its publication life in 2018. The present scientific journal is published in December and June, with two issues per year. The working languages of the journal are English and German. *Turkish Journal of Applied Social Work* is meeting the academic community with the first issue in December, 2018 and the processes required to be screened in many indexes have already started. Our journal, which is the first academic Social Work Journal in Turkey operating in foreign languages (English and German), is planning to have a new lease on social work and expects the support of the authors.

Any publications which can contribute to the development of the social work academic field and the related areas are welcome to our journal.

AIM

Turkish Journal of Applied Social Work started its publication life in 2018. This journal has embarked on the Open Access Policy with the idea that scientific information produced by academics, professionals, and others can be accessed by anyone, both locally and internationally, without any limitation.

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Any publications which can contribute to the development of the social work academic field and the related areas are welcome to our journal. Academic studies which were carried out by academicians from social work field, social workers, social work undergraduate and graduate students, professionals from different professions working in the field of social work, and other academic units with social work on mind are the scope of this journal.

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Turkish Journal of Applied Social Work is an international refereed journal that adopts double-blind peer-review process. Editorial board of our journal follows Editorial Policy of the Council of Scientific Committee.

PUBLICATION PERIOD

Our journal is published twice a year in June and December.

Publications are made from the following areas, which will contribute to the development of social work discipline and contribute to the literature:

Other disciplines assessed in relation to Social Work, Sociology, Medicine, Psychology, Psychological Counseling and Guidance, Human Rights, Social Policy, Philosophy, Law, Economics, Health Management, Nursing, Physiotherapy, Gerontology, Geriatrics, Child Development, Special Education.

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TR *Türk Uygulamalı Sosyal Hizmet Dergisi, Türkiye'de sosyal hizmet alanına özgü, İngilizce ve Almanca dillerinde, Türk akademisyenlerin ve araştırmacıların yanısıra İngiltere, ABD, Avustralya, İsveç, Almanya, Portekiz, Romanya, Polonya, Çekya, Bosna Hersek, Letonya ve Slovenya'dan akademisyenlerin ve araştırmacıların katkılarıyla yayın hayatına devam eden ilk akademik dergi olma özelliği taşır. Dergimiz 2018 yılından itibaren yılda 2 sayı olarak yayınlanmaktadır. Sosyal hizmetin tüm alanlarını içeren dergimizin 2021-7. sayısını siz değerli okurlarımızla buluşturmaktan onur duyuyoruz. Sosyal hizmet çalışmalarına ve sosyal hizmete gönül veren tüm akademisyen, araştırmacı ve sosyal hizmet mensubu dostlarımıza bu sayının faydalı olmasını diler, saygılarımızı sunarız.*

PROF. DR. MEHMET ZAFER DANIŞ
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FROM EDITOR(S)

EN

Dear readers,

The Turkish Journal of Applied Social Work, is the first academic journal specific to the field of social work in Turkey in Turkish, German and English language continued its publication life with the contributions of academics and researchers from Turkey as well as from the UK, USA, Australia, Sweden, Germany, Portugal, Romania, Poland, Czechia, Bosnia and Herzegovina, Latvia and Slovenia.

The journal has been published twice a year since 2018. We are pleased to present you the 2021-7 edition, which covers all areas of social work.

We hope this edition will be useful, and we pay our respects to all of our academics, researchers, and social workers who are committed to social work.

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"Turkish Journal of Applied Social Work" ist eine sozialarbeitsspezifische - englisch- und deutschsprachige akademische Zeitschrift, die in Kooperation mit Akademikern aus der Türkei, England, den USA, Österreich, Schweden, Deutschland, sowie Portugal, Rumnien, der Tcheschei, Bosnien und Herzogowina, Litauen, und Slowenien erscheint.

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TURKISH JOURNAL OF APPLIED SOCIAL WORK

CONTENTS

TURKISH JOURNAL OF APPLIED SOCIAL WORK
Volume: 4 Number: 2 Year: 2021

Research Article
Makale Gönderim Tarihi: 13.06.2021
Makale Kabul Tarihi: 27.09.2021

AGING SEXUAL ATTITUDES SCALE: TURKISH VALIDITY AND RELIABILITY STUDY

YAŞLANMA CİNSELLİK TUTUM ÖLÇEĞİ: TÜRÇE GEÇERLİK VE GÜVENİRLİK ÇALIŞMASI

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Yaşar, S.H., and Boyacıoğlu, E.N. (2021). Aging Sexual Attitudes Scale: Turkish Validity And Reliability Study. Turkish Journal Of Applied Social Work. 4(2). Pp. 90-104.
: https://doi.org/10.54467/trjasw.951794

Kısa Başlık: Yaşlanma Cinsellik Tutum Ölçeği
Running Head: Aging Sexual Attitudes Scale

ABSTRACT

Sexuality, which can be the cause or result of health problems, changes dimension in old age and continues until the 80s. The fact that healthcare professionals have information about the sexual lives of the elderly can give an important clue about their general health status. This study aims to evaluate the validity and reliability of the Aging Sexual Attitudes Scale in Turkish. The sample of the study, which was carried out with a methodological research design, consisted of a total of 616 students studying at different departments of a state university's health sciences faculty. The data of the study were collected between April and May 2020 using the Internet-based data collection technique, the Personal Information Form, and ASAS. As a result of the factor analysis made for ASAS, a single factor structure that explains 34.62% of the total variance was obtained. The mean score obtained from the scale is 40.18±.20.14; internal consistency coefficient 0.905; The item-total correlation coefficient was found to vary between 0.352 and 0.717. In addition, the Spearman-Brown, Guttman split-half and Cronbach α reliability coefficients, which were performed to calculate the two-half test reliability coefficient of the scale, were found to be sufficient. Turkish adaptation of ASAS which is a tool that can be used to determine sexual attitudes in old age, can be applied easily, has sufficient internal reliability and validity for healthcare professionals.

Keywords: Old Age, Attitude, Reliability and Validity, Sexuality

ÖZET

Sağlık sorunlarının nedeni veya sonucu olabilen cinsellik, yaşlılık döneminde boyut değiştirerek, 80'li yaşlara kadar devam etmektedir. Sağlık çalışanlarının, yaşlıların cinselliği hakkında bilgi sahibi olması, onların genel sağlık durumu hakkında önemli bir ipucudur. Bu çalışmada, Yaşlanma Cinsellik Tutum Ölçeği'nin (YCTÖ) Türkçe geçerlilik ve güvenirliğinin yapılması amaçlanmıştır. Metodolojik araştırma deseni ile gerçekleştirilen araştırmanın örneklemini, bir devlet üniversitesinin sağlık bilimleri fakültesinin farklı bölümlerinde öğrenim gören toplam 616 öğrenci oluşturmuştur. Araştırmanın verileri Nisan-Mayıs 2020 tarihleri arasında internet tabanlı veri toplama tekniği ile Kişisel Bilgi Formu ve YCTÖ kullanılarak toplanmıştır. YCTÖ için yapılan faktör analizi sonucunda toplam varyansın %34.62'sini açıklayan tek faktörlü bir yapı elde edilmiştir. Ölçekten alınan ortalama puan 40.18±20.14 olup; iç tutarlılık katsayısının 0.905; madde-toplam korelasyon katsayısının 0.352 ve 0.717 arasında değişim gösterdiği bulunmuştur. Ayrıca ölçeğin iki yarı test güvenilirlik katsayısını hesaplamak amacıyla yapılan Spearman-Brown, Guttman split-half ve Cronbach α güvenilirlik katsayıları yeterli düzeyde bulunmuştur. YCTÖ Türkçe uyarlaması; sağlık alanında çalışan profesyonellerin, yaşlı bireylerin cinsel tutumlarını belirlemede kullanılabilecek, kolayca uygulanabilen, yeterli iç güvenirlik ve geçerliliğe sahip bir araçtır.

Anahtar kelimeler; Yaşlılık, Güvenilirlik ve Geçerlilik, Tutum, Cinsel

TURKISH JOURNAL OF APPLIED SOCIAL WORK

AGING SEXUAL ATTITUDES SCALE: TURKISH VALIDITY AND RELIABILITY STUDY

INTRODUCTION

Sexuality is a basic human need that starts with birth and lasts until death (Von Humboldt et al., 2020). Sexuality in elderliness is a major indicator of the physical and psychological wellbeing of the elderly individuals (Von Humboldt et al., 2020; Ševčíková & Sedláková, 2020). Because sexuality is an instinct that has the potential to be the beginning or end of all health problems of the individual (McCabe et al., 2016). While certain studies demonstrate that individuals with sexual dysfunction experience depression, distress, problems in the relation with the partner and low quality of life (Mitchell et al., 2011; Polat, 2019) some others indicate that conditions like sexual myths, chronic diseases, incontinence and menopause/andropause influence sex life (Ševčíková & Sedláková, 2020; Wang et al., 2008).

In the literature, it is indicated that even though sexuality despite going through certain changes quality and quantity wise, sexual life of an individual continues until his/her 80s and even 90s (Herbenick et al., 2010; Wang et al., 2008). In elderly people, sexuality is necessary to maintain emotional intimacy, experience physical satisfaction and to fulfill continuing biological needs (Reyhan et al., 2018). While the sexual goal in young people can be sexual intercourse behavior, for elderly, it may be viewed as love, romance, friendship and spending time together. In other words, sexuality during this period can be defined as the need to feel loved and make the other person feel loved (Ševčíková & Sedláková, 2020). In qualitative studies with elderly individuals who indicate they are sexually active, sexuality in elderliness is defined within a broad spectrum. This spectrum ranges from rubbing, kissing, hugging, evening walks to friendship, communication and romance and to personal/mutual masturbation and sexual intercourse (Ševčíková & Sedláková, 2020; Von Humboldt et al., 2020).

Even though in the literature, the importance of sexual life is emphasized, it has not received necessary attention from health professionals. Because in current society, sexuality and sexual life is associated with beauty and youth (Reyhan et al., 2018; Şen et al., 2018). Thus, because elderly people don't fit this pattern, society has tended to believe they wouldn't have any sexual life. Sexual life, which is perceived to be normal for every age, is not perceived to be normal for elderly and is even thought to be totally non-existent. And as a reflection of this social mentality, elderly people tend to believe sexuality is not suitable for them and to be too shy to share their potential sexual problems and fail to get necessary support (Mahieu et al., 2013; Şen et al., 2018).

Health professionals' attitude towards sexuality in elderliness, is important in ensuring a healthy sexual life for elderly people. Thus, more studies should be conducted in this area (Lee et al., 2004; Şen et al., 2018). A review of studies on attitude towards sexuality in elderliness shows that most studies were conducted on a uniform occupational group (such as medicine, nursing etc.) (Azevedo et al., 2009; Doğan et al., 2008; Mahieu et al., 2013). However, elderliness is a multidisciplinary period. Studies on attitude towards sexuality in elderliness should be carried out across different occupational groups and importance of sexuality in elderliness should be emphasized. Among the tools used to evaluate attitude towards sexuality in elderliness, is the Aging Sexual Attitudes Scale (ASAS) developed by White et al. in USA in 1982 (White, 1982). This scale is widely used in various cultures such as in Europe, Asia and America (Azevedo et al., 2009; Lee et al., 2004; Mahieu et al., 2013; Yan & Lee, 2013; Wang et al., 2008). No study on the validity and reliability of this scale in Turkish has been noted. Thus, the purpose of the current study is to test the validity and reliability of the ASAS scale developed by White et al. (1982) to measure attitude towards sexuality in elderliness, in health professionals in Turkish society.

Research Questions

Is Aging Sexual Attitudes Scale valid and reliable for Turkish society?

METHODS

Study Design:

This study was conducted methodologically.

AGING SEXUAL ATTITUDES SCALE: TURKISH VALIDITY AND RELIABILITY STUDY

Study Population and Sample:

The study population comprises a total of 2275 undergraduate students studying at the school of health sciences of a public university during academic year of 2019-2020. Study sample comprises 616 undergraduate students enrolled in different departments of the school of health sciences and during academic year of 2019-2020 and selected using simple random sampling technique which is a non-probability sampling method. And for factor analysis, while there's no consensus in the literature regarding sample size, it is recommended to set the sample size equal to at least twice and preferably 10 or more times the number of variables (Büyüköztürk, 2007). Moving from here, Aging Sexual Attitudes Scale scale used in the study having 26 scale items shows that the sample size is sufficient of this study. Table 1 summarizes the socio-demographic characteristics of the study participants.

Data Collection Tools:

Data for the study was collected between April-May 2020 using web-based data collection method (Google Forms Questionnaire), a Personal Information Form and ASAS scale.

Personal Information Form:

This form created to evaluate socio-demographic characteristics of the participants comprises a total of 12 questions related to age, gender, education, family type, income level and the situation of living or not living with an elderly person.

Aging Sexual Attitudes Scale (ASAS):

ASAS was developed by White et al. (1982) in USA and is a tool for measuring attitude towards sexuality in elderliness. Thanks to its non-technical terminology, the scale can be used by the elderly individuals, their caregivers and professionals working with elderly. The scale comprises 26 items. Every scale is designed as 5-item Likert scale and the responder is expected to make a selection from among items ranging from "1-Totally Disagree" to "5-Totally Agree". Reverse coding was used for items 9, 10, 12, 15, 16, 17, 18, 19, 20, 22 and 24 in the scale. Higher scores obtained in the scale indicate a more positive attitude towards sexuality in elderliness. Item factor loads of the original scale range between 0.221 and 0.696 found to be in an acceptable range. And the Cronbach alpha internal validity coefficient of the scale ranges between 0.76 and 0.87 for different groups (White, 1982).

Translation:

English to Turkish translation of the scale was done by 2 different translation companies. Translated texts were reviewed by the authors and the final translated text were re-evaluated by a proficient Teacher of Turkish Literature in terms of grammar and cohesion. Also, in order to test the comprehensibility of the questions, a preliminary study was conducted with 10 students enrolled at the school of health sciences (social services, tocology, health administration) after which the text was finalized. Finally, the scale was translated to English by an independent translator. After comparing the statements here with the original English statements, Turkish version was re-evaluated.

Data Analysis:

Data collected were analyzed using SPSS Software Package. Data analysis was given under two main topics, namely validity and reliability of ASAS. Internal consistency, scale-total score correlations and split-half reliability methods were used to demonstrate the reliability of ASAS. For internal consistency, Cronbach alpha reliability which is recommended for Likert style scales, was calculated. Scale total score correlations were analyzed using Pearson correlation coefficient. For split-half reliability, Spearman-Brown, Cronbach α reliability coefficients were analyzed and Guttman split-half analysis was conducted. To demonstrate construct validity of Aging Sexual Attitudes Scale, descriptive factor analysis and confirmatory factory analysis were conducted.

AGING SEXUAL ATTITUDES SCALE: TURKISH VALIDITY AND RELIABILITY STUDY

Ethical Aspects of the Study:

Charles White who developed the ASAS, was contacted and the necessary necessary permission to use the scale was obtained via e-mail. Prior to the study, an ethical board permit was obtained from the institution where the study was conducted (meeting dated 21.06.2018 and numbered 06). Prior to data collection, administrators and instructors of the school of health sciences were informed about the study. This study was developed in accordance with the Principles of the Helsinki Declaration and participants' consent to join the study was obtained digitally before administration of the survey. Students volunteering to take part in the study filled the questionnaire.

RESULTS

Reliability Assessment for the Measurement Scale

It demonstrates the ability of a scale to measure a certain characteristic accurately, its repeatability and sustainability. A reliable assessment scale demonstrates that the scale items are mutually consistent and are adequate (Makmur, 2012). In this study, as part of reliability assessment for Aging Sexual Attitudes Scale, internal consistency reliability was evaluated. Internal consistency reliability assessment is carried out to determine whether or not the items of a scale are mutually consistent with single administration.

For ASAS, Cronbach α internal consistency coefficient was calculated to be 0.865. According to Tavşancıl (2019), if the Cronbach α coefficient is less than 0.40 then the scale is not reliable and if it is between 0.40-0.59 then the scale has low reliability, if it is between 0.60-0.79, then the scale is reliable, and if it is between 0.80-1.0 then the scale is highly reliable (Tavşancıl, 2019). A review of Cronbach α coefficients calculated after an item is deleted from the scale, deleting the items (1, 6, 13) in question hardly increased the internal consistency of the subscale (0.866, 0.867, 0.866). But elimination of one item (10) slightly improved the internal consistency of the subscale in question (0.893) (Table 2). As a result, ASAS scale with its 25 items and with a calculated Cronbach α scale of 0.893. is believed to be highly reliable. A high level of Cronbach α coefficient calculated for measuring internal consistency reliability of the assessment scale indicates both the reliability and construct validity of the scale (Büyüköztürk, 2007). Cronbach α coefficient is believed to be an indicator of homogeneity of the assessment tool and it is believed that as the Cronbach α coefficient approaches 1, the assessment scale will have more of a single-dimensional structure.

Split-half reliability analysis was used to measure the level of consistency among the responses to the scale (Berkün, 2010). To calculate the split-half reliability coefficient of the scale, Spearman-Brown, Guttman split-half, and Cronbach α reliability coefficients were analyzed. With Guttman split-half formula, correlation coefficient was calculated to be 0.906 while with Spearman Brown formula, split-half reliability was calculated to be 0.910. Cronbach α value for the first half (odd-numbered items) was calculated to be 0.878, and for the second half (even-numbered items) it was calculated to be 0.767.

As item statistics for the items in ASAS, item-total correlation was calculated. Item-total correlation defines the relationship between score obtained from each item and the total score (Büyüköztürk, 2007). A review of the item-total score correlations of the scale showed that the item correlations ranged from 0.207 and 0.696 (Table 2). One item (10) was found to have a negative item–total correlation ($r = -0.756$). Elimination of this item slightly improved the internal consistency of the scale in question. Three items (1, 6, 13), furthermore, correlated rather weakly ($0.20 < r < 0.30$). Although a low item– total correlation might indicate that the corresponding item is not measuring the same construct as measured by the other items, deleting the items in question hardly increased the internal consistency of the scale. As there is some inconsistency with regard to the

AGING SEXUAL ATTITUDES SCALE: TURKISH VALIDITY AND RELIABILITY STUDY

cut-off value that should be used (0.20 or 0.30), we decided not to eliminate these items. In terms of interpretation of item total correlations, items with value of 0.20 and above were considered to sufficiently represent the measurement scale and accordingly, one item with total score correlation coefficients negative and below 0.20 (item 10) were removed from the scale. Scale items that make up the final scale of 25 items can be argued to sufficiently discriminative (Tavşancıl, 2019). With its final format comprising 25 items, the scale's total item correlation values were at acceptable and reliable level. Table 2 summarizes the correlation coefficient of each item.

Validity Assessment of the Scale

Validity which is defined as the degree to which the measurement scale measures the characteristics in line with the purpose, means that the scale is able to measure the characteristics it is supposed to measure (Çakmur, 2012).

Descriptive Factor Analysis (DFA)

Descriptive factor analysis is carried out with the goal of determining whether or not the correlations among the item scales measures a single structure (Tavşancıl, 2019). With the factor analysis carried out in order to analyze the construct validity of ASAS, prior to Principal Component Analysis (PCA) done to determine the factors, in order to determine whether or not the data are fit for factor analysis Bartlett Test and Kaiser-Meyer-Olkin Test (KMO) were applied. KMO Test is used as an adequacy test that aims to test the correlation among variables and the adequacy of the factor analysis. For adequacy of data for factor analysis, Kaiser-Meyer-Olkin (KMO) value must be greater than 0.60 and chi-square value calculated with Barlett Test should be statistically significant (Büyüköztürk, 2007). KMO analysis value obtained in this study which was 0.892 (>0.60) and Barlett's Test of Sphericity analysis result which indicated statistical significance shows that the data are adequate for factor analysis ($\chi2=7308.890$; $p=0.0001$). Because the original scale comprises a single dimension, the analysis was conducted using a single limiting factor method without applying any reversing method. As a result of the Descriptive Factor Analysis (DFA), a single factor structure that explains 34.62% of the total variance which has eigenvalue of 7.66 was obtained. The fact that a variance of 34,62% is explained with a single factor, is a major indication that the structure in question has a single factor (Kuzucu, 2008). Scale's factor loads vary between 0.352 and 0.717. PCA results, internal consistency coefficients and explained variance for ASAS are given in Table 3.

Confirmatory Factor Analysis (CFA)

Confirmatory Factor Analysis is carried out to assess fit between certain variables and the factors that are specified or configured based on a theoretically grounded model (Sümer, 2000). With CFA, in order to determine the sufficiency of fit between the theoretical model and the observed data, different fit indices with varying strengths and weaknesses are used (Büyüköztürk, 2007). Among the most frequently used fit indices are Chi-square Fit Test, Goodness of Fit Index (GFI), Adjusted Goodness of Fit Index (AGFI), Comparative Fit Index (CFI), Normed Fit Index (NFI) and Root Mean Square Error of Approximation (RMSEA). For Chi-square Fit Test ($\chi2/d$) acceptable fit value is $2\leq\chi2/df\leq5$; for GFI, CFI, NFI and AGFI indices, acceptable fit value is $0.90\leq GFI<0.95$; and for RMSEA acceptable fit value is $0.05<RMSEA\leq0.08$; and for Chi-square Fit Test ($\chi2/d$) good fit value is $0\leq\chi2/df\leq2$; for GFI, CFI, NFI and AGFI indices, good fit value is $0.95\leq GFI\leq1.00$; and for RMSEA, good fit value is $0\leq RMSEA\leq0.05$ (Schumacker & Lomax, 2010; Şimşek, 2007).

In this study, fit indices of the model obtained using CFA were analyzed and minimum Chi-square value ($\chi2=223.59$, $N=616$, $p<0.05$) was found to be statistically significant. And the fit index values calculated were RMSEA=0.053, NFI=0.91, CFI=0.92, GFI=0.92 and AGFI=0.90. According to these results, Chi-square fit test value ($\chi2/df=2,35$) was "good"; and fit index values of RMSEA (0.053), GFI (0.92), CFI (0.92), NFI (0.91) and AGFI (0.90) were "acceptable". These results showed that fit index values of the scale were within standard values range.

AGING SEXUAL ATTITUDES SCALE: TURKISH VALIDITY AND RELIABILITY STUDY

DISCUSSIONS AND CONCLUSION

Certain changes that happened during elderliness may have an impact on the sex lives of elderly people. Sexuality, which is one of the most important components of life for many elderlies, is among the most neglected topics within the realm of elderly health and wellbeing. However, sexuality which is an important fact that influences quality of life and boosts self-esteem and self-confidence, is required in elderly to maintain emotional intimacy, to experience physical satisfaction and to meet ongoing biological needs. However, the general misconception in society that sexuality ends or should not be present in elderliness is a major obstacle in providing sexual health consultancy services to elderly people. Accordingly, measurement tools for assessing attitude towards sexuality in elderliness are needed. In relation to this, the purpose of this study is to adapt ASAS to Turkish language and to conduct its validity and reliability assessments. In order to assess construct validity of the scale, Descriptive Factor Analysis (DFA) and Confirmatory Factor Analysis (CFA) were conducted. And to assess reliability of the scale, internal consistency Cronbach alpha item total correlations and split-half test methods were used. As a result of the Descriptive Factor Analysis (DFA), a single factor structure that explains 34.62% of the total variance was obtained. Factor loads of scale items range between 0.352 and 0.717. As a result of the CFA conducted to determine whether or not the form structure of the unique form can be confirmed within the study sample, it was seen that the model demonstrated sufficient level of fit. With CFA, fit indices of the model at hand were analyzed and minimum Chi-square value was statistically significant and that the fit index values are within the desired range. Accordingly, it can be argued that the Turkish version of ASAS supports the structure of the original scale.

For reliability assessment of ASAS, Cronbach Alpha internal consistency coefficient and the Spearman-Brown and Guttman Split-Half reliability coefficient obtained using split-half method were analyzed. Accordingly, Cronbach α reliability coefficient was 0.893; Spearman-Brown coefficient was 0.910 and Guttman Split-Half coefficient was 0.906. In addition, item analysis was conducted to demonstrate the scale items' ability to predict the total score. Item analysis demonstrated that the adjusted item total correlations of the scale items ranged between 0.207 and 0.696. In terms of interpretation of item total correlations, items with value of 0.20 and above were considered to sufficiently represent the measurement scale and accordingly, one item with total score correlation coefficients negative and below 0.20 (item 10) was removed from the scale. Scale items that make up the final scale of 25 items can be argued to sufficiently discriminative. These results regarding the reliability of the scale, indicate that the scale is sufficiently reliable.

As a result of social prejudice, health professionals that act as educators, caregivers and consultants in elderly care as well tend to ignore the issue of sexuality. ASAS is widely used in many different languages to measure attitude towards elderly sexuality. Thanks to its non-technical terminology, the scale can be used easily by the elderly themselves, their caregivers and other occupational groups that work with elderly. The aim of the current study was to assess validity and reliability of Turkish version of ASAS in healthcare professionals. The results of the study demonstrated that the Turkish version of ASAS is an easy-to-administer tool with sufficient level of internal reliability and validity that can be used to determine attitude towards sexuality in elderliness.

Limitations

Data collected in this study were based on personal statements and the study sample is limited to volunteer health professional university students with internet access. Thus, it cannot be generalized to all individuals.

AGING SEXUAL ATTITUDES SCALE: TURKISH VALIDITY AND RELIABILITY STUDY

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AGING SEXUAL ATTITUDES SCALE: TURKISH VALIDITY AND RELIABILITY STUDY

Table 1. Socio-demographic characteristics of Study Participants

Variables	Categories	N	%
Gender	Female	*407*	*66.1*
	Male	209	33.9
College Year	Freshman	*131*	*21.3*
	Sophomore	152	24.8
	Junior	151	24.6
	Senior	180	29.3
Family Type	Freshman	*405*	*65.7*
	Sophomore	165	26.8
	Junior	46	7.5
	Senior	202	32.8
Income Level	High	*375*	*61*
	Moderate	38	6.2
	Low	301	48.9
Living with an elderly	Yes	314	51.1
	No	301	48.9
Age	*21.26±2.06 (Range: 18-50)*		

AGING SEXUAL ATTITUDES SCALE: TURKISH VALIDITY AND RELIABILITY STUDY

Table 2. Aging Sexual Attitudes Scale Item Statistics

Scale Item	Average Item Score	Item Standard Deviation	Scale (N=300)		Scale (n = 300) after the elimination of item 10		
			Item Total Correlation	Cronbach Alpha if Item Deleted	Item Total Correlation		Cronbach Alpha if Item Deleted
1	2.92	2	0.214		0.866	0.221	0.894
2	1.47	1.29	0.545		0.858	0.550	0.888
3	2.10	1.78	0.635		0.853	0.651	0.885
4	1.86	1.64	0.517		0.857	0.526	0.888
5	1.67	1.49	0.488		0.859	0.494	0.889
6	3.08	2	0.192		0.867	0.207	0.894
7	1.74	1.55	0.675		0.853	0.696	0.884
8	1.75	1.56	0.648		0.854	0.664	0.885
9	1.98	1.72	0.521		0.857	0.525	0.888
10	4.05	1.71	-0.756		0.893	-	-
11	2.38	1.90	0.530		0.857	0.551	0.887
12	1.63	1.46	0.308		0.863	0.293	0.893
13	1.49	1.32	0.195		0.866	0.215	0.895
14	1.72	1.54	0.554		0.857	0.566	0.887
15	1.66	1.48	0.578		0.856	0.566	0.887
16	1.53	1.35	0.446		0.860	0.431	0.890
17	1.71	1.53	0.462		0.859	0.451	0.890
18	1.65	1.48	0.449		0.860	0.437	0.890
19	1.71	1.53	0.544		0.857	0.540	0.888
20	1.44	1.26	0.399		0.861	0.384	0.891
21	1.93	1.69	0.597		0.855	0.619	0.886
22	1.52	1.34	0.443		0.860	0.432	0.890
23	1.65	1.47	0.505		0.858	0.514	0.889
24	1.91	1.68	0.593		0.855	0.597	0.886
25	2.63	1.97	0.531		0.857	0.546	0.888

AGING SEXUAL ATTITUDES SCALE: TURKISH VALIDITY AND RELIABILITY STUDY

26	*2.70*	*1.97*	*0.350*	*0.863*	*0.367*	*0.893*
Cronbach's a scale		*0.865*		*0.893*		

Table 3. Factor Loads for Aging Sexual Attitudes Scale and their Explained Variance Values

Scale Item	Factor Load Values
1. Aged people have little interest in sexuality (aged = 65 + years of age).	*0.715*
2. An aged person who shows sexual interest brings disgrace to himself/herself.	*0.440*
3. Institutions such as nursing homes ought not to encourage or support sexual activity of any sort in its residents.	*0.605*
4. Male and female residents of nursing homes ought to live on separate floors or in separate wings of the nursing home.	*0.446*
5. Nursing homes have no obligation to provide adequate privacy for residents who desire to be alone, either by themselves or as a couple.	*0.441*
6. If a relative of mine, living in a nursing home, was to have a sexual	
relationship with another resident I would: Complain to the management.	*0.724*
7. If a relative of mine, living in a nursing home, was to have a sexual	
relationship with another resident I would: Move my relative from this institution	*0.725*
8. If a relative of mine, living in a nursing home, was to have a sexual	
relationship with another resident I would: Stay out of it as it is not my concern.	*0.676*
9. In case a relative of mine living in a nursing home had sexual intercourse with another nursing home resident I would choose to remain outside of it as it is none of my business.	*0.606*
11 It is-immoral for older persons to engage in recreational sex.	*0.624*
12. I would like to know more about the changes in sexual functioning in older years.	*0.466*
13. I feel I know all I need to know about sexuality in the aged.	*0.638*
14. I would complain to the management if I knew of sexual activity between any residents of a nursing home.	*0.540*
15 I would support sex education courses for aged residents of nursing homes.	*0.693*
16. I would support sex education courses for the staff of nursing homes.	*0.665*
17. Masturbation is an acceptable sexual activity for older males.	*0.834*
18. Masturbation is an acceptable sexual activity for older females.	*0.836*
19. Institutions such as nursing homes, ought to provide large enough beds for couples who desire such to sleep together.	*0.635*

AGING SEXUAL ATTITUDES SCALE: TURKISH VALIDITY AND RELIABILITY STUDY

20. Staff of nursing homes ought to be trained or educated with regard to sexuality in the aged and/or disabled..	*0.664*
21. Residents of nursing homes ought not to engage in sexual activity of any sort.	*0.581*
22. Institutions such as nursing homes should provide opportunities for the social interaction of men and women.	*0.558*
23. Masturbation is harmful and ought to be avoided.	*0.633*
24. Institutions such as nursing homes should provide privacy so as to allow residents to engage in sexual behavior without fear of intrusion or observation..	*0.651*
25. If family members object to a ~vidowed relative engaging in sexual relations with another resident of a nursing home, it is the obligation of the management and staff to make certain that such sexual activity is prevented.	*0.560*
26. Sexual relations outside the context of marriage are always wrong.	*0.550*
Explained Total Variance	*34.62*
Eigenvalue	*7.66*
Internal consistency	*0.893*
Kaiser-Meyer-Olkin (KMO)	*0.892*
Bartlett's Testi	*ChiSquare=7308.89 df=300 p=0.0001*

EK.1 Yaşlanma Cinsellik Tutum Ölçeği	*Hiç Katılmıyorum (1)*	*Katılmıyorum (2)*	*Kararsızım (3)*	*Katılıyorum (4)*	*Tamamen Katılıyorum (5)*
Yaşlı insanların cinselliğe çok az ilgileri vardır (yaşlı = 65 yaş ve üzeri)					
Cinselliğe ilgi gösteren yaşlı bir kişi kendini rezil eder.					

AGING SEXUAL ATTITUDES SCALE: TURKISH VALIDITY AND RELIABILITY STUDY

Huzurevleri gibi kurumlar kendi sakinlerine yönelik herhangi bir cinsel faaliyeti teşvik etmemeli veya desteklememelidirler.					
Huzurevlerinde yaşayan kadın ve erkek bireyler huzurevinin ayrı katlarında veya ayrı bloklarında kalmalıdırlar.					
Huzurevlerinin tek başlarına ya da çift olarak beraber kalmak isteyen bireylere yeterli mahremiyet sağlama zorunluluğu yoktur.					
Kişi yaşlandıkça (65 yaş sonrası) cinselliğe olan ilgisi kaçınılmaz olarak kaybolur.					
Huzurevinde kalan bir yakınım, başka bir sakinle cinsel ilişkiye girse yönetime şikayet ederdim.					
Huzurevinde kalan bir yakınım, başka bir sakinle cinsel ilişkiye girse yakınımı bu kurumdan alırdım.					
Huzurevinde kalan bir yakınım, başka bir sakinle cinsel ilişkiye girse beni ilgilendirmediği için olayın dışında kalırdım.					
Bir huzurevinin isteyen sakinleri için cinsel faaliyete izin verdiğini ve desteklediğini bilsem bir yakınımı o huzurevine yerleştirmem.					
Yaşlıların eğlence amaçlı olarak cinsel ilişkiye girmeleri ahlaki değildir.					
İleri yaşlarda cinsel faaliyetlerde meydana gelen değişiklikler hakkında daha fazla bilgi almak isterdim.					
Yaşlılıkta cinsellik hakkında bilmem gereken her şeyi bildiğimi düşünüyorum.					
Bir huzurevinde sakinler arasında cinsel aktivite olduğunu bilsem bu durumu yönetime şikayet ederdim.					
Huzurevinde kalan yaşlılara yönelik cinsel eğitim kurslarını desteklerdim.					
Huzurevleri çalışanlarına yönelik cinsel eğitim kurslarını desteklerdim.					
Mastürbasyon yaşlı erkekler için kabul edilebilir bir cinsel faaliyettir.					
Mastürbasyon yaşlı kadınlar için kabul edilebilir bir cinsel faaliyettir.					
Huzurevleri gibi kurumlar birlikte kalmak isteyen çiftler için yeterli düzeyde geniş yataklar sağlamalıdır.					
Huzurevi çalışanları yaşlı ve/veya engellilerin cinselliği konusunda eğitilmelidir.					
Huzurevi sakinleri herhangi bir tür cinsel ilişkide bulunmamalıdır.					

AGING SEXUAL ATTITUDES SCALE: TURKISH VALIDITY AND RELIABILITY STUDY

Huzurevleri gibi kurumlar erkeklerin ve kadınların sosyal etkileşimi için fırsat sağlamalıdır.					
Mastürbasyon zararlıdır ve ondan kaçınılmalıdır.					
Huzurevleri gibi kurumlar, müdahale veya gözetlenme korkusu olmadan sakinlerinin cinsel davranışlarda bulunmalarına izin verecek mahremiyeti sağlamalıdır.					
Aile üyeleri huzurevinde kalan dul bir yakınlarının huzurevinin başka bir sakini ile cinsel ilişkiye girmesine karşı çıkıyorlarsa, yönetim ve çalışanlar bu tür bir cinsel faaliyetin engellendiğinden emin olmakla yükümlüdür.					
Evlilik dışındaki cinsel ilişkiler her zaman yanlıştır.					

TURKISH JOURNAL OF APPLIED SOCIAL WORK
Volume: 4 Number: 2 Year: 2021

Research Article
Makale Gönderim Tarihi: 21.10.2021
Makale Kabul Tarihi: 11.12.2021

DEPRESSION LEVELS OF UNIVERSITY STUDENTS IN TERMS OF SOME PSYCHIATRIC AND SOCIO-DEMOGRAPHIC VARIABLES IN TURKEY

TÜRKİYE'DE BAZI PSİKİYATRİK VE SOSYO-DEMOGRAFİK DEĞİŞKENLER AÇISINDAN ÜNİVERSİTE ÖĞRENCİLERİNİN DEPRESYON DÜZEYLERİ

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Saruç, S. and Aslantürk, H. (2021). Depression Levels Of University Students In Terms Of Some Psychiatric And Socio-Demographic Variables In Turkey. Turkish Journal Of Applied Social Work. 4(2). Pp:105-115. https://doi.org/10.54467/trjasw.1012312

ABSTRACT

This study aims to research the depression levels of university students in terms of some psychiatric and socio-demographic features in Turkey. The study group includes a total of 504 students who recently study at the various faculties of Anadolu University. The data of the study was collected through "Personal Information Form" and "Beck Depression Inventory" (BDI). At the end of the study, the mean Beck Depression Inventory score of the students is 13.6. As a result of this research 41.5% of the university students has a minimal level, 24.2% has a mild level, 28% has a moderate level, and 6.3% has a severe level of depression. Depression scores of the students whose parents are divorced were found to be significantly higher than the scores of those whose parents are together. There is a significant relationship between the depression levels and these variables which are psychiatric disease status, psychiatric support status, self-harm status and self-harm status of family members. The BDI scores of those students who stated having a psychiatric disorder, having been receiving psychiatric support, having a tendency to self-harm, and having a family member with a tendency to self-harm were found to be high. In addition, the depression scores of the students whose parents are divorced were seen to be higher than the scores of those whose parents are together.

Keywords: Depression level, university student, psychiatric variables, socio-demographic variables

ÖZET

Bu çalışma, Türkiye'de üniversite öğrencilerinin depresyon düzeylerini bazı psikiyatrik ve sosyodemografik özellikler açısından araştırmayı amaçlamaktadır. Çalışma grubunu Anadolu Üniversitesi'nin çeşitli fakültelerinde öğrenim gören toplam 504 öğrenci oluşturmaktadır. Araştırmanın verileri "Kişisel Bilgi Formu" ve "Beck Depresyon Envanteri" (BDE) aracılığıyla toplanmıştır. Çalışma sonucuna göre öğrencilerin Beck Depresyon Envanteri puan ortalaması 13.6'dır. Araştırma sonucunda üniversite öğrencilerinin %41,5'i minimal düzeyde, %24,2'si hafif düzeyde, %28'i orta düzeyde ve %6,3'ü ağır düzeyde depresyona sahiptir. Anne-babası boşanmış öğrencilerin depresyon puanları, anne-babası birlikte olanlara göre anlamlı düzeyde yüksek bulunmuştur. Öğrencilerin psikiyatrik hastalık durumu, psikiyatrik destek alma durumu, kendine zarar verme durumu ve aile üyelerinin kendine zarar verme durumu ile depresyon düzeyleri arasında anlamlı bir ilişki vardır. Psikiyatrik bozukluğu olduğunu, psikiyatrik destek aldığını, kendine zarar verme eğilimi olduğunu ve ailesinde kendine zarar verme eğilimi olduğunu belirten öğrencilerin BDÖ puanları yüksek bulunmuştur.

Anahtar kelimeler; Depresyon düzeyi, üniversite öğrencisi, psikiyatrik değişkenler, sosyodemografik değişkenler

TURKISH JOURNAL OF
APPLIED SOCIAL WORK

DEPRESSION LEVELS OF UNIVERSITY STUDENTS IN TERMS OF SOME PSYCHIATRIC AND SOCIO-DEMOGRAPHIC VARIABLES IN TURKEY

INTRODUCTION

Beck and Alford, who define depression in detail (2009), define it as a disorder which reveals itself as a distinct change in mood (loneliness, sadness, insensitivity), a feeling of self-blame relating negative sense of self, backward and self-punishing desires (desire to escape, hide or die), involuntary changes, changes and regression in activity level. The World Health Organization (2018) defines depression as a loss of interest accompanied by cognitive, behavioural and psychological symptoms that significantly affect the functionality of the individual in addition to depressive mood and considers it as the fourth most common public health problem in the world. In this context, the depressive mood is described as individuals' sadness, distress, reluctance, pessimism, loneliness, hopelessness and so on.

According to the DSM-V which was published by the American Psychiatric Association (APA, 2013), the depression disorders are classified into seven different categories. These disorders are categorised as; persistent depressive disorder (dysthymia), major depressive disorder, premenstrual dysphoric disorder, depressive disorder due to another medical condition, substance/medication-induced depressive disorder, other specified depressive disorder, disruptive mood dysregulation disorder, and unspecified depressive disorder (APA, 2013). According to the DSM-5, the general symptoms of these disorders are sadness, feeling of emptiness and irritation, physical and cognitive changes which significantly affect the activity level of the individual. The duration of these symptoms, the time of the occurrence, and the conditions in which the person has can vary among these disorders (APA, 2013). The most common of these disorders is major depression.

Considering the fact that depression is quite common in Turkey and around the world, depression disorders are ones of the most common mental disorders seen during the life of the general population. The World Health Organization remarks that 20% of the diseases related to mental disorders occur due to depression. In this context, depression is one of the main diseases that threaten public health. Although depression is common worldwide, major depression is the major cause of disability in the United States. The major depression prevalence in the United States is approximately 3-5.8%. One-year prevalence is stated as 2.6-6.2%. On the other hand, it is reported that 20% of the psychiatric disorders in Europe are caused by depression and this ratio reaches up to 26% in some countries. When it is evaluated in terms of sex, the life-long risk is 3-12% for men and 10-26% for women. In society in general, the life-long prevalence is approximately 15% (Yüksel, 2014). The occurrence age of the disease is reported to be between 20 and 50. The recent studies emphasis that depression disorders are becoming more common among the individuals younger than 20s (Sadock, Sadock, & Ruitz, 2014).

In Turkey, depression is considered as a common disorder which causes serious workforce loss and disability, too. When we look at the prevalence in Turkey, the study of the Mental Health Profile of Turkey (1998) shows that the prevalence of 12-month depression attacks is 5.4% in women, 2.3% in men, 4.0% in the whole population. Moreover, almost every type of mental disorders, except alcohol and substance addiction, is stated to be twice as common in women as men and the most common mental disorder is major depression. Depression in women occurs between the ages of 18 and 44 and it is higher after the age of 25 (Yüksel, 2014). The studies on depressive disorders in Turkey after 2000 were conducted on the national-scale common and other depressive disorders with sub-groups as women, generally after giving birth, teenagers, university students, and other groups (Binbay, Direk, Aker, Akvardar, & Alptekin, 2014).

There are different arguments trying to explain depression. The psychoanalytic theories define depression as a situation developed in relation to anger, guilt, despair, and loss of love which occurs due to lack of needs such as love and care during the early period of life and due to the inability of establishing close relationships (Bailey, Sauer, & Herrell, 2002). On the other hand, the analytic approach explains depression as anger and aggression towards the object lost in imagination or reality, as it turns to the individual's own self. According to this approach, major losses in early childhood, especially losing mother, increase the susceptibility to depression. Besides, insufficiency of social support, isolation, living alone and divorce are important risk factors (Yüksel, 2014). Yet, the cognitive approach describes depression as untruthful beliefs in a person's thoughts about himself/herself and the world (Cornwell, 2003). In this context, Beck's studies on depression are prominent in this model. The cognitive model of Beck consists of specific cognitive disorders. Beck argues that despair and hopelessness are of special importance in the development of depression. In Beck's view, affective disorders develop in parallel with the

DEPRESSION LEVELS OF UNIVERSITY STUDENTS IN TERMS OF SOME PSYCHIATRIC AND SOCIO-DEMOGRAPHIC VARIABLES IN TURKEY

cognitive impairments that are activated in the face of stress. These people have cognitive impairments such as negative self-perception, negative interpretations of environment and life events, and negative opinions about the future, and hopelessness and despair evolve on this cognitive structure. In other words, according to Beck, depressive people tend to assess themselves, their environment and their future adversely and they have cognitive distortions in their mindset (Beck, 1976).

It is suggested that some risk factors cause susceptibility to depression. These factors are discussed in six dimensions by Riso, Miyatake and Thase (2002). These factors include developmental factors, personality and personality disorders, psychosocial factors, comorbid disorders such as anxiety and substance addiction, biological factors and cognitive factors. The negative life events of the individual during childhood are among the developmental factors. The personality and personality disorders of the individual are also considered as risk factors for depression. Some personality traits are known to be among the risk factors that predispose to depression. These traits are; low self-esteem, obsessive traits, addiction, neuroticism, the low threshold of frustration, dependence on others for support and approval, and easily changeable emotions (Yüksel, 2014). Psychosocial factors emphasise socio-economic status, loss, trauma, social support, stressful life events, etc. (Riso et al., 2002). Biological risk factors include elements such as genetic factors, biology, sleep physiology. Finally, the individual's mindset, attitudes, schemes and methods of dealing with things are discussed among the cognitive factors (Beck & Alford, 2009).

Many people undergo periods of sadness, hopelessness and despair depending on their personality and the way they deal. These are considered natural. It should be remembered that depressive mood is a universal feeling. However, clinical depression is separated from them in terms of both intensity and duration (Yüksel, 2014).

University education in the early years of adulthood takes place in a very important period for young people. This period is a period in which many changes are experienced by young people. University students face many stress-related situations in which they have to make many important decisions about their lives. Generally, mental diseases also develop during and after adolescence. In this case, the onset of mental disorders corresponds to the university period. Especially depression and anxiety disorders are the most common mental disorders in the youth (Fraser & Blishen, 2007; Kessler et al., 2005; WHO, 2018).

As a result, depression, which is considered as a very common disorder in the youth, is an important situation that should be examined as a disorder that affects the mental health of university students, damages their academic performance, and may even cause suicide. In order to detect and prevent depression in university students, the factors causing depression should be known. In this context, the aim of this study is to define the prevalence of depression among university students and to investigate the relationship between depression and some psychiatric and socio-demographic characteristics in Turkey.

METHOD

Study Design and Participants

The research is a study conducted by relational screening method which is a type of general screening model. In this study, it was aimed to investigate the depression levels of university students according to some socio-demographic variables and psychiatric characteristics; therefore, relational screening method was preferred.

The study group includes a total of 504 students who study at the various faculties of Anadolu University in the academic year of 2017-2018. This study was conducted based on the 1964 Helsinki Declaration. Informed consent was obtained from all individual participants included in the study. The authors declare that they have no conflict of interest.

Data Collection Tools

Personal Information Form and Beck Depression Inventory (BDI) were used at the study.

Personal Information Form: The personal information form which was issued by the researcher includes questions about age, sex, if the parents are living, the education and marital status of the parents, economic status, number of siblings and which child (in order) the participant is, and the information relating romantic relations, as well as whether or not having a diagnosed disorder, if s/he has ever done something self-harming, and if his/her family members have ever done something self-harming.

Beck Depression Inventory (BDI): Beck Depression Inventory was developed by Beck, Ward, Mendelson, & Erbaugh (1961). The inventory is composed of 21 categories which were developed to determine the degree of emotional, somatic, cognitive and motivational symptoms of depression. The Turkish adaptation of the inventory was done by Hisli (1989). Each category consists of 4 self-assessment items and a score of 0-3 can be taken from each item. The lowest score from the inventory is 0 and the highest is 63. A high score from the inventory indicates a high level of depression. The aim of the inventory

DEPRESSION LEVELS OF UNIVERSITY STUDENTS IN TERMS OF SOME PSYCHIATRIC AND SOCIO-DEMOGRAPHIC VARIABLES IN TURKEY

is not to diagnose depression, but to put the degree of the symptoms into numbers objectively. The validity and reliability of the inventory were tested by Beck, Steer, Ball, & Raneri (1996) and the reliability coefficient was found to be .91. The validity and reliability measurement of the Turkish form of the inventory was conducted by Hisli (1989) and it was found that the split-half reliability coefficient of the Turkish form is 0.74 and the criterion-related validity coefficient varies between 0.47 and 0.63. In this study, the Cronbach's alpha internal consistency coefficient of the Beck Depression Inventory was calculated as 0.90.

Data Analysis

The analysis of the data at the study was carried out with the data collected from the 504 students. The data collected from the participants were analyzed by being transferred into SPSS (Statistical Package for Social Sciences) Chicago IL, Version 21.00 Windows package program. At the statistical evaluation of the data, the Kolmogorov Smirnov test and skewness-kurtosis values were checked in order to assess normal distribution. As a result of the statistical analysis, the data of the study were not corresponding to the normal distribution, therefore, non-parametric tests were used. Mann-Whitney U test was preferred for paired comparison, while Kruskal Wallis test was used for comparisons of groups more than two.

FINDINGS

Table 1 shows the socio-demographic characteristics of the university students who participated in the study. Accordingly, 70.8% of the student is female and 29.2% is male. 37.2% of the student is between the age of 18-20, 53.2% is between the age of 21-23, and 9.3% is above the age of 24. The average of the students' age is 21.33± 2.46, the youngest is 18 and the eldest is 41. 89.7% of the parents lives together, 5.5% is divorced, and 4.8% lives separately. 47.0% of the student is the first child, 21.3% is the middle child, and 31.2% is the youngest child in their families. 43.7% of the students' mothers is primary school graduate, 24.4% is high school graduate, 18.3% is secondary school graduate, 9.3% is university graduate, and 4.2% is illiterate. On the other hand, the education status of the fathers are as follows: 30.6% is primary school graduate, 28.6% is high school graduate, 18.6% is secondary school graduate, and 20.8% is university graduate. 3.2% of the students has an income of 1000 TL and below, 27.4% has an income between 1001-2000 TL, 30.2% has an income between 2001-3000 TL, and 39.3% has an income of 3001 TL and above. When the place where the students have spent the majority of their lives were checked, it was seen that 11.7% spent the majority of their lives in villages, 24.2% lived mostly in towns, 29.2% spent it in cities, and 34.9% lived mostly in metropolitans.

Table 1. The Socio-demographic characteristics of the students

Socio-demographic characteristics	*Number*	*(%)*	*Socio-demographic characteristics*	*Number*	*(%)*
*Age**			*Sex*		
18-20	*188*	*37.2*	*Female*	*357*	*70.8*
21-23	*269*	*53.2*	*Male*	*147*	*29.2*
24 and above	*47*	*9.3*			
Marital Status of the Parents			*Number of the Siblings of the Participants*		
Together	*452*	*89.7*	*First Child*	*238*	*47.0*
Separated	*24*	*4.8*	*Middle Child*	*108*	*21.3*
Divorced	*28*	*5.5*	*Youngest Child*	*158*	*31.2*
Education Status of the Mothers			*Education Status of the Fathers*		

DEPRESSION LEVELS OF UNIVERSITY STUDENTS IN TERMS OF SOME PSYCHIATRIC AND SOCIO-DEMOGRAPHIC VARIABLES IN TURKEY

Illiterate	*21*	*4.2*	*Illiterate*	*4*	*.8*
Primary School graduate	*220*	*43.7*	*Primary School graduate*	*155*	*30.6*
Secondary School graduate	*92*	*18.3*	*Secondary School graduate*	*93*	*18.6*
High School graduate	*123*	*24.4*	*High School graduate*	*144*	*28.6*
University graduate	*48*	*9.5*	*University graduate*	*108*	*21.4*
Income Levels of the Participants			*The Place Where the Majority of the Life was Spent*		
1000 TL and below	*16*	*3.2*	*Village*	*59*	*11.7*
Between 1001-2000 TL	*138*	*27.4*	*Towns*	*122*	*24.2*
Between 2001 TL-3000 TL	*152*	*30.2*	*City*	*147*	*29.2*
3001 TL and above	*198*	*39.3*	*Metropolitan*	*176*	*34.9*
Total	*504*	*100*	*Total*	*504*	*100*

* Mean = 21.33; Std. Deviation = 2.46; Youngest - Eldest = 18 - 41

Table 2 shows the distribution of the students' total scores at the Beck Depression Inventory. Accordingly, the depression level of 41.5% of the students is minimal, 24.2% has mild, 28.0% has moderate, and 6.3% has severe depression. The mean BDI of the students is 13.46, the lowest is 0 and the highest is 58.

Table 2. Distribution of the Total BDI Scores of the Students

*Depression Level**	*Frequency*	*Percentage*
Minimal depression (Score Between 0-9)	*209*	*41.5*
Mild depression (Score Between 10-16)	*122*	*24.2*
Moderate depression (Score Between 17-29)	*141*	*28.0*
Severe depression (Score Between 30-63)	*32*	*6.3*
Total	*504*	*100.0*

* Mean = 13.46; Std. Deviation = 9.62; Lowest - Highest = 0 - 58

When the relationship between some socio-demographic characteristics of the students and the mean BDI scores was examined, no significant difference was found in relation to age, sex, sibling order, mother's education status, father's education status, income level and the place where the majority of life passed ($p > 0.05$).

However, a significant difference was discovered between the parents' marital status and the mean BDI scores ($p<0.05$). Table 3 presents the findings of the comparison between the marital status of the students' parents and the BDI.

DEPRESSION LEVELS OF UNIVERSITY STUDENTS IN TERMS OF SOME PSYCHIATRIC AND SOCIO-DEMOGRAPHIC VARIABLES IN TURKEY

Table 3. Kruskall Wallis Test Results for the BDI Scores According to the Marital Status of the Students' Parents

Dependent Variable	*Marital Status of the Parent*	*N*	*Mean*	*Std. D.*	*X2*	*P*
BDI	*Together*	*452*	*12.96*	*9.19*	*9.300*	*.010**
	Separated	*24*	*15.66*	*10.82*		
	Divorced	*28*	*19.71*	*12.77*		

**p<0.01*

When we examine the BDI scores according to the variable as the parents' marital status at the Table 3, it is seen that the mean BDI score of the students whose parents are divorced is 19.71, the mean BDI score of the students whose parents are separated is 15.66, and the mean BDI score of the students whose parents are together is 12.96. Therefore, the BDI scores differ statistically significantly according to the parents' marital status, (χ2=9.300;p=0.010). According to this, the depression scores of the students whose parents are divorced were found to be significantly higher than those of the students whose parents are together.

Table 4 illustrates the data in relation to the comparison between the psychiatric characteristics of the students and the BDI scores. 6.3% of the students (N=32) has an ongoing psychiatric disorder. 21% of the students (N=105) stated having been receiving psychiatric support. 13.9% of the students (N=70) stated having done self-harming things during their lives. The family members (Mother/Father/Siblings) of 7.3% of the students (N=37) did acts of self-harm.

Table 4. Mann whitney u test results in relation to the comparison between the psychiatric characteristics of the students and the bdi scores

Dependent Variable	*Psychiatric Disorder Status*	*N*	*%*	*Mean*	*Df*	*Z*	*P*

DEPRESSION LEVELS OF UNIVERSITY STUDENTS IN TERMS OF SOME PSYCHIATRIC AND SOCIO-DEMOGRAPHIC VARIABLES IN TURKEY

BDI	*Yes*	*32*	*6.3*	*21.06*	*8.95*	*-4.609*	*.000***
	No	*472*	*93.7*	*12.95*	*9.45*		
	If Receiving Psychiatric Support	*N*	*%*	*Mean*	*Df*	*Z*	*P*
	Yes	*105*	*20.8*	*17.13*	*10.66*	*-4.051*	*.000***
	No	*399*	*79.2*	*12.50*	*9.10*		
	Does s/he self-harm?	*N*	*%*	*Mean*	*Df*	*Z*	*P*
	Yes	*70*	*13.9*	*19.08*	*11.97*	*-4.325*	*.000***
	Np	*434*	*86.1*	*12.56*	*8.87*		
	Do the family members self-harm?	*N*	*%*	*Mean*	*Df*	*Z*	*P*
	Yes	*37*	*7.3*	*18.21*	*12.90*	*-2.256*	*.024**
	No	*467*	*92.7*	*13.09*	*9.22*		

*p<0.05 ** p<0.01

When we look at the findings relating the comparison between the psychiatric characteristics of the students and the BDI scores, it is seen that the mean BDI score of those having a psychiatric disorder is 21.06 and the mean BDI score of those who reported not having any psychiatric disorder is 12.95. According to that, the mean BDI score of those who stated having a psychiatric disorder was found to be higher than those of the students who don't have any psychiatric disorder. It is seen that there is a meaningful difference between the students' psychiatric disorder status and the BDI (Z=-4.609;p=0.000) In other words, the depression scores of those who have a psychiatric disorder are higher than the scores of those who don't have any. The mean BDI score of the students who stated having received psychiatric support is 17.13 and the mean BDI score of those who have not received psychiatric support is 12.50. Accordingly, the mean BDI of the students who stated having received psychiatric support was found to be higher than that of the students who haven't received any. The difference between the students' psychiatric support status and the BDI was found to be statistically significant (Z=-4.051; p=0.000). According to that, the depression scores of those who have received psychiatric support is higher than the scores of those who haven't received any.

Among the students, the mean BDI score of those who stated having done acts of self-harm is 19.08 and the mean BDI score of those who haven't done any act of self-harm is 12.56. According to that, the mean BDI of those who reported having done acts of self-harm was found to be higher than the mean BDI of those who haven't done any. An important difference was found between the students' status of having done any act of self-harm and the BDI (Z=-4.325; p=0.000). Accordingly, the depression scores of those who have done acts of self-harm are higher than the scores of those who haven't. done any.

The mean BDI score of the students who stated having a family member who has done acts of self-harm is 18.21 and the mean BDI score of those who don't have a family member having done any act of self-harm is 13.09. According to that, the mean BDI of those having a family member who has done acts of self-harm was found to be higher than the mean BDI of those who don't have a family member having done any act of self-harm. A significant difference was found between the students' status of having done any act of self-harm and the BDI (Z=-2.256; p=0.024). Accordingly, the depression scores of those who have a family member having done acts of self-harm are higher than the scores of those who don't have a family member having done any act of self-harm.

DEPRESSION LEVELS OF UNIVERSITY STUDENTS IN TERMS OF SOME PSYCHIATRIC AND SOCIO-DEMOGRAPHIC VARIABLES IN TURKEY

DISCUSSION

In this study, the relationship between the depression levels and some psychiatric & socio-demographic characteristics of the university students was examined. No significant relationship was found between the depression level and the variables as age, sex, parents' education status, income status, sibling order, and place where the majority of the life was spent.

41.5% of the university students has a minimal level, 24.2% has a mild level, 28% has a moderate level, and 6.3% has a severe level of depression. The mean depression level of the students is 13.46. At some studies, the cutoff score was suggested as "17" (Hisli, 1989). When the cutoff score was taken as 17 according to the Beck Depression Inventory, the depression rate at the clinical level was found to be 34.3%. Within the framework of these findings, it can be said that a significant number of the students has high levels of depression and are therefore susceptible to depression. When we look at the previous studies in the literature, the studies with similar findings are found. In the study of Ceyhan, Ceyhan, & Kurtyılmaz (2005), the mean depression level of the university students is 12.72 and 21% of the students has clinical and severe depression. In another study by Ceyhan and Ceyhan (2011), the mean depression level of the students is 19.81 and 56'18% has clinical and severe depression. In another study conducted by Özdel, Bostancı, Özdel O & Oğuzhanoğlu (2002), the mean BDI score is 12.8. When the cutoff score was taken as 17 according to the Beck Depression Inventory, the depression ratio at the clinical level was found to be 26.2%. In another study conducted with university students in China, the mean BDI score of the university students is 6.31, and the BDI score of 40.1% is between 5-13, that of 8.4% is between 14 and 20, and that of 3.3% is between 21 and 63 (Chen et al., 2013).

No significant relationship was found between sex and depression levels of the university students. This finding shows similarities with some other studies. In previous studies, no significant relationship was found between sex and depression levels, too (Grant et al., 2002; Sümer, Poyrazlı, & Grahame, 2008). However, depression levels of male students were found to be higher than those of female students in some studies (Ceyhan & Ceyhan, 2011; Sağar, 2018).

A significant relationship was found between the marital status of the students' parents and the depression levels. Depression scores of the students whose parents are divorced were found to be significantly higher than the scores of those whose parents are together. This finding is supported by other research findings showing that university students whose parents are divorced have high levels of depression (Sağar, 2018).

No significant relationship was found between the students' grade and the depression levels. This finding is supported by similar studies in the literature, too. However, in some studies, depression scores of senior students are higher than that of first-year students (Bostancı et al., 2005; Chen et al., 2013; Özdel et al., 2002). In other words, as students' grade gets higher, depression scores increase. Yet, in some other studies, depression levels of first-year students are higher than that of senior students (Ceyhan & Ceyhan, 2011; Sağar, 2018).

No meaningful relationship was found between income and depression levels of the students. In the literature, there are studies showing that students from families with low socioeconomic status have higher levels of depression than those from families with high socioeconomic status (Bayram & Bilgel, 2008; Bostancı et al., 2005). Having a low socio-economic status is a risk factor for depression (Binbay et al., 2014). It can be said that socio-economic conditions increase the likelihood of depressive symptoms.

No important relationship was found between the parents' education status and the students' depression levels. Same results were found in similar studies (Özdel et al., 2002). However, in some studies, it was found that parents' education status has an effect on students' depression levels. In the study by Chen et al. (2013), it was observed that the students whose father has a low education status have higher depression. It can be said that the education status of parents has important effects on the mental health of children. In this context, it can be said that parents with a high level of education are more interested in students' psychological problems and have healthier communication with them.

No significant relationship was found between the place where the students lived during the majority of their lives and the depression levels. This finding is similar to the previous studies in the literature (Özdel et al., 2002).

Another characteristic that was examined in relation to depression in the university students is psychiatric characteristics. There is a significant relationship between the depression levels and these variables which are psychiatric disease status, psychiatric support status, self-harm status and self-harm status of family members. According to that, those who stated having a psychiatric disorder, those who say they receive psychiatric support, those who indicate having self-harm behaviours, and those who have a family member having self-harm behaviours have higher levels of depression than those who do not

have these characteristics. There are similar findings in the previous studies in the literature. There is a significant relationship between getting professional help and depression level. In Bozkurt's study (2004), the depression levels of the students who reported that they received psychological counselling for their "private problems" are higher than the levels of those who received psychological counselling for "professional issues". Similarly, in the study of Ceyhan & Ceyhan (2011), the mean depression of the students who contacted the psychological counselling centre in order to get help is 19.81.

CONCLUSION

As a result of the study, it was concluded that more than one third (34.3%) of the university students has high levels of depression and their depression levels differ according to some psychiatric and socio-demographic variables. The findings from the study show that the depression levels of the students whose parents are divorced, who stated having a psychiatric disorder, who receive psychiatric support, who have a tendency to self-harm, and who have a family member having a tendency to self-harm are high.

It is thought that university students who enter into individualization process due to the university life very quickly after leaving family and home need professional support during this period. The biggest obstacle to receiving psychological help is to have an awareness towards the need for this service. It is considered as an important step in terms of preventive mental health that university students should have a knowledge of positive mental health and an awareness of the symptoms of depression. In addition, there is a need for the development of effective psychological support services for university students in universities and for easy access of students to these services. Early diagnosis of depression among university students and the development of programs including prevention studies are considered to be important both for the mental health of the young people and for the mental health of society. Besides, another important issue to be emphasized about the students is social support. The studies emphasise that students with low social support levels have higher levels of depression (Sümer et al., 2008). The most important source of social support is the family and immediate circle of the individual. For this reason, it is recommended to develop a model at the psycho-social support studies, which will include the family and immediate circle of the students within the framework of the bio-psychosocial model. It is thought that a multidisciplinary and human rights-based approach, which includes all mental health professionals such as psychiatrist, psychologist, social worker, mental health nurse, where the individual is evaluated and supported in a multidimensional manner, will create a significant change in this issue.

DEPRESSION LEVELS OF UNIVERSITY STUDENTS IN TERMS OF SOME PSYCHIATRIC AND SOCIO-DEMOGRAPHIC VARIABLES IN TURKEY

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DEPRESSION LEVELS OF UNIVERSITY STUDENTS IN TERMS OF SOME PSYCHIATRIC AND SOCIO-DEMOGRAPHIC VARIABLES IN TURKEY

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TURKISH JOURNAL OF APPLIED SOCIAL WORK
Volume: 4 Number: 2 Year: 2021

Research Article
Makale Gönderim Tarihi: 10.11.2021
Makale Kabul Tarihi: 15.12.2021

THE SCALE OF KNOWLEDGE AND AWARENESS ABOUT CHILD MOLESTERS (KACMS): VALIDITY AND RELIABILITY STUDY*

ÇOCUK CİNSEL İSTİSMARCILARINA YÖNELİK BİLGİ VE FARKINDALIK DÜZEYİNİN DEĞERLENDİRİLMESİ: BİR ÖLÇEK GELİŞTİRME ÇALIŞMASI

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Gönültaş, B. M. and Sarıçam, H. (2021). The Scale Of Knowledge And Awareness About Child Molesters (Kacms): Validity And Reliability Study. Turkish Journal Of Applied Social Work. 4(2). Pp:116-126. https://doi.org/10.54467/trjasw.1021951

ABSTRACT

The purpose of this research is to develop the Child Molesters Knowledge and Awareness Scale (KACMS) and examine the psychometric properties of the scale. Two study groups were conducted among a total of 610 (366+244) Turkish adults aged from 18 to 49. According to explanatory factor analysis results, it was found that the KACMS had two-factors and this model explained 48.80% of variance related to the attribute it measured. In confirmatory factor analysis, fit index values were found as χ^2= 132.26, df= 50 (χ^2/df= 2.64), RMSEA= .08, SRMR=.065, NFI= .94, RFI= .92, IFI= .96, CFI= .96, and TLI= .95. Factor loadings ranged from .40 to .91. In the concurrent validity, the KACMS had significant relationship with the Perceptions toward Criminals Scale (r= .64). Cronbach's alpha internal consistency coefficient was α=.94 for the whole scale, α=.96 for the grooming methods, α=.75 for the characteristics of child molesters. Corrected item-total correlations ranged from .32 to .85. According to these results, it can be said that the scale is a valid and reliable assessment instrument in order to scale knowledge and awareness level of undergraduates (school counseling, social work, psychology, pedagogy, forensic psychiatry, and other fields) who are able to work children on sexual molesters and their grooming methods.

Keywords: Sexual abuse, child molesters, offender, perpetrator, grooming methods, scale, validation, and reliability.

ÖZET

Bu çalışmanın amacı Çocuk Cinsel İstismarcılarına Yönelik Bilgi ve Farkındalık Ölçeğini (ÇCİBFÖ) geliştirmek ve psikometrik özelliklerini incelemektir. Araştırma kapsamına yaşları 18 ile 49 arasında değişen iki farklı çalışma grubunda yer alan toplam 610 (366+244) yetişkin katılımcı alınmıştır. Açımlayıcı faktör analizi sonuçlarına göre ÇCİBFÖ'nün iki boyuta sahip olduğu ve bu iki boyutlu yapının ölçtüğü özellikle ilgili toplam varyansın %48,80'ini açıkladığı görülmüştür. Doğrulayıcı faktör analizi sonucu ölçeğin uyum iyiliği değerleri χ^2= 132.26, sd= 50 (χ^2/sd=2.64), RMSEA= .08, SRMR=.065, NFI= .94, RFI= .92, IFI= .96, CFI= .96, TLI= .95 olarak hesaplanmıştır. Ayrıca madde faktör yükleri .40 ile .91 arasında sıralanmaktadır. Ölçüt (benzer ölçek) geçerliği çalışmasında, ÇCİBFÖ ile Suçlulara Yönelik Algılar Ölçeği arasında r= .64 pozitif ilişki tespit edilmiştir. Cronbach alfa iç tutarlık katsayısı ölçeğin bütünü için α=.94, cinsel istismara uygun hale getirme metotları (grooming) alt boyutu için α=.96 ve çocuk cinsel istismarcısının karakteristiği alt boyutu için α=.75 olarak bulunmuştur. Düzeltilmiş madde toplam korelasyon katsayıları .32 ile .85 arasında değişmektedir. Tüm bu sonuçlara göre, Çocuk Cinsel İstismarcılarıyla İlgili Bilgi ve Farkındalık Ölçeği, ileride çocuklarla çalışabilecek alanlarda eğitim gören öğrencilerin (öğretmenler, psikolojik danışma ve rehberlik, sosyal hizmet, pedagoji, psikoloji, adli psikiyatri vs. gibi) cinsel istismarcıların özellikleri ve çocuklara yaklaşma metotları konusunda bilgi ve farkındalık düzeylerini ölçmeden kullanılabilecek geçerli ve güvenilir bir ölçme aracı olduğu söylenebilir.

Anahtar kelimeler; Cinsel istismar, çocuk tacizcileri, cinsel istismarcı, cinsel istismar faili, grooming metotları, ölçek, geçerlik ve güvenirlik.

*This work is supported by the Scientific Research Project Fund of Sivas Cumhuriyet University under the project number EDB-043

TURKISH JOURNAL OF
APPLIED SOCIAL WORK

THE SCALE OF KNOWLEDGE AND AWARENESS ABOUT CHILD MOLESTERS (KACMS): VALIDITY AND RELIABILITY STUDY

INTRODUCTION

American Psychological Association (APA) defines that "sexual abuse is unwanted sexual activity, with perpetrators using force, making threats or taking advantage of victims not able to give consent" (APA, 2000). Sexual abuse contains psychological, sociological, medical, behavioral etc. aspects. It is one of the crimes known as dark spots in criminology. It is estimated that the real prevalence of sexual abuse is much higher, with only 15% of cases occurring (Cohen & Galynker, 2002). According to Douglas and Finkelhore's (2003) study, 9-32% of women and 5-10% of men were exposed to sexual violence during their childhood. In Turkey, according to Turkish Statistical Institute, the number of victims child of sexual violence has been increasing in 2015-2017 compared to previous years (30%). The disclosure of sexual abuse is complex and disclosing rates by the child victims are also less (Gönültaş, 2013). It is obvious that measurement tools are needed to scale knowledge level to be aware of child molesters. Thus, professionals working with children could be increased knowledge level to prevent sexual abuse.

In child molestation, an adult or older adolescent uses a child for sexual stimulation, namely "any sexual behavior toward a child by an adult" (APA, 2000). The point that makes sexual abuse dangerous and vulnerable for the child is related to the characteristics and grooming methods of child molesters (CM). CM, who were previously seen as irrational and impulsive types who cannot control their behavior, have been found to be strategic, versatile, planned, and risk-evaluator with recent studies (Gönültaş et al., 2021; Gönültaş & Sahin, 2018; McAlinden, 2006; Kaufman et al., 1998; Smallbone & Wortley, 2001; Leclerc et al., 2009). This situation makes us wonder what kind of nature do they have? For this purpose, theories on the nature of CM are applied (Ward & Siegert, 2002; Finkelhor, 1994): these individuals appear to have problems controlling their behaviors, emotions, and sexual impulses, and they lack the social interaction ability with an adult in a normal way. They are incapable of benefiting social support from the society. They tend to distort the child's behavior, perceiving the child as a false adult. For example, "she/he is close to me, so she/he must be interested in me...". Negative emotional states may cause these individuals to opportunistically turn to children to meet their sexual needs. This is uncontrolled. They can use sexual behaviors as a calming method. Also, sexual fantasies accompany certain sexual behaviors, and they help to raise one's mood (feeling grandiose). A history of crime and especially substance use is expected. In this sense, they may show delinquent behaviors once they were children and adults and may be diagnosed with behavior disorders.

In terms of CM's methods in order to approach to children, relevant research focuses on the grooming methods of the molesters (Van Gijn & Lamb, 2013). Grooming methods involve a number of deceptive methods that seem innocent and prosocial (such as establishing friendships) in order for the abuser to engage in sexual activity with the child, thus allowing the victim to obey or remain unresponsive. Common grooming methods are deception, bribery, promises, compliments, manipulation, threats, and coercion (McAlinden, 2006; Smalbone & Wortley, 2001; Kaufman et al., 1998; Craven et al., 2006). In a study conducted in the sample of Istanbul (Gönültaş, Zeyrek-Rios and Lester, 2021), CM use a child as "intermediary" to reach other children. The intermediary has been abused by the molester before, and this method serves that 1- the other children comply with the offer from their friend (intermediary) and are not suspicious (for example, "there is an uncle, he is a very good person, he gives me a ride with his car"), 2- the CM does not attract the attention of other adults and police.

These methods help the CM to prepare the child for abuse. With these methods, the CM approaches the child (becoming physically close to child), breaks his/her resistance, and manages to take it under his control (McAlinden, 2006; Ost, 2009; Finkelhore, 1994; Kaufman et al., 1998). It also ensures that the victim remains silent after abuse and re-victimization (Craven et al., 2006). In this process, the CM "learns what children like and dislikes, interests and fears, and uses this knowledge to manipulate the child to engage in sexual contact" (Singer et al., 1992). Behaviors such as threats and coercion also help the child to be under control and obey, just like persuasion-deception methods (Gönültaş, 2013; Van Gijn & Lamb, 2013). Also, abduction can be used as a tool to become physically close to the child (Gönültaş, 2018). In the process that develops towards the act of abuse, spending time with the child and engaging in prosocial behaviors such as playing games with the child, and these serve to gain the child's trust and make it easier to control him/her (Gönültaş, 2016). For this purpose, strategies such as the use of bribery, isolation of the child so that he can be vulnerable, desensitization by sexualizing and the use of force are

THE SCALE OF KNOWLEDGE AND AWARENESS ABOUT CHILD MOLESTERS (KACMS): VALIDITY AND RELIABILITY STUDY

followed (Plummer, 2018). Molesters can apply these methods to their parents as well as children, so that the parent becomes ineffective in protecting their child (Gönültaş, Oral, & Elitez, 2021).

CM are in an effort to approach children within the framework of the processes set out above (Gönültaş et al., 2021). For this purpose, they may want to take positions where they can interact with children. These positions such as teacher, sports teacher, course trainer, school bus driver may offer opportunities to be physically close with children (Koçtürk, 2018). These positions often take place in environments where the child is out of parental supervision, and if children are not actively supervised and protected, CM can easily "infect (becoming closest)" children through these positions.

Schools are the environments where children spend the most time apart from parental supervision, and teachers are prominent professionals in the active supervision-protection of children. For this reason, teachers should be at the forefront of professionals who should know about CM and their methods. As a matter of fact, Sanderson (2004, cited in Koçtürk, 2018) warns teachers about observing adults, especially their colleagues, who may show abusive approach and behavior to children. However, the education of teachers on sexual abuse at the undergraduate level and also in-service training, is not sufficient for sexual molesters (Tugay, 2008) and it is suggested that these trainings should be developed (Gönültaş, 2018). In this context, in order to gain the ability, first of all, it is necessary to understand the level of knowledge and awareness of professionals (especially undergraduates) who will work with children on CM and their grooming methods.

Aim of the present study

Studies to measure professionals' knowledge and awareness level related to CM and grooming methods are quite limited in the literature (Wurtele et al., 2008). One part of the "Myths About Sexual Abuse Scale" developed by Collings (1997) includes questions about common perceptions of sexual abusers in society. It has been found that teachers are generally affected by myths about sexual abuse in society (Wurtele et al., 2008). Similarly, in Turkey, the "Parent Form of the Childhood Sexual Abuse Myths Scale" developed by Koçtürk and Kızıldağ-Şahin (2020) has two sub-dimensions. The second one is "abusive characteristics". In this sub-dimension, there are 9 items measuring the myths that are common in Turkish society about molesters. In a qualitative study conducted by Kanak and Arslan (2018) with 25 preschool teachers regarding CMs, they were asked questions about the age, intimacy with children, personality traits, physical appearance, and educational status of the CMs, and they found that the participants generally had information in line with the literature. Doğan and Bayar (2018), in their study with n=216 education faculty students, applied a 17-item questionnaire to measure the level of knowledge about sexual abuse. In this questionnaire, four questions measure their knowledge about sexual abusers (gender, intimacy status, socioeconomic status, appearance). While these studies generally study awareness and attitudes of professionals working with children on the effects of sexual abuse on children, they do not specifically address CMs and their grooming methods. In this sense, it is seen that there is a need for a measurement tool to see awareness and knowledge levels about CM in order to recognize these people who cause sexual abuse. Based on this need, the present study aims to develop a measurement in order to scale about knowledge and awareness level of teachers, prospective teachers, and psychological counselor candidates who are able to work children on sexual molesters and their grooming methods.

METHODS

Participants

For this study, convenience sampling technique has been carried out for participant selection. Data was obtained from 610 education faculty students who volunteered to take part in this study. Draft scale was filled in by 366 prospective teachers, and final scale was filled in by 215 psychological counselor candidates and 29 master students in Educational Sciences. The participants were all aged between 18 and 49, with a mean age of 25.03 years. Males made up 74.75% (N = 456) of all participants, and females 25.25% (N = 154). Ethical approval was obtained from Sivas Cumhuriyet University Social Sciences Ethics Committee with 13.09.2018 and the number of 2018/3. Data collection was conducted between August-October 2021.

Instruments

Perceptions toward Criminals Scale (PCS): The PCS was developed by Gönültaş et al. (2019). It consists of 12 items

THE SCALE OF KNOWLEDGE AND AWARENESS ABOUT CHILD MOLESTERS (KACMS): VALIDITY AND RELIABILITY STUDY

and two factors [1. Perceptions of Moral/Personal Characteristics of Criminals (e.g., "Criminals are prone to recidivism"); 2. Perceptions of Criminals' Social Networks (e.g., "Criminals come from broken families")]. Each item required a respondent to answer on a 5-point, Likert-type scale, the degree to which the item applied to them (1= Strongly disagree, through to 5= Strongly Agree). The validity analysis of the scale was conducted on a sample of 310 students and the indices showed a good fit ($\chi 2/df=2.43$, AGFI=.90, CFI=.94 GFI=.935, NFI=.90, RMSEA= .68). In addition, internal validity analyses were performed, and the scale was found to have internal validity. Cronbach's alpha internal consistency coefficient was found as $\alpha= .82$ and split-half analysis coefficient was found as r=.80. In this study, Cronbach's internal consistency coefficient was found as $\alpha= .93$.

Preparation of the items and data analysis

In addition to the scales mentioned above, there are also some measurement tools within the scope of child abuse in Turkey. For example, Pekdoğan (2017) wants to evaluate whether the behavior of parents towards their children is abuse via the Child Abuse Awareness Scale-Parent Form. Choo, Walsh, Chinna, and Tey (2013) developed the Child Sexual Abuse Attitude Scale. This scale was intended to evaluate whether experts (teachers) are aware of sexual abuse towards children. Almost all the same scales in this regard are related to awareness of abuse. However, it is not possible to prevent sexual abuse without knowing the child molesters (perpetrators) and their grooming methods. In this context, it is aimed to provide a measurement tool in the literature to increase the awareness of the child's molesters and their grooming methods. While preparing the items pool, we used the declarations/expressions of children who were sexually abused and publications in the field of forensic psychology (i.e., Turner & Briken, 2015; Winters & Jeglic, 2017; 2021; Winters, Jeglic, & Kaylor, 2020; Wolf, Linn, & Pruitt, 2018). First, a detailed literature review was carried out related to child sexual abuse. Especially, pedophilia (e.g. Marshall, 1997), sex offenders (e.g. Ebisike, 2007; Keenan & Ward, 2000; Quinsey, Lalumie`re, Rice, & Harris, 1995), child molesters (e.g. Hayashino, Wurtele, & Klebe, 1995), child maltreatment (e.g. Belsky, 1980), child abuse (e.g. Clark, Clark, & Adamec, 2007) victimization of sexual abuse (e.g. Finkelhor, 1979), risk factors for sexual abuse (e.g. Assink et al., 2019), grooming methods (e.g. Pollack & MacIver, 2015) and crime theory (e.g. Gottfredson & Hirschi, 1990) were reviewed in-depth. Secondly, to constitute an item pool, the previous same scales were utilized, and suitable items were included in the scale or they were redesigned to fit the subject and the rest of the items were created by the researchers. Eventually 66 items were generated. These items were analyzed by four associated professors in social work, psychological counseling, and child development. Upon receiving comments from the four experts through face-to-face conversations and mailing, some items were removed, wordings of a couple of items were altered, some items were shortened, and the order of the items were rearranged. As a result, 40 items were decided to be appropriate for the draft scale. The items in the scale were arranged to have a 7-point Likert-type rating (1=Strongly disagree, 2= Disagree, 3= Somewhat disagree, 4= Neutral, 5= Somewhat agree, 6=Agree, and 7=Strongly agree). A pilot study was conducted on a sample of 43 participants to test the intelligibility and readability of the items. After it was determined that there was no problem, the actual data collection study was started. For structural validity of the KACMS, exploratory factor analysis (EFA) was performed on the data collected from the 366 prospective teachers, and confirmatory factor analysis (CFA) was performed on the data collected from the 215 psychological counselor candidates and 29 master students in Educational Sciences. EFA was used where there is no knowledge among the items of the KACMS, that is, how many factors there are between the items and which factors are determined by which items (Orçan, 2018). CFA was used to test the validity of the structure obtained after EFA (Worthington & Whittaker, 2006). With CFA, the existence of a previously proven structure is investigated with a new data set (Orçan, 2018). In SEM model, the application of RMSEA, CFI, and TLI is heavily contingent on a set of cutoff criteria. Browne and Cudeck (1993) suggested that the RMSEA value of $< .05$ indicates a "close fit," and that $< .08$ suggests a reasonable model–data fit. Baumgartner and Homburg (1996) recommended that TLI $> .90$ indicates an acceptable fit. $p<.01$ is based as the level of significance. Perceptions toward Criminals Scale was used for concurrent validity. Concurrent

THE SCALE OF KNOWLEDGE AND AWARENESS ABOUT CHILD MOLESTERS (KACMS): VALIDITY AND RELIABILITY STUDY

validity indicates the amount of agreement between two different assessments. Generally, one assessment is new while the other is well established and has already been proven to be valid (Adams et al., 2014). For the validity and reliability analysis of the KACMS, a statistical computer program package was used (SPSS and AMOS).

FINDINGS

Construct Validity:

Exploratory Factor Analysis (EFA): In order to assess the appropriateness of the data for factor analysis, Kaiser-Meyer-Olkin (KMO) coefficient was calculated, and Bartlett Test of Sphericity was applied. Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was .93 and there was a significant result on Bartlett's test of Sphericity χ^2=3212.17 (df=171, p< .001). Then EFA was applied, because KMO should be equal to or higher than 0.50 and the Bartlett's Test of Sphericity should be significant (p< .05) (Netemeyer, Bearden, & Sharma, 2003). As a result of the EFA applied to data from the study conducted on 366 prospective teachers. According to Principal Component Analysis and Rotated Component Matrix, two-factor structure explains 48.8 % of the total variance, and which consists of 19 items, and two subscales (Characteristics of child molesters=6 items, Grooming methods=13 items). Results was given Table 1. Coefficients smaller than .35 were suppressed as factor loadings which are higher than .40 are considered significant. Concluding the item correlation and factor analysis, the correlation of the items was evaluated and accordingly, 21 items were thrown.

Table 1. *EFA Factor Loading and Variance rates of the KACMS*

Item No	***Grooming methods***	***Characteristics of child molester***
30	*.862*	
29	*.782*	
33	*.770*	
34	*.759*	
31	*.757*	
26	*.743*	
35	*.733*	
27	*.635*	
28	*.630*	
32	*.572*	
36	*.555*	
14	*.492*	
37	*.418*	
16		*.759*
18		*.640*
20		*.639*
24		*.543*
23		*.530*
21		*.463*
Total variance 48.80%	*34%*	*14.80%*

THE SCALE OF KNOWLEDGE AND AWARENESS ABOUT CHILD MOLESTERS (KACMS): VALIDITY AND RELIABILITY STUDY

As seen Table 1, the first factor of the scale explains 34% of the total variance, and the factor loadings of the items range between .42 and .86. The second factor of the scale explains 14.80% of the total variance, and the factor loadings of the items range between .46 and .76.

Moreover, internal consistency (Cronbach's alpha) coefficient was calculated to check reliability in this group. Cronbach's α= .72 for the characteristics of child molesters; α=.90 for the grooming methods, and α= .90 for whole scale.

Confirmatory Factor Analysis (CFA): Due to its significance in terms of determining if the model structured in EFA is a good fit or not, CFA was applied to a different data set (215 psychological counselor candidates and 29 master students in Educational Sciences). In the confirmatory factor analysis applied for the two-dimension model, fit indices values were χ^2= 132.26, df= 50 (χ^2/df=2.64), RMSEA= .08, SRMR=.065, NFI= .94, RFI= .92, IFI= .96, CFI= .96, TLI= .95. CFA path diagram standardized analysis coefficients for factor-item relations calculated with CFA are presented in Figure 1.

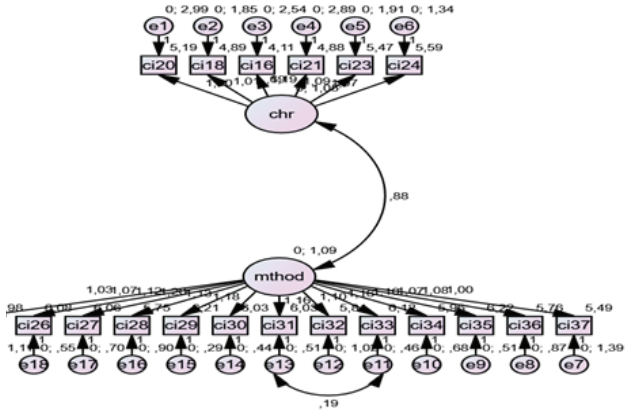

Figure 1. CFA Path Diagram

As seen on Figure 1, a single modification was made between ci31 and ci 33 and the scale was validated. The factor loadings of the items range between .40 and .91. The observed factor-item relationships were found to be significant (p<.01).

Concurrent Validity: Correlation coefficient between the KACMS and the PCS was determined as r=.64 for concurrent validity (Convergent validity). In addition, correlation coefficients of the sub-dimensions are shown in Table 2.

Table 2. Correlation coefficient between the KACMS and the PCS

Dimension	1. CCM	2. GM	3. KACMS	4. PM/PCC	5. PCSN	6. PCS
1. CCM	-	.67**	..84**	.49**	.49**	.55**
2. GM		-	.95**	.57**	.52**	.61**
3. KACMS (Total)			-	.59**	.55**	.64**
4. PM/PCC				-	.56**	.95**
5. PCSN					-	.80**
6. PCS (Total)						-

p<.01 **CCM: Characteristics of Child molesters; **GM:** Grooming methods; **KACMS:** Knowledge and Awareness Scale On the Child Molesters' Characteristics and Grooming Methods; **PM/PCC:** Perceptions of Moral/Personal Characteristics of Criminals; **PCSN**: Perceptions of Criminals' Social Networks; **PCS:** Perceptions toward Criminals Scale

THE SCALE OF KNOWLEDGE AND AWARENESS ABOUT CHILD MOLESTERS (KACMS): VALIDITY AND RELIABILITY STUDY

As seen on Table 2, Total KACMS have positive correlations with PM/PCC and PCSN (r=.49, .49). There are also positive correlations among dimensions of both scales.

Reliability

Internal Consistency: Cronbach alpha internal consistency coefficient was α=.94 for the whole scale, α=.96 for the grooming methods, α=.75 for the characteristics of child molesters.

Item Analysis

Corrected item-total correlation: In addition, corrected item-total correlations of the scale items are shown in Table 3.

Table 3. Corrected item-total correlations coefficients

Item No	Corrected Item-Total Correlation (r)	Item No	Corrected Item-Total Correlation (r)
m1	.44	**g5**	.85
m2	.52	**g6**	.84
m3	.32	**g7**	.81
m4	.49	**g8**	.72
m5	.58	**g9**	.81
m6	.65	**g10**	.78
g1	.70	**g11**	.80
g2	.80	**g12**	.74
g3	.76	**g13**	.65
g4	.76		

As seen on Table 3, The corrected item-total correlations range between .32 and .85 for whole scale.

DISCUSSION

In this study, it was aimed to develop the KACMS in order to scale knowledge and awareness level of teachers, prospective teachers and psychological counselor candidates about child molesters, especially their characteristics and grooming methods. For this purpose, the validity of the KACMS was determined with factor analysis and concurrent validity. Factor analyses were conducted as descriptive factor analysis (EFA) and confirmatory factor analysis (CFA). Comrey (1988) stated that if the number of items did not exceed 40, a sample size of 200 individuals would be sufficient. For EFA, factor loadings are higher than the value .40 which is acceptable in the literature. Costello and Osborne (2005) recommended that taking the .40 value as a criterion for the common variance would be more meaningful and accurate for the social sciences. For CFA, scores of IFI, CFI, and TLI satisfy the criteria for absolute fit. On the other hand, χ^2/df, SRMR, RMSEA, NFI, RFI satisfy the criteria for acceptable fit. Kline (2011) stated that if the score for SRMR is .00 ≤ SRMR ≤ .05, criteria for absolute fit can be said. Or, if the score for SRMR is .05 ≤ SRMR ≤ .10, criteria for acceptable fit can be said. Byrne and Campbell (1999) declared if the score for RMSEA is .00 ≤ RMSEA ≤ .05, criteria for absolute fit can be said. Or, if the score for RMSEA is .05 ≤ RMSEA ≤ .08, criteria for acceptable fit can be said. According to Kline (2011) and Byrne (2016), χ2/df< 2, NFI>.95, CFI>.95, IFI>.95, RFI>.95, TLI> .95 are the criteria for absolute fit. For concurrent validity, the scale has positive relation with the Perceptions toward Criminals Scale at the level of p<.01 significance. It was therefore concluded that it met criterion. If the findings of reliability study and item analysis of the KACMS were controlled, the correlation coefficients which were obtained by Cronbach's alpha value and corrected item-

THE SCALE OF KNOWLEDGE AND AWARENESS ABOUT CHILD MOLESTERS (KACMS): VALIDITY AND RELIABILITY STUDY

total correlation are above at an acceptable criterion. With Cronbach's alpha internal consistency reliability coefficient higher than .70 and corrected items total correlation values higher than .30 (Cohen & Swerdlik, 2017), it shows that the KACMS is a trustworthy or consistency scale. In other words, even if KACMS is applied to the same group at different times, it will give similar results.

The present study has also limitation. Data were collected from students from educational faculty. In the future studies, this scale should be conducted with professionals working with children.

CONCLUSION

As in many countries, child abuse is one of the most problematic and harrowing issues in Turkey. It looks like this problem will continue for a while, because it is very difficult to detect the child molesters. In Turkey, the KACMS is the first and only measure of sexual grooming behaviors, methods and characteristics of child molesters that is based on the content validated KACMS. Future research can provide further support for the psychometric properties of the KACMS and cover in the numerous gaps in the sexual grooming literature. KCMS can also be used in order to scale professionals' knowledge and awareness level of child molesters, when they are appointed to work with children. Thus, professionals can be empowered to child molesters with pre-service and in-service educations and trainings. This scale, as well as the associated empirical findings, will be useful in numerous practical settings, especially field of school counseling, social work, psychology, pedagogy, forensic psychiatry.

THE SCALE OF KNOWLEDGE AND AWARENESS ABOUT CHILD MOLESTERS (KACMS): VALIDITY AND RELIABILITY STUDY

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TURKISH JOURNAL OF APPLIED SOCIAL WORK
Volume: 4 Number: 2 Year: 2021

Research Article
Makale Gönderim Tarihi: 02.12.2021
Makale Kabul Tarihi: 15.12.2021

A SPIRITUAL SOCIAL WORK INTERVENTION PROPOSAL IN THE FIELD OF MEDICAL SOCIAL WORK: UMRAN MODEL

TIBBİ SOSYAL HİZMET ALANINDA MANEVİ BİR SOSYAL HİZMET MÜDAHALE ÖNERİSİ: UMRAN MODELİ

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Beki, F. and Beki, A. (2021). A Spiritual Social Work Intervention Proposal In The Field Of Medical Social Work: Umran Model. Turkish Journal Of Applied Social Work. 4(2). Pp:127-142.
https://doi.org/10.54467/trjasw.1031455

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ABSTRACT

The social work discipline and occupation have generally aimed at biological, psychological, and social well-being in evaluating people. However, ignoring the spiritual dimension of human beings will cause a deficiency in achieving full well-being. The reason for this is that evaluating humans from a holistic perspective requires taking into account the spiritual dimension as well as the biological, psychological, and social dimensions. The problem of the study is to reveal whether oncology patients have spiritual needs and if they do so, how a spiritual social work intervention proposal can be developed in the field of medical social work. In Turkey, it is important to develop an application model proposal due to the inadequacy of applications for spiritual needs in medical/oncological social work. The study aims to offer a spiritual social work intervention model suitable for Turkish society and values by conducting in-depth interviews with oncology patients and reviewing the relevant international literature. The fact that suggestions were made to meet the needs of oncology patients for spiritual social work in this study reveals its originality. The case study technique, one of the qualitative research methods, was used in the study. In this context, semi-structured in-depth interviews were conducted with 25 cancer patients. A semi-structured interview form was used in the interviews. According to the findings, it was determined that oncology patients have spiritual needs, no spiritual social work intervention is applied in our country, and spiritual social work interventions are carried out in the world for these needs of patients. At the end of the study, an example of spiritual social work intervention was developed in accordance with Turkey's cultural codes.

Keywords: Spiritual social work, spiritual intervention, oncological social work

ÖZET

Sosyal hizmet disiplini ve mesleği insanı değerlendirmede genellikle biyolojik, psikolojik ve sosyal iyilik halini amaç edinmiştir. Ancak insanın manevi boyutunun göz ardı edilmesi tam iyilik halini sağlamada eksik bir durum ortaya çıkaracaktır. Çünkü insanı holistik bir perspektiften değerlendirmek, biyolojik, psikolojik ve sosyal boyutun yanında manevi boyutu hesaba katmayı gerektirir. Araştırmanın problemi; onkoloji hastalarının manevi ihtiyaçlarının olup olmadığı, eğer hastaların manevi ihtiyaçları varsa tıbbi sosyal hizmet alanında nasıl bir manevi sosyal hizmet müdahale önerisi geliştirilebileceğini ortaya koymaktır. Türkiye'de, tıbbi/onkolojik sosyal hizmet alanında manevi ihtiyaçlara yönelik uygulamaların yetersiz olması nedeniyle bir uygulama modeli önerisi geliştirmek önem arz etmektedir. Araştırmanın amacı; onkoloji hastaları ile derinlemesine görüşmeler yapılarak ve konu ile ilgili uluslararası literatür taraması ile birlikte Türkiye toplumuna ve değerlerine uygun bir manevi sosyal hizmet müdahale modeli ortaya koymaktır. Bu çalışmada onkoloji hastalarının manevi sosyal hizmete duyduğu gereksinimi karşılayacak önerilerin getirilmiş olması, araştırmanın özgünlüğünü ortaya koymaktadır. Araştırmada nitel araştırma yöntemlerinden durum çalışması tekniği kullanılmıştır. Bu kapsamda 25 kanser hastası ile yarı-yapılandırılmış derinlemesine görüşmeler yapılmıştır. Görüşmelerde yarı-yapılandırılmış görüşme formu kullanılmıştır. Elde edilen bulgulara göre; onkoloji hastalarının manevi ihtiyaçlarının olduğu, ülkemizde manevi sosyal hizmet müdahalesinin uygulanmadığı ve dünyada hastaların bu ihtiyaçlarına yönelik manevi sosyal hizmet müdahalelerinin gerçekleştirildiği belirlenmiştir. Çalışmanın sonunda, Türkiye'nin kültürel kodlarına uygun bir manevi sosyal hizmet müdahale örneği geliştirilmiştir.

Anahtar kelimeler; Manevi sosyal hizmet, manevi müdahale, onkolojik sosyal hizmet

TURKISH JOURNAL OF
APPLIED SOCIAL WORK

A SPIRITUAL SOCIAL WORK INTERVENTION PROPOSAL IN THE FIELD OF MEDICAL SOCIAL WORK: UMRAN MODEL[1]

INTRODUCTION

Social work is an occupation that supports social change based on the principles of human rights and social justice, aims to solve problems, strengthen and liberate human relations for the improvement of the well-being of people, and for this, it intervenes at the points of interaction of people with their environment by making use of theories regarding human behavior and social systems." (IFSW, 2014).

Social work science supports social change, problem-solving in human relations, empowerment, and liberation in order to increase welfare. In the 3rd article of the Social Services Law (SHK) No. 2828, which came into effect in 1983 in our country, social services are defined as follows: They are the whole of systematic and programmed services aiming to eliminate the material, moral, and social deprivations of individuals and families arising from their own structure and environmental conditions or beyond their control, helping to meet their needs, preventing and solving their social problems, and improving and raising their living standards" (SHK, 1983). Within the scope of the aforementioned law, it is stated that the basic needs of individuals are defined as a material, moral, and social deprivation and that material, moral, and social deprivations should be eliminated for meeting these needs, and it is also stated that social services should be carried out with a holistic perspective.

In this context, one of the social work practices for sick individuals is medical social work and its sub-branch, oncological social work. It is seen that medical social work is called "medical social work" or "clinical social work" (Ronen & Freeman, 2007) in the literature. Friedlander (1963) defined medical social work as an application area of the social work profession. Both individual and, when necessary, group work methods are used to solve the problems that affect the patient socially and emotionally during his illness and treatment. Dr. Richard Cabot's contributions are of importance in the process of medical social work taking place and spreading in hospitals in the USA. It is seen that medical social work practices started in Massachusetts General Hospital for the first time in the USA in the early 1900s (Howard, 1913: 1966; Beder, 2006; Gehlert, 2006). They were the times when the professional job descriptions of social workers who would work in hospitals were discussed, what social work means in medicine, and the practice standards of social work in the hospital were tried to be established (Howard, 1913; Gehlert, 2006).

Medical social work aims to help individuals, families, and groups be happier, more confident, and more productive. On the other hand, it is significant that the goals and intervention techniques used to achieve the goals in this collaboration are measurable, reasonable, close, and realistic (Ronen & Freeman, 2007). According to Butrum (1967), the focus of medical social work is that "it is a service for the adjustment of patients and families to social and emotional problems related to the illness and its medical treatment". Rubinow (1943) defined medical social work as "a type of service that understands the needs of the patient and the circumstances surrounding him/her and considers how these affect his/her illness". Medical social work is an application area of the social work discipline, which includes professional social work interventions conducted for psycho-social and economic problems which cause the disease before the disease, accompany the diagnosed disease, affect the patient and his/her family in different dimensions during the treatment and follow-up process, disrupt the compliance and motivation to the treatment, bring about complex emotions, and require new arrangements in life (Özden and Özcan, 2020). As can be understood from the definitions, medical social work covers the dimension of the application of the social work profession in the field of health. Medical social work helps the medical care and treatment system to serve more humanely and more effectively. Social workers undertake other roles as well as treatment activities in medical care institutions (Duyan, 1996).

One of the fields of study of medical social work is oncological social work. In oncological social work, the patient, the individual, and his/her family are the main elements of the intervention. Therefore, the family is supported since the role of the family and its environment cannot be denied in the empowerment of the individual with cancer. Therefore, social workers are obliged to act as a bridge between the individual and his/her family through the intermediary role of the profession. It is important to cooperate with

A SPIRITUAL SOCIAL WORK INTERVENTION PROPOSAL IN THE FIELD OF MEDICAL SOCIAL WORK: UMRAN MODEL[1]

the family in the treatment of oncology patients. It is necessary to support not only the patient but also the family. The focus is on the psycho-social dimensions that the physician overlooks in his/her relationship with the patient and his/her family. Physicians should receive feedback, especially from the social worker, and incorporate the feedback they receive into the medical treatment process. Families and patients may blame themselves for cancer. Patients and their families should be considered as an important system. Likewise, the task of the oncology team should not be limited to the treatment process of the patients but should help patients and their families in their social adaptation to cancer (Yıldırım, Acar, & Tuncay, 2013).

It is observed that spirituality has been used in social work practices since 1980 (Canda & Furman, 1999). The importance of spirituality is undeniable in the practice of social work, which considers the bio-psycho-social and spiritual needs of the individual. For example, an individual who is unemployed experiences difficulties not only economically but also spiritually. Individuals with cancer will need medical social work and a social service that will appeal to them, to the things they give meaning to in their lives, in short, to spiritual social work.

Although spiritual social work is used with many different definitions in the literature, it is explained as one of the fields of social work and a type of practice. While social Work academics Prof. Michael Sheridan (2004), Clinical Social Worker Dr. Maria M. Carroll (1998), Prof. Harald Walach (2005), and Prof. Carlean M. Gilbert (2000) are defining spiritual social work as spirituality in social work, Ann M. Callahan (2017) and Ian Mathews (2017) defined spiritual social work as spirituality and social work. Prof. Au-Dean S. Cowley (1993) and Clinical Social Worker Dr. Elizabeth D. Smith (2001) defined spiritual social work as "transpersonal social work". In addition, Social Work academics Prof. Edward R. Canda and Dr. Leola Dyrud Furman (1999), Prof. David R. Hodge (2001a), Emel Yeşilkayalı (2018), and Hıdır Apak (2020) defined spiritual social work as "spiritually sensitive social work".

Zeki Karataş (2015) defined spiritual social work as "spiritual-based social work", while Tarık Tuncay (2007) and Emrah Akbaş (2014) defined spiritual social work as "moral social work". Spiritual focused social work and spiritually oriented social work terms are also used in the literature. Prof. Edward R. Canda, Mitsuko Nakashima and Dr. Leola Dyrud Furman (2004) and Prof. David S. Derezotes (2006) defined spiritual social work as "spiritually oriented social work". Ali Seyyar (2008) and Rukiye Karaköse (2020) used the concepts of "spiritual social work" and "spiritual social works". In this study, the term "spiritual social work" was preferred.

As Canda and Furman (2010) stated, spiritual-focused social work is a very important issue when the integrity of the service offered to the individual is taken into consideration. For example, for a postpartum woman who has just lost her baby, for a young person who is excluded from the community due to her religious/spiritual view, or for a single Muslim woman who has been physically abused, it will not be enough for a social worker to just write a Social Inquiry Raport (SIR) to meet their medical, psychological, and economic needs. The most accurate service to be offered to these individuals is spiritual social work, which deals with the spiritual dimension of the individual as well as other services. As Canda and Furman stated it, "holistic help is healing". For a holistic understanding of the individual and the environment, spiritual social work means evaluating the individual as a whole (Canda & Furman, 2010).

Spiritual focused social work in social services is "the product of an approach that aims to present the sources of moral support, which are thought to be effective in coping with the problems of the applicant, for the benefit of him/her by connecting with spirituality within the framework of professional discipline" (Yeşilkayalı, 2016). The general aim of spiritual social services is to improve the spiritual capacities of individuals in solving their spiritual problems that affect their social lives, to enable individuals to be connected with belief systems that provide spiritual openings, to create a foundation and institutional structure for belief systems to be more effective on people and to contribute to the development and implementation of policies for different social groups (for example, developing and implementing a spiritual care model for individuals in need of care) in accordance with the spirit of spiritual social work.

A SPIRITUAL SOCIAL WORK INTERVENTION PROPOSAL IN THE FIELD OF MEDICAL SOCIAL WORK: UMRAN MODEL[1]

According to Mathews (2009: 129), the first reason for the existence of spiritual social work "is the fact that every person has spiritual needs, regardless of race, age, ethnic origin, gender, and abilities". "Another reason is that if there is no spiritual social work, social workers lose their professionalism and cannot provide individual-centered politic intervention and care" (Mathews, 2009). Also, including religious and spiritual elements in social work theory and practice is a controversial issue. "In this subject, there are those who think that people who need social services also have spiritual needs, and therefore there should be religious and spiritual approaches in this field of service besides those who think that the religious and spiritual field has no place in the theory of social work" (Çekin, 2014). Social work, which does not have a spiritual concept, primarily gives importance to people's social behavior patterns, well-being, and bodily desires and wants to ensure the adaptation and happiness of people in this way. In addition to this, spiritual social work addresses people's spiritual world based on their spiritual happiness (Seyyar, 2008).

METHOD

The qualitative research design was preferred in the study, and case study was used as the study technique. The case study includes multidimensional data collection (interviews, focus group, observations, document analysis) (Yıldırım & Şimşek, 2005: 75). A case study is an empirical study type that provides the researcher with the opportunity to collect rich data in-depth, seeking answers to questions that start with how or why questions specific to a current situation examined (Yin, 2014: 17). For this reason, it was preferred in the study.

Data Collection Tools

The case study was carried out using semi-structured interview techniques and document analysis, which are qualitative data collection tools. The study examined literature and practice models related to international social work and spirituality in detail, and semi-structured interview questions were prepared for the patients.

Study Group

In the study, the study group consisted of 25 cancer patients who were diagnosed with different types of cancer and were receiving treatment. Participating patients were selected using the snowball method. While deciding on the number of participants, "data saturation point" was determined as a criterion. The data saturation point is to continue until the study sample is not unusual (Silverman, 2017).

Considering the demographic characteristics of the participants, 23 of 25 patients were female, and 2 were male. Among the 25 participants, there are 3 people in the 17-25 age range, 2 people in the 33-37 age range, and 20 people in the 42-68 age range. 17 of the participants are married and 5 are single. 1 is widowed and 2 is divorced. 13 of the married participants have 3 or 4 children and 5 people have 1-2 children. 7 people do not have children. 24 of the participants live with their families. 1 lives alone. 16 of the participants are housewives. 3 of them work in the private sector and 1 in the public sector. 5 of the participants do not work. 3 of the 25 participants are undergraduates and 2 are postgraduate. 11 of the participants are high school graduates, 2 are secondary school graduates, 8 are primary school graduates, and 1 is illiterate.

Participants include patients with 10 different types of cancer, including breast, uterus, ovarian, thyroid, leukaemia, lymphoma, kidney cancer, colon, lung cancer, and rare multiple myeloma cancer. Some of the participants still continue the treatment process. The treatment of the others has been completed, and they continue their routine check-ups. The profile of the patient participants is diverse in terms of socio-economic and worldview. Also, the participants consisted of patients who defined themselves in different categories in terms of belief and spirituality level.

A SPIRITUAL SOCIAL WORK INTERVENTION PROPOSAL IN THE FIELD OF MEDICAL SOCIAL WORK: UMRAN MODEL[1]

Data Collection

The study, which was carried out during the Covid-19 epidemic process, was carried out using online tools between 30 September and 15 November 2020. The interviews with the participants lasted an average of 60 minutes. Interview records were written in detail.

Data Analysis

In the study, the data were collected via electronic sources and printed sources and interpreted by the theory and applications in the literature. The descriptive analysis method was used to analyze the data obtained from the semi-structured in-depth interviews in the study.

Descriptive analysis was used to determine the categories, and content analysis was used to determine the themes. With descriptive analysis, the data were arranged according to the themes that emerged from the study questions, and the data summarized and organized in this way were examined in-depth with content analysis (Yıldırım & Şimşek, 2011).

Ethical Issues

Ethics Committee approval was obtained with the decision dated 30.09.2020 and numbered 2020/09 before the study data were collected. In the field practice of the study, verbal consent was obtained from the oncology patients before the interview was conducted.

Findings: A Spiritual Social Work Intervention Proposal in the Field of Medical Social Work: Umran Model

In the study process, the examples of spiritual social work intervention in the world were studied, the spiritual social work needs of oncology patients were determined, and the UMRAN MODEL was created as a unique spiritual social work intervention in the medical field, considering the social work intervention stages and methods. The word UMRAN is an Arabic word that means "building, improving, inhabiting, culture, and civilization" (Mutçalı, 2012). Ibn Khaldun, who is the first user of the concept of Umran (Meriç, 1996), stated that the superiority in establishing the Science of Umran belongs to him first because at that point, he was the pioneer and the guide. Then, he reveals that the concept of Umran includes elements that correspond to the meaning content of the concepts of society, civilization, and culture (Mahdi, 1964; Okumuş, 2018).

In order to summarize, Umran is a concept that means civilization, prosperity, progress, and happiness, and in Meriç's (1996) expression, it refers to history and people as a "whole". The main reasons for naming this model UMRAN are:

1.The construction of civilization begins with humans. It is possible for people to build a civilization with their happiness and well-being. Meeting their spiritual needs is one of their most basic needs. The concept of UMRAN was used to present a model in accordance with the civilization and cultural codes of individuals.

2.Social work is a profession and field of practice that prioritizes the "welfare and happiness" of individuals, families, groups, and societies. The concept of Umran was also preferred in naming the model as a concept aimed at ensuring the welfare and happiness of all people.

3.Umran model also brings a holistic perspective (bio-psycho-social-spiritual) to humans in the context of human beings in two different physical and spiritual dimensions and the concept of Umran "expressing human as a whole".

The UMRAN Model includes planned intervention processes in spiritual social work that social workers can apply to oncology patients. The method, technique, and application studies outlined in this process can also be applied to all sick individuals. Some of the elements outlined in this model are methods that can be used in psychology, psychology of religion, nursing, social work, geriatrics, medicine, etc., and are evaluated within the framework of a multidisciplinary approach.

Ethical Principles of Social Worker in the UMRAN Model

A SPIRITUAL SOCIAL WORK INTERVENTION PROPOSAL IN THE FIELD OF MEDICAL SOCIAL WORK: UMRAN MODEL[1]

UMRAN Model has principles consisting of those professional and ethical that social workers must comply with. First, social workers need to know the religious/spiritual characteristics of the applicants before starting the social work practice with them. Social Worker should empathize with patients. It is possible by taking time to listen to the patient and using therapeutic communication techniques. It is important in terms of social work ethics that social workers do not reflect their own religious and spiritual characteristics to the applicant and exhibit an unbiased attitude in their practices regarding them. While dealing with the spiritual dimension in the planned change process, Social Workers should evaluate each individual as "unique" and avoid generalizations. Social Workers should be able to apply one or more of the service or service modules among the application modules listed below, according to the personal characteristics and needs of the applicants. While making moral interventions for applicants, Social Workers should put forward a study for them to make their own decisions within the framework of the principle of "self-determination" instead of directing them. Social Workers should help patients find purpose and meaning. Social Workers should fulfill the role of bringing together applicants with experts in matters that go beyond themselves in spiritual intervention. Social Workers should work on moral support with patients in different time periods (at least twice a week) according to the spiritual needs of the patient.

Planned Change Process in the UMRAN Model

In the UMRAN model, the planned change process consists of five steps. These are acceptance and meeting, data collection and pre-assessment, planning and contracting, intervention and monitoring, and evaluation and termination (Sheafor and Horejsi, 2014). The intervention model that will be put forward regarding spiritual social work was discussed within this planned change process framework.

In acceptance and meeting, which are the first step of the planned change process in the UMRAN model, Social Workers perform their social work activities in three steps. They are preparation, initial connection, and acceptance. First, social workers prepare for the first interview by first examining the available information about the applicants, choosing the meeting place and time that will be convenient and comfortable for them, deciding who should attend the first interview, and considering their point of view in the help process and other factors that may affect the services to be provided to them. In the second step, Social Workers will begin the process of making connections by helping clients clarify and articulate their concerns and demands. Third, Social Workers must determine whether they can meet the spiritual needs of the applicants (Sheafor & Horejsi, 2014).

In the data collection and preliminary evaluation, which is the second step of the planned change process in the UMRAN model, the Social Workers use spiritual evaluation methods. In the UMRAN Model, spiritual evaluation methods are divided into five. They are indirect spiritual assessment, implicit spiritual assessment, and comprehensive assessment. a) In indirect moral evaluation, the applicant is evaluated together with all its dimensions, and this evaluation includes the biological, familial, cultural, and somatic history of the applicant, which serves to strengthen the direct interview (Faiver et al., 2001; Cashwell & Young, 2011; Hodge, 2015). In this context, the SIR report prepared by the Social Workers and described as social history (Sheafor & Horejsi, 2014) should also be used in the evaluation. In indirect evaluation, this information should be collected in an ethical framework, including applicant consent (Cashwell & Young, 2011). b) Implicit moral assessment was developed to provide an alternative approach to spiritual assessment. Implicit evaluation can be effective for applicants who are uncomfortable with spiritual language or who hesitate to talk regarding spirituality (Hodge, 2015).

Implicit spiritual evaluation is made by asking existential questions. Implicit spiritual evaluation is made by using an existential or psycho-spiritual language that indicates a transcendent dimension (Hodge, 2015). Concepts that focus on implicit spiritual evaluation are generally those such as meaning, passion, purpose, etc. (Swinton, 2010). When making an implicit spiritual

A SPIRITUAL SOCIAL WORK INTERVENTION PROPOSAL IN THE FIELD OF MEDICAL SOCIAL WORK: UMRAN MODEL[1]

evaluation, practitioners' spiritual radar should be alert to changes during a conversation with the applicant (Griffith & Griffith, 2002). As a matter of fact, the emergence of a different emotion during the interview may indicate that a spiritually important point has been pointed out for the applicant. For example, a glint in the eyes or a smile during an interview may indicate the existence of a situation of spiritual importance for the practitioner (Hodge, 2015). The implicit spiritual evaluation questions aim to assess the applicant's spiritual history, current spirituality, spiritual experiences, spiritual competence, spiritual environment, and thoughts about the future, meaning, and purpose in life (Hodge, 2015) (Canda & Furman, 2010). c)

Comprehensive assessment, on the other hand, is shown as a model that integrates implicit and explicit spiritual evaluations into a unified conceptual framework. In the comprehensive evaluation, the main theme of the evaluation is that the social worker creates a spiritually empathetic environment that respects and cares for the applicant's spirituality (Hodge, 2015). Spiritual history, spiritual life map, spiritual genogram, spiritual ecomap, and spiritual echogram can be used for comprehensive evaluation (Hodge & Reynolds, 2018). While doing this, the client should be carefully explained which method is used for what, for example, the reason and purpose of the transition to a comprehensive assessment (Hodge, 2015). It is possible to develop a mixed approach that will best suit the applicant with comprehensive evaluation methods. After examining the types of evaluation, it is also an important question which spiritual evaluation method social workers will choose.

In the UMRAN Model, spiritual history, spiritual life-map, spiritual genograms, spiritual eco-maps, and spiritual ecogram are used to evaluate the client as a data collection method. These data collection methods have been used in many different studies before (Hodge, 2001a; Bullis, 1996; Derezotes, 2000; Hodge, 2015; Sheafor & Horejsi, 2014; Sheridan, 2004; Gilligan & Furness, 2005; McGoldrick, Gerson & Shellenberger, 1999; Cashwell & Young, 2011; Connolly, 2005; Frame, 2000; Hodge, 2001b; Hodge & Limb, 2010).

In the planning and contract, which is the third step of the planned change process in the UMRAN model, Social Workers make a plan about the way he/she will follow with the information obtained as a result of the above-mentioned method, technique, scale, SIR, etc. inventories and observations. This planning must be prepared together with the applicants, and approval must be obtained from them.

As stated in the National Comprehensive Cancer Network (NCCN) Stress Management 2020 Guideline (Version 1: DIS25), in the light of the methods and techniques used above, the following issues regarding the applicant can be evaluated in the spiritual intervention planning for cancer patients;

a. Conflicts related to spiritual/religious beliefs and practices (a concern that illness is a punishment from God, etc.)
b. Concerns about lack of meaning/purpose
c. Problems with morals and values
d. Doubts about beliefs
e. Perception of being attacked by demons, djinns, etc.
f. Dealing with forgiveness issues
g. Concerns about the relationship with the sacred
h. Concerns about dying/death and/or life after death
i. Grief/loss
j. Feelings of worthlessness or burden
k. Loneliness
l. The conflict between false religious beliefs and recommended treatment
m. Ritual/worshipping needs (NCCN, 2020: DIS25)

A SPIRITUAL SOCIAL WORK INTERVENTION PROPOSAL IN THE FIELD OF MEDICAL SOCIAL WORK: UMRAN MODEL[1]

Interventions for oncology patients regarding these identified problem areas should be planned. While some of these plans are provided by social workers, some of them should be directed to professional staff such as clergy/theologians, psychologists/ religious psychologists, etc., through social workers. These are spiritual support/care, spiritual counseling, spiritual education, spiritual/religious rituals, meditation and/or prayer, referral to spiritual/religious community resources (e.g., particular faith community, spiritual leader, pastoral psychotherapist) (NCCN, 2020: DIS25), and group interviews with patients.

In the intervention and monitoring, which is the fourth step of the planned change process in the UMRAN model, Social Workers perform a spiritual social work intervention for all patients without distinguishing individuals' religious/spiritual elements. In addition, the Social Worker implements a spiritual social work intervention for Muslim individuals, considering the sociological structure and religious and cultural codes of our country. In the detailed examinations of the international social work and spirituality literature, it was seen that many examples of spiritual social work interventions designed in accordance with the religious, spiritual, and cultural structures of their own societies had been applied from the past to the present. A study called "Spiritual Intervention Techniques for Christians" (Çekin, 2014: 72-76), which is applied to sick individuals belonging to the Christian religion, is one of the currently applied models. The structure outlined in the UMRAN Model was presented to be used not only for oncology patients but also for all patients and clients facing social problems. However, the methods used in this model should be considered within the framework of each applicant's characteristics. Social Workers should determine the necessary intervention methods, taking into account the "uniqueness" of their applicants.

In the UMRAN Model, there are two spiritual intervention models for all (sick) individuals and Muslim (sick) individuals:

1. Spiritual Intervention for All Patients in the UMRAN Model

The spiritual support elements that can be applied by Social Workers to all sick individuals, regardless of any religious/ spiritual elements, are as follows:

1.Compassionate presence: Social workers' showing that they are with oncology patients and that patients are not alone should be offered spiritual support (Puchalski et al., 2009). For example, even the fact that Social Workers sit quietly next to patients can mean spiritual support for patients (Hodge, 2005).

2.Empathic listening: Social Workers' listening to the patients in an empathetic frame (Puchalski et al., 2009). Smiling at the patients, holding their hand, answering their questions, etc. (Hodge, 2005).

3.Talking about spiritual concepts (Eck, 2002; Fukuyama & Sevig, 1999; Cashwell & Young, 2011).

4.Spiritual self-disclosure (Denney, Aten & Gingrich, 2008; Cashwell & Young, 2011).

5.Enabling the applicants to confront their spirituality (Eigen, 2001; Cashwell & Young, 2011).

6.Approval: Discovering the patients' sense of meaning and purpose in life, exploring attitudes, beliefs, ideas, values, and concerns about life and death, affirming life and value by encouraging recollection of the past (NHS Scotland, 2007: 3; Puchalski et al., 2009: 895; Mutter & Neves, 2010: 166; Walker, 2010).

7.Awareness studies: Within the scope of body-mind-spirit interventions, awareness exercises/experiential focus (Gendlin, 1998; Hinterkopf, 1998).

8.Meditation: Contemplation. (Gendlin, 1998; Hinterkopf, 1998; Schure, Christopher, & Christopher, 2008; Simpkins & Simpkins, 2009; Cashwell & Young, 2011; Puchalski et al., 2009; Bedri, 2012; Good, 2010; Walker et al., 2004; Lee et al., 2018; Moadel et al., 2007; Liu et al., 2018).

9.Yoga: (Gendlin, 1998; Hinterkopf, 1998; Schure et al., 2008; Simpkins & Simpkins, 2009; Cashwell & Young, 2011; Puchalski et al., 2009; Bedri, 2012; Good, 2010; Walker et al., 2004; Lee et al, 2018; Liu et al., 2018).

10. Mindful awareness studies (MBSR, Mindfulness Based Stress Reduction): Making mindfulness-based interventions (Cramer, Lauche, Paul, Dobos, 2012; Bishop, 2002). The primary purpose of MBSR is to provide education in meditation techniques to bring "awareness" to patients. Mindfulness is generally conceptualized as a state in which one is highly aware and focused on the present moment's reality and accepts it without being caught up in thoughts or emotional reactions to the situation (Kabat-Zinn, 1982).

11.Relaxation techniques: (Lee et al., 2009; Liu et al., 2018), breathing exercises (Sharma & Haider, 2013),

12.Art therapy (music, art): (Sharma & Haider, 2014; Puchalski et al., 2009).

13.Spiritual journaling: (Vaughn & Swanson, 2006; Cashwell & Young, 2011).

14.Imagery: Spiritual relaxation and imagery with people or things that are spiritually important (Maher, 2006; Cashwell & Young, 2011).

A SPIRITUAL SOCIAL WORK INTERVENTION PROPOSAL IN THE FIELD OF MEDICAL SOCIAL WORK: UMRAN MODEL[1]

15.Forgiveness: Forgiving oneself or others (Enright, 2001; Worthington, 2005; Cashwell & Young, 2011).

16.Spiritual socialization: Participating in spiritual support groups, providing spiritual socialization (Cashwell & Young, 2011; Puchalski et al., 2009).

17.Dream work: Exploring the spiritual elements of dreams (Cashwell & Young, 2011; Bedri, 2012; Merter, 2014; Good, 2010; Walker et al., 2004).

18.Therapeutic intervention (for clinical social workers): Providing spiritual therapeutic interventions for oncology patients, cognitive behavioral therapy (Lawson & Snow, 2021), transpersonal therapy (Maslow, 2001), logo-therapy (Frankl, 1992), and implementation of Acceptance and Commitment Therapy-ACT (Nieuwsma, Walser & Hayes, 2016).

19.Giving homework: Giving daily homework for patients.

20.Social and artistic activities: Watching spiritual movies with patients and exchanging views on them. To contribute to the well-being of sick individuals by keeping them busy with art, music, painting, animals, soil, etc.

21.Seeing the illness as an educator: Enabling the patient to see the illness as an educator and focusing on the lessons that can be learned from it.

22.Visiting spiritual places: To encourage patients to visit places they value spiritually and to strengthen them in these terms.

2. Spiritual Intervention for Muslim Oncology Patients in the UMRAN Model

According to the religion of Islam, there are spiritual support elements that can be applied to all sick individuals who are accepted as applicants in terms of the social work profession. "It is possible to see many elements of spiritual support in the words of the Qur'an and behaviors and the Prophet (PBUH), which are accepted as the two main sources of the religion of Islam" (Beki, 2018: 97). Therefore, by using these basic references, findings, theories, and approaches obtained from different scientific data, Social Workers have spiritual support elements that they can apply to them during the intervention phase for Muslim oncology patients:

1.Spiritual support at the point of faith and belief: Social Workers ensure that Muslim patients are informed and supported related to their beliefs within the "reinforcement principle" framework.

2. Contemplation: Clients are allowed to be alone with themselves or to contemplate in a quiet atmosphere (Cashwell & Young, 2011; Bedri, 2012: 65; Good, 2010; Walker et al., 2004). Thus, the Muslim person is made to think regarding the disease he/she believes in coming from Allah, what the disease is, what kind of spiritual contribution it makes for him/her to have the disease, and what kind of internal transformation he/she enters for the meaning and purpose of life with the disease (Al Imran 3/190-191). According to Bedri (2012: 123), many Muslims welcome bodily ailments. The reason for this is that they say that such ailments allow deeper contemplation and reflection and encourage the soul more for worship and dhikr.

3.Tawakkul: As a religious and mystical term, tawakkul is defined as "a person's surrendering himself/herself to Allah, knowing Allah as a guarantor for his sustenance and affairs and trusting only Him" (Gazzali, IV; cited in Çağrıcı, 2012). Almighty Allah shows a way out for those who are faced with difficulties and emphasizes that they should pray: "When a calamity befalls them, they say, "Surely we belong to Allah (with everything) and to Him we shall certainly return" (Baqara 2/156)". In this regard, many verses indicate that servants should trust Allah. The following expressions will contribute to the patients' coping with the disease and strengthening them as spiritual support: "Trust in Allah, Allah is sufficient as a proxy" (Al-Ahzab 33/3), "Allah loves those who trust in Him" (Al Imran 3/159) and "Allah is sufficient for us, what a good guardian He is" (Al Imran 3/173).

4.Surrender: "The need of a person, who is weak and helpless in the face of problems, to be connected to supernatural power is one of the basic needs in human nature. Being weak and powerless by nature and likely to face many problems at any moment, relying on a transcendent power and surrendering to it is one of the most important moral supports that comforts him/her materially and spiritually" (Beki, 2020).

5.Worship: The verse "Ask for help from your God with patience and prayer" (Baqarah 2/45) in the Qur'an states that a believer can seek help from Allah by showing patience and praying in the face of diseases and problems he/she encounters (Yazır, 1995; Çekin, 2014; Puchalski et al., 2009; Iqbal, 1998).

5a. Prayer: To provide spiritual support for individuals 5 times a day by enabling them to meet with the Creator.

5b. Hajj and Umrah: To strengthen the patient by cooperating with the necessary personnel at the point of going to Hajj or Umrah.

5c. Reading the Qur'an: Supporting the patient in reading/listening to the Qur'an, understanding and reflecting on it. The fact that the Qur'an is a source of healing is expressed by Almighty Allah in Surah Isra as follows: "We are sending something from

A SPIRITUAL SOCIAL WORK INTERVENTION PROPOSAL IN THE FIELD OF MEDICAL SOCIAL WORK: UMRAN MODEL[1]

the Qur'an that is healing and mercy for believers." (Isra 17/82). "At the point of medical treatment, the practices of the Prophet of Islam also support the above verse, at the point that people can be treated with spiritual support by reading the Qur'an after fulfilling their responsibilities. It has become a tradition to recite surahs such as Al-Fatiha, Baqara, Al-Falaq, and Al-Nas for people to relax and find peace" (Rahman, 1989: 74-75; Sonn, 1996). The Prophet, in particular, states that reading Surah Al-Fatiha will cure many ailments, and reading some parts of the Qur'an will also relieve people (Abu Dawud, Tıb, 17).

5d. Pray: (Frame, 2003; Cashwell & Young, 2011; Cunningham, 2012; Carson & Koenig, 2004; Derezotes, 2006; Mathews, 2009; Puchalski, 2006).

The word "pray" in the dictionary means "to call, to ask, to ask for help, and the texts that express the demands to be submitted to Allah verbally or in writing are also called prayer" (Cilacı, 1994). Since the main goal of prayer is for people to present their condition to God and to pray to Him, prayer means a dialogue between the servant and God. In other words, prayer is a bridge built by the limited, finite, and helpless being with unlimited and infinite power. For this reason, human has never been away from prayer in any period of history" (Gazzali, 1989).

In the surah of Al-Furqan, Allah states, "What is the importance of you if you don't have your prayer" (Al-Furqan, 25/77) that humans can gain value in front of his God by praying and Allah orders him/her to pray to Him.

6. Reading spiritual/religious stories with spiritual content and their use in intervention by the Social Workers (Spiritual bibliotherapy technique): (Walker, 2010; Cashwell & Young, 2011; Puchalski et al., 2009; Mutter & Neves, 2010). The stories of Prophets such as Job, Joseph, Jonah, etc., and works such as Rumi's Masnavi, Yunus Emre, etc., also help patients get stronger in terms of spiritual support.

7. Hope, God's forgiveness: Exploring the individual's hopes and fears for the present and the future (NHS Scotland, 2007). To instil hope in the patient that the healing will come from Allah: "When I am sick, it is He who heals me" (Ash-Shu'ara 26/80).

8. Forgiveness of the patient: "God is forgiving, he loves to forgive" (An-Nisa 4/99, 149). Allah also loves those who forgive. While Muslims are called to this virtue in the Qur'an, it is said, "Let them forgive and tolerate. Do you not want Allah to forgive you?" (An-Nur 24/22) Individuals who are faced with the reality of illness contribute to their spiritual well-being if they forgive those around them to whom they are offended.

9. Referring to the religious resources that the applicant considers sacred: (Quran, Hadith-i Sharifs, religious books, etc.) (Keutzer, 1984; Cashwell & Young, 2011; Puchalski et al., 2009; Walker et al., 2004)

10. Aid and solidarity: Encouraging the patient to help, solidarity, altruism, self-sacrifice, and service to other patients (Midlarsky & Kahana, 2007; Cashwell & Young, 2011). The role of others is to comfort the patient. Helping other people allows patients to become stronger.

11. Visitation: Supporting the patient to visit other patients. As a matter of fact, the Prophet ordered Muslims to accompany the funeral ceremonies, visit the sick, and greet everyone (Sahih al-Bukhari, 2009), thus showing that visiting the sick is an important spiritual support for the patient.

12. Patience and gratitude: In the Qur'an, Allah states that He will test people in many materials and spiritual matters. It has been stated that the way to be successful in this test is to show patience against sicknesses and calamities, and it is given the good news that those who are patient will attain the grace, mercy, and eternal salvation of their God (Al-Baqara, 2/155; Al Imran, 3/142; Muhammad, 47/31). Attention is drawn to the concept of patience with the phrase "give good news to those who are patient" at the end of the verses that contain statements on this subject.

On the other hand, spiritual support with gratitude in patience is supporting individuals who are faced with the disease to be thankful that they have not experienced a worse situation.

"In the dictionary, the word "gratitude" is used in the dictionary with the meaning of knowing the good done and spreading it, praising the benevolent with his goodness. Conceptually, gratitude is defined as "To express gratitude for the blessings and favors from Allah or people, to respond to the blessing with words and deeds, and to do what is necessary by obeying Allah and avoiding committing sins" (Çağrıcı, İA. "şükr" art.). In Surah An-Naml (27/40), it is said from the tongue of Prophet Solomon, "He who is grateful only gives thanks for his good, and whoever is ungrateful should know that my God does not need anything, He is the owner of great generosity."

The subject of patience and gratitude has also been studied mainly in Sufi-ethical works. The most important of which is Ghazali's The Revival of the Religious Sciences. The 32nd chapter of the work, which consists of 40 main parts, is titled "Patience and Gratitude" (IV, 60-141). Here, Ghazali answered the question of whether people should be grateful for the troubles and calamities

A SPIRITUAL SOCIAL WORK INTERVENTION PROPOSAL IN THE FIELD OF MEDICAL SOCIAL WORK: UMRAN MODEL[1]

they face emphasizing that "every calamity and misfortune must be given thanks" (Gazzali, 1975):

"It is not desired or demanded that worldly troubles such as illness befall a person, but when it does, it is to look at it from the point of destiny and be thankful in order to turn it into profit in the hereafter. Because bodily and worldly troubles are not a real calamity. Every calamity a person has is lighter than any other calamity. No disease, trouble, or calamity is the worst. Therefore, to be grateful for the situation that a person has not faced with a bigger calamity than he/she has faced. Since the world is in the field of the hereafter, all diseases encountered in the world will be rewarded in the hereafter in return for patience. Therefore, to be grateful that the persecution and suffering in the world are instrumental in the elimination of the punishments in the hereafter.".

13. Repentance and forgiveness: According to Islam, one of the spiritual support elements necessary for people to get rid of the negative conditions is repentance and forgiveness from sins. Almighty Allah says in Surah Nuh (71/10.12): "...Ask forgiveness from your God, for He is very forgiving. Ask forgiveness so that it will rain abundantly from the sky on you. May He increase your wealth and your sons, grant you gardens, and make rivers flow for you." In another verse: "Ask forgiveness from your Lord, and then repent to Him so that He makes you benefit well for an appointed time (the end of your life) and reward every virtuous person for his virtue..." (Hud 11/3). In the hadiths, the Prophet (PBUH) said: "If a person does not forget to ask for forgiveness, Allah will show him a way out of every trouble, a way out of every sadness, and will provide him with sustenance from where he/she did not expect" (Abu Dawud, Vitir, 26; Ibn Majah, Adab, 57).

14. Therapeutic intervention (for clinical social workers): Spiritual therapeutic interventions for oncology patients, Islamicly modified cognitive behavioral therapy, spiritually modified cognitive therapy (Hodge, 2006; Hodge & Nadir, 2008; Bedri, 2018), implementation of transpersonal therapy (Maslow, 2001), religious-cultural psychotherapy (RCP) (Koenig & Al Shohaib, 2014), logotherapy (Frankl, 1992), and acceptance and commitment therapy ACT (Nieuwsma, Walser & Hayes, 2016).

15. Engaging in useful things: Disadvantaged sick individuals spending their time with things that will benefit themselves, their social environment, and society will bring significant gains both for themselves and for the other party. It is not possible for individuals who cannot get rid of the psychological state they are in to get rid of their problems. Therefore, by developing a sense of social responsibility, even if they are in adverse conditions, their mental and physical preoccupation with beneficial things and society will strengthen them in terms of spiritual support. In the Surah Al-Inshirah of the Qur'an, which supports this, it is ordered: "(O Muhammad!) Didn't we open your chest and widen it? Haven't we lifted the weight that bent your back? Have we not raised your glory? Surely there is a difficulty with ease. Really, there is a difficulty with ease. So, when you've finished one task, start another." Al-Inshirah, 94/1-8) It is important that Allah commands man to occupy his life with something.

16. Awareness of death: To inform that death is not nothingness or non-existence and that all living creatures will face the reality of death. The verse "Every soul will taste death" (Al-Anbiya 112/35; Al-Ankabut 29/57) reflects this fact.

17. Concerns and worries about the hereafter: Considering the spiritual martyrdom of Muslim patients due to their death due to illness and revealing the hope that their sins will be cleansed by means of the troubles they suffered due to illness and that they will be forgiven by Allah in the hereafter through repentance and forgiveness.

18. Spiritual/religious socialization of the patient: One of the moral support elements of the patient is establishing contact with the religious group and communities to which he is affiliated in the context of social support and supporting participation in mosques and groups at certain times.

19. Visiting spiritual/religious places: Encouraging patients to visit places they value spiritually and religiously and deem important to strengthen them spiritually.

In evaluation and termination, which is the fifth and last step of the planned change process in the UMRAN model, at the end of the planned change process, which is carried out in four stages, Social Workers should evaluate together with the applicants whether there is a change in the spirituality of them, what kind of changes have occurred, and if not, the reasons for this as stated in the ethical codes of NASW (NASW, 1996, Code of Ethics: 5.02a). In case that it is determined that the spiritual problems revealed as a result of the evaluation have been eliminated and an improvement has been made in the spiritual well-being of the applicant, the planned change process is terminated.

If it is determined that spiritual problems cannot be resolved, the main reasons for it should be addressed by Social Workers, and a new planning process should be started for it. Social Workers should conclude their study by referring clients to the necessary specialists. Termination, the last stage that is important in helping the applicant, is to approach every issue that may arise while a relationship is ending with sensitivity and guide to the termination (Sheafor & Horejsi, 2014: 471).

Terminating services to an applicant is a planned component of the assistance process. Social Workers should direct the

A SPIRITUAL SOCIAL WORK INTERVENTION PROPOSAL IN THE FIELD OF MEDICAL SOCIAL WORK: UMRAN MODEL[1]

following questions to the applicant in order to terminate the service; "1) Were the intervention methods successful? 2) Is the problem or situation that brought the applicant to the institution sufficiently resolved? Thus, will the applicant be able to live at an acceptable level? Has the risk of harming himself/herself or others been eliminated? 3) Has the worker and/or institution made a reasonable investment of time, energy, or skill without the required results? 4) Did one or both of the applicants and/or workers reach a point without expecting any significant benefit from their future contacts? 5) Has the applicant become inappropriately dependent on the worker or institution? 6) Was it beneficial for the applicant to refer to another institution or worker? (Sheafor and Horejsi, 2014: 501).

It is of importance that social workers, who have adopted the principle of serving the disadvantaged individual, family, group, and society, serve especially for oncology patients, address their spiritual aspects, and give them spiritual support and strength in the difficult processes they experience. Especially oncology patients who struggle with the disease alone are likely to have more difficulties in this process. For this reason, it was determined that it is important to provide spiritual support by social workers for oncology patients who do not receive sufficient social support from their relatives or who do not have any relatives or for patients who do not have any spiritual support.

CONCLUSION AND RECOMMENDATIONS

The needs of patients have not changed for centuries, and only in our way of dealing with them various paradigm shifts have occurred. It is required to develop new social work intervention models and techniques with a multidisciplinary approach and a holistic perspective for all patients, especially oncology patients, and to carry out structural arrangements in compliance with the principles of human rights and social justice and the understanding of the social state.

In this respect, according to the findings obtained as a result of both literature review and field study, it was determined that there is a need for social work practice for the spiritual needs of patients in the field of oncological social work, which is one of the sub-fields of medical social work. It was concluded that there is a serious need for social workers who are effective and competent in the field of spirituality in the diagnosis, treatment, and rehabilitation processes to ensure oncology patients' full well-being. At the point of meeting this need, it was determined that social workers working in the field of medical social work have a lack of knowledge related to how and with which methods and techniques they will do this. Based on this need, it is recommended to use the UMRAN Model as an example of spiritual social work intervention in the field of medical social work.

A SPIRITUAL SOCIAL WORK INTERVENTION PROPOSAL IN THE FIELD OF MEDICAL SOCIAL WORK: UMRAN MODEL[1]

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TURKISH JOURNAL OF APPLIED SOCIAL WORK
Volume: 4 Number: 2 Year: 2021

Research Article
Makale Gönderim Tarihi: 05.11.2021
Makale Kabul Tarihi: 21.12.2021

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

AİLE İÇİ ŞİDDETİN KADINLARIN AİLE İŞLEVLERİ ALGISINA OLAN ETKİSİNİN İNCELENMESİ

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CORRESPONDENCE

Yıldırım, Ş. and Çağlayan, F. (2021). Investigation Of The Effect Of Domestic Violence On Women's Perception Of Family Functions. Turkish Journal Of Applied Social Work. 4(2). Pp:143-156. https://doi.org/ 10.54467/ trjasw.101957[4]

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ABSTRACT

The goal of this study was to see how violence affected women's perceptions of family activities. Women who volunteered to participate in the study stayed at shelters linked with the Ministry of Family, Labour, and Social Services of Izmir between October 2016 and September 2017. A socio-demographic data form and then a Family Assessment Device were applied to the participants, and a relational screening model was used in the study. 96 women who were and were not victims of violence were interviewed, and a socio-demographic data form and then a Family Assessment Device were applied to the participants, and a relational screening model was used in the study. It was seen that the majority of the women participating in the study were between the ages of 25-39 at the rate of 58%, the majority of them were married at the rate of 68.8% and they did not work at the rate of 75%. 91.5% of the women who experienced violence stated that they were exposed to violence from their spouses or partners. It was discovered that being a victim of violence had a detrimental impact on the view of family functions, and that there was a statistically significant link between women's experiences of violence and all of the Family Assessment Device sub scores. Furthermore, all types of violence were assessed separately, and it was discovered that all types of violence had a statistically significant link with all sub scores of the Family Assessment Device. Violence has a negative impact on women's perceptions of family functions, as well as the family as a whole. The struggle against violence on women, as a phenomenon that has a negative impact on the entire society, starting with the individual and family, necessitates societal unity and determination in addition to international, national, and state-run social policies.

Keywords: Perception of Family Functions, Domestic Violence Against Women, Women's Shelter, Social Work, Social Services

ÖZET

Bu araştırmada, şiddetin kadınların aile işlevleri algıları üzerinde etkisinin incelenmesi amaçlanmıştır. Araştırma, İzmir Aile, Çalışma ve Sosyal Hizmetler Bakanlığı'na bağlı kadın sığınma evlerinde Ekim 2016 ile Eylül 2017 tarihleri arasında kalan ve çalışmaya katılmaya gönüllü kadınlar ile yapılmıştır. Araştırma kapsamında şiddet mağduru olan ve olmayan 96 kadın ile görüşülmüş ve katılımcılara sosyo-demografik veri formu ve ardından aile değerlendirme ölçeği uygulanmış ve çalışmada ilişkisel tarama modeli kullanılmıştır. Araştırmaya katılan kadınların çoğunluğunun % 58 ile 25-39 yaş aralığında olduğu, % 68, 8 ile çoğunluğunun evli olduğu ve % 75 oranında çalışmadıkları görülmüştür. Şiddet mağduru kadınların % 91,5'i ile neredeyse tamamına yakını partnerleri tarafından şiddete maruz bırakılmışlardır. Şiddet mağduru olmanın aile işlevleri algısını olumsuz etkilediği görülmüş ve kadınların şiddet yaşantısı durumları ile Aile Değerlendirme Ölçeği alt puanlarının tamamı arasında istatistiksel olarak anlamlı bir ilişki bulunmuştur. Ayrıca tüm şiddet türleri ayrı ayrı değerlendirilmiş, yine aynı şekilde tüm şiddet türleri ile Aile Değerlendirme Ölçeği alt puanlarının tamamı arasında istatistiksel olarak anlamlı bir ilişki bulunduğu belirlenmiştir. Şiddet kadınların aile işlevleri algısını olumsuz etkileyerek beraberinde aileye de etki etmektedir. Birey ve aileden başlayarak tüm toplumu olumsuz etkileyen bir olgu olarak, kadına yönelik şiddetle mücadele, uluslararası düzenlemeleri, ulusal düzenlemeleri ve devlet eli ile yürütülen sosyal politikaların yanında toplumsal dayanışmayı ve kararlılığı gerektirmektedir.

Anahtar kelimeler; Aile İşlevleri Algısı, Kadına Yönelik Aile İçi Şiddet, Kadın Konukevi, Sosyal Hizmet, Sosyal Hizmetler.

TURKISH JOURNAL OF APPLIED SOCIAL WORK
Volume: 4 Number: 2 Year: 2021

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

INTRODUCTION

Human lineage and human culture continued to exist within the family institution, which started with the marriage contract and was considered indispensable by all societies throughout human history (ASAGEM, 2011:25). In the Current Turkish Dictionary of the Turkish Language Institution, the family was defined as the smallest union in the society formed by the relations between the husband, wife, children and siblings based on marriage and blood relation, all of the people of the same lineage or who have kinship relations between them, all of the relatives and relatives living together (TDK, 2018).

Murdock defines the family as "a social group characterized by common housing, economic cooperation and reproduction" (Murdock 1949:1). Although there are many definitions about the family, it is seen that each of them considers the family as one of the main elements of social life and many definitions include the functions of the family. Murdock argued that the nuclear family, a universal social group, has four basic functions that apply to each society,

a. Regulation of sexual relations,

b. Reproductive function,

c. Sharing economic duties and responsibilities and

d. Education and socialization of children (Murdock1949:10).

Generally, the family that performs its functions is considered "healthy" and the family that does not perform its functions is considered "unhealthy". The healthy and unhealthy family depends on socio-economic characteristics, services, support and opportunities in the society, inherited characteristics and personality structures of family members, factors such as dynamic structure in family relations. In a healthy family, individuals approach each other with interest and love, spend time together, feel loyal to each other, are happy with each other's existence, are successful in solving their conflicts, accept each other as they are, appreciate each other, have common tastes, express their ideas and feelings comfortably, do not have difficulties in this regard and have the ability to joke about the events in the family and approach events humorously. In unhealthy families, with the interference of communication barriers, family members feel intense anger and resentment towards each other, they have difficulty in showing love and interest to each other, they are insecure and incomprehensible towards each other, they have difficulty in solving conflicts between them, there is a lack of empathy between them, resentment between family members who postpone problems lasts for days, family members talk to each other in insulting or abusive sentences, children experience behavioural disorders or mental problems in family members, family members do not approach each other with compassion and do not show mercy, situations such as violence or abuse occur in the family (Canel, 2012:91).

In this study, the evaluation of family functions was discussed with the McMaster Family Functions model.

The McMaster family functions model is based on system theory. The system is a concept that means the existence of regular relationships between the parts. Important assumptions of system theory, which is the basis of the McMaster Family Functions Model, are as follows:

a. All members of the family are related to each other,

b. It cannot be understood when a part of the family is isolated from the rest of the family system,

c. The functionality of the family cannot be fully understood only as one of the family members or subgroups in the family,

d. Family structure and institution are important factors that strongly affect and determine the behaviours of family members,

e. Operational models of the family system strongly shape the behaviours of family members (Miller et al. 2000: 168-189).

In the McMaster Family Functions Model, functionality is evaluated in terms of different dimensions to determine the effectiveness of a family. These dimensions are six: problem solving, communication, roles, ability to react emotionally, showing the necessary attention and behaviour control. (Miller et al. 2000: 168-189).

Problem-solving dimension is defined as the ability of the family to solve their material and spiritual problems at the

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

level that ensures effective family functioning and covers the period from the emergence of the problem to its resolution. Solving problems that threaten family integrity and functionality is challenging for families. However, not all problems are within this scope. Some families can maintain their functionality without solving problems that threaten their integrity and functionality (Miller et al. 2000: 168-189; Bulut 1990:7).

Roles are repetitive patterns of behaviour that individuals perform for the sustainability of family functions and meet the material and spiritual needs of the family. These are routine family tasks, such as cooking or taking out garbage (Miller et al. 2000: 168-189; Bulut 1990:7). There are many different reasons why any individual in the family refuses or does not fulfil the responsibilities required by their roles adequately. Resistance to renewal by role perceptions created by gender stereotypes in the face of changing living conditions can lead to role conflicts within the household, especially between spouses.

The McMaster Family Functions Model attaches particular importance to verbal communication in communication. (Miller et al. 2000: 168-189). In strong and healthy families capable of healthy communication, individuals communicate with each other more openly, more clearly, more frequently and directly. They can share their feelings, thoughts, dreams, fears, hopes, pains, joys, experiences and needs with each other, and they can create a healthy family environment by exchanging ideas and using each other's knowledge and experiences to understand each other, support each other (Canel 2012:102).

Emotional responsiveness is defined as the ability of the family to respond emotionally to certain stimuli in appropriate quality and quantity. (Miller et al. 2000: 168-189; Bulut 1990:7). Family members are expected to be able to express all kinds of emotions easily in a functional family.

The dimension of interest is defined as the degree of interest, love and appreciation shown by family members to each other. Attention is not only the degree of family togetherness, but also the degree of attitude among family members (Miller et al. 2000: 168-189). Healthy families are expected to be moderately interested in each other. Much care is considered to be the determinant of the family being too dependent on each other and less care is considered to show little love and interest to each other (Bulut 1990:8).

Behaviour control dimension is defined as the model that manages family behaviour in three types of situations. These three situations are physical danger, physiological needs that must be met and interpersonal socialization behaviour (Miller et al. 2000: 168-189). Healthy families are expected to control and discipline their behaviours in these three situations.

DOMESTIC VIOLENCE AGAINST WOMEN

We all come into the world as baby boys or girls without our own choice. Being born a boy or a girl is a reason for our biological existence, just like being mortal. (Ünaldı 2014:9). Another important factor in defining women and men is the definitions of women and men in different cultures called gender-social gender, which, unlike biological gender, is formed as a result of social structuring and can be changed. Gender discrimination shapes the lives of women and men and causes inequalities (Akın and Demirel 2003:73). Violence against women is gender-based, that is, violence against women because they are women and affects women disproportionately (KSGM 2014:34).

Violence, as is often perceived, does not mean only physical acts such as hitting, kicking, injuring, intention to kill or killing. Psychological, economic, sexual violence are other forms of violence that are less visible but are frequently used.

Physical violence is the use of physical methods to punish, such as slapping, punching, kicking, pushing, biting, bending your arm, squeezing your throat, wounding with a sharp or piercing instrument, torturing, burning with fire or boiling water, which damage the body integrity of someone else and make them suffer (Özgentürk et al. 2012). Sexual violence is one of the types of severe violence against women. Examples of sexual violence include humiliation of female gender, sexual harassment, body control, virginity control, child marriage, incest, coercion to sexually humiliating acts, sexual assault, coercion of women into forms

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

of relationships that they do not want, making them watch sexual intercourse with third parties, coercion to sexual intercourse with third parties (Karşıyaka Municipality, 2016).

Psychological violence is also called emotional violence. Making women worthless, name-calling, insults, swearing, humiliating, intimidating, threatening, controlling and creating a sense of helplessness in the eyes of others are examples of psychological violence (Karşıyaka Municipality, 2016).

Since the income entering the household in patriarchal societies is perceived as a common budget, economic violence is not as visible as other types of violence, but it is as important as other types of violence. Examples of economic violence include exploitation of women's labour, unpaid family work, preventing women from working or causing them to leave their jobs, taking away women's income and not giving money for home expenditures (Karşıyaka Municipality, 2016).

PLACES OF REFUGE FOR WOMEN

The most important of the intervention services offered to women exposed to violence or at risk in the fight against violence against women is the services offered in women's shelters (KSGM 2008). Women's shelters are boarding social services institutions where women can stay temporarily by providing protection from violence, solving and strengthening their psycho-social and economic problems and meeting their needs together with their children, if any. As of December 2016, 101 women's shelters affiliated to the Ministry of Family, Labour and Social Services have a capacity of 2647; 32 women's shelters affiliated to local governments have a capacity of 741; 4 women's shelters affiliated to NGOs have a capacity of 45 and a total of 137 women's shelters have a capacity of 3433 (KSGM 2016:24).

Women who want to be admitted to a shelter in our country should apply to the Provincial Directorate of Family and Social Services, the Violence Prevention and Monitoring Centre (VPMC), the relevant referral units or law enforcement units of public institutions and organizations performing similar duties. In addition, notifications of third parties who are aware of violence are also considered as denunciations. Direct applications of women to shelters are not accepted. The age of admission to the shelters is eighteen. Girls under the age of eighteen can only benefit from the shelter with their mother. Women with male children over twelve years of age and women with children with disabilities, provided that there is no risk of life safety, are rented and sheltered by renting an independent house if deemed appropriate by the VPMC based on the social examination report indicating that it is required. The length of stay in the shelter is six months from the date of admission to the woman's first admission unit (http://www.resmigazete.gov.tr/eskiler/2013/01/20130105-5.htm, Accessed: 10.06.2018).

It is clear that violence will damage the respect and perspective of the family. Within the scope of the research, how violence against women in the family is reflected in the way women perceive family functions was investigated.

In this study, it was aimed to reveal the effects of violence experienced by women in the family on their perceptions of family functions

METHODOLOGY OF THE RESEARCH

Relational screening model, one of the screening models, was used as the research model for the purpose of the research. Within the scope of the study, interviews were conducted with women staying in women's shelters affiliated to the Provincial Directorate of the Ministry of Family, Labour and Social Services in Izmir province, "Socio-Demographic Data Form" prepared by the researcher was completed in face-to-face interviews with women and "Family Assessment Device" was applied to the same women. By evaluating the data obtained, the ways in which women who have been subjected to violence and who have not been subjected to violence perceive the functions of the family institution were compared.

POPULATION AND SAMPLE OF RESEARCH

The population of the study consists of women staying in women's shelters in Izmir province.

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

The sample of the study consists of women staying in women's shelters affiliated to the Provincial Directorate of the Ministry of Family, Labour and Social Services in Izmir and volunteering to participate in the study. 96 women participated in the study. 59 of these women are victims of violence and 37 are women who have not been exposed to violence.

Within the scope of the study, interviews were conducted with two female shelters in Izmir and serving under AÇSHB (Ministry of Family, Labour and Social Services) in a first admission unit and the data collection process was completed. In the process of placing women in shelters in Turkey, it is essential to give priority to women with a history of violence. Women with violent experiences and especially life safety risks are placed in the first reception unit without wasting time and then in the shelters planned to stay longer. Only women with shelter problems are directed by evaluating the conditions and taking into account the legal periods they can stay in the shelter within the possibilities of their shelters, whether they have previously benefited from the shelter for shelter purposes, and if the shelter problems are economical, the relevant units are contacted and enabled to benefit from appropriate social service models. Therefore, in the research process, it took time to reach women who did not have a history of violence in the shelters where the study was conducted. In order for the distribution to be balanced in the comparisons, it was necessary to wait for a long time in order to work with women without a history of violence, and interviews were held only with women who benefited from the shelter service due to the housing problem until a sufficient number was reached.

DATA COLLECTION TOOLS

In the research conducted within this approach; "Socio-Demographic Data Form" prepared by the researcher in order to obtain the demographic information of the families and "Family Assessment Device" (FAD) (Bulut 1990) were used to determine the family functions. The research data were collected between 01.10.2016-01.09.2017 through interviews with women staying in women's shelters affiliated to Izmir Provincial Directorate of Ministry of Family, Labour and Social Services.

The Family Assessment Device (McMaster Family Assessment Device) is a measurement tool developed by Brown University in the USA in cooperation with Butler Hospital within the framework of the Family Research Program, which determines the subjects in which the family can and cannot perform its functions. In 1983, Epstein and Bishop conducted a validity and reliability study and obtained it by applying the previously developed McMaster Model of Family Functioning (MMFF) on families clinically. The scale was introduced to our language by Bulut (1989) by conducting validity and reliability studies in Turkey. This scale was designed to distinguish the structural and organizational characteristics of the family and the interaction between family members as "healthy" and "unhealthy". (Bulut 1990)

The FAD consists of seven subscales, six subscales discussed in the McMaster Family Functions Model and a subscale added in the FAD. While addressing problem solving, communication, roles, emotional responsiveness, showing the necessary attention, behaviour control, problem areas in family functions one by one, the general functions added afterwards generally evaluate whether the family is healthy. The number of questions, 53 according to the McMaster Family Functions Model, was increased to 60 questions in a way that does not affect the correlation between dimensions in order to increase the validity of the three sub-dimensions (communication, problem solving and roles). Some of the items describe healthy functions and some describe unhealthy functions. Each item consists of a sentence containing positive and negative statements about family life. At the beginning of the scale, there is a directive on how to answer the questions as a separate page. According to this directive, family members are asked to read the articles and mark the appropriate options considering the last two months. Questions 2, 12, 24, 38, 50 and 60 in the scale include statements related to the problem solving dimension, questions 3, 14, 18, 22, 29, 35, 43, 52, and 59 include statements related to the communication dimension, questions 4, 8, 10, 15, 23, 30, 34, 40, 45, 53 and 58 include statements related to the role dimension, questions 9, 19, 28, 39, 49 and 59 include statements related to the emotional response dimension, questions 5, 13, 25, 33, 37, 42 and 54 include statements related to the showing the necessary interest dimension, questions 27 , 32 , 44 , 47 , 48 and 55 include

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

statements related to the behaviour control dimension, questions 1, 6, 11, 16, 21, 26, 31, 36 , 41, 46, 51 and 56 include statements related to the general functions dimension. (Bulut 1990:9)

The FAD scale gives the family functionality score of all family members over 12 years of age when applied individually and averaged by all members. When applied to a single family member, it reveals the individual's perception of family functionality. In the evaluation of the scale, 2.00 is considered to be a distinguishing number. It is noted that the average score above 2.00 is an indicator of an unhealthy trend in family functions. However, in this case, it is noteworthy that the health area is wider because the lowest score is 1.00. (Bulut1990:10)

The validity study of the Family Assessment Device was conducted by Epstein and Bishop in 1983. The scale was applied to only one person from 218 normal, 98 psychiatric patient families, and the mean scores of their families in each subscale were lower than the mean scores of the patient families, that is, healthier. The same people performed regression analysis by simultaneously applying the Philadelphia Geriatric Morale Scale and Locke Wallace Marriage Satisfaction Scale together with 178 retired couples aged 60 years to determine the validity of ADS compliance and found a significant relationship between ADS and Locke Wallace Marriage Satisfaction Scale (R = 0.53). In addition, the relationship between the scores obtained from ADS and the scores obtained by both men and women from the Philadelphia Geriatric Morale Scale was found to be 0.47 (Bulut1990:12-13). The second validity and reliability study were conducted in 1985. In order to determine whether the scale was affected by social likability orientations, 164 family members in 72 families were given the ADS together with the Marlowa-Crowne Social Likeability Orientations Impact Scale, and the correlations of this scale with each of the six dimensions were low. This result showed that FAD was affected by social appreciation. (Miller, Bishop, Epstein, Keitner, 1985:345-356. Bulut, 1990:13)For the reliability study on score invariance, the scale was applied to a group of 45 people twice with an interval of fifteen days, and the correlations between the two applications varied between 0.66 (Problem Solving) and 0.76 (Emotional Response Ability). This revealed that the scale was reliable in terms of score invariance. For FAD compliance validity, the scale was applied to the same group together with FACES II and Family Unit Inventory, the measurement tool of the Circumplex Family Functions Model developed by Olson, and a high correlation was found between FUI and FAD. Correlations with FACIS II are not significant. The researchers state that this result may also be due to the difference in the scoring of the Circumplex Family Model. In the examination of the validity of FAD according to external criteria, FAD scores of family members were compared with the clinical evaluations of an experienced family therapist regarding the family. The FAD mean scores of the individuals in the subscales evaluated by the therapist as unhealthy were also found to be unhealthy, except for the "Behaviour Control" subscale. (Bulut 1990:13-14)

For the construct validity of the scale in Turkey, a scale was applied to 25 women or men in the divorce process and to each of the 25 couples maintaining the normal marriage. A significant distinctive difference was found between the divorced and non-divorced groups. In addition, it is seen that the mean scores of the subjects in the families with and without mental illness are significant. (Bulut 1990:16)

ANALYSIS OF DATA

The demographic characteristics of women stated in the Socio-Demographic Data Form are indicated by their number and percentage distributions. In the analysis of the sub-problems of the research, the data obtained using the Mann-Whitney U test, one of the nonparametric tests, were interpreted to determine whether the difference between the data of two independent groups was significant. Kruskal-Wallis H test was used to test whether the difference between the data of more than two groups was significant.

The responses of women to the seven FAD sub-dimensions were scored and calculated, and the mean and standard deviations were calculated separately for each sub-dimension. The way women perceive family functions was scaled as healthy and unhealthy and their data were analysed by entering into the SPSS program. In the responses given, if the mean sub-dimension

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

was less than 2 and 2, it was scaled that the woman perceived that sub-family function as healthy, and if it was greater than 2, she perceived it as unhealthy. The significance level was accepted as 0.05.

At the meeting of the Ethics Committee of Manisa Celal Bayar University dated 22.06.2016 and numbered 233, it was decided that the research was ethically appropriate.

FINDINGS

In the study, findings regarding the socio-demographic characteristics of the participants, findings regarding exposure to violence, the scores of the participants from the FAD, and the relationship between the scores obtained from the FAD and the exposure to violence were obtained. These findings are presented in tables below.

Table 1. Socio-Demographic Characteristics of The Participants (n=96)

Features	***Number***	***%***
Age		
18-25 years old	*22*	*22,9*
26-39 years old	*56*	*58,3*
40-49 years old	*15*	*15,6*
50 and above	*3*	*3,1*
Education Status		
Never educated	*6*	*6,3*
Literate	*5*	*5,2*
Primary School	*23*	*24*
School Secondary School	*22*	*22,9*
High School	*33*	*34,4*
University - College	*7*	*7,3*
Marital Status		
Formally Married	*66*	*68,8*
Divorced - separated	*16*	*16,7*
Informal relationship	*8*	*8,3*
Single	*6*	*6,3*
Period of Marriage		
0-2 years	*19*	*21,1*
3-5 years	*15*	*16,7*
5-10 years	*19*	*21,1*
10 years and above	*37*	*41,1*

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

Number of Children		
No Children	*18*	*18,8*
She has 1 child	*37*	*38,5*
She has 2 children.	*27*	*28,1*
She has 3 children.	*6*	*6,3*
She has 4 children.	*8*	*8,3*
Working Status		
Not working	*72*	*75*
Has a Regular Income Job	*12*	*12,5*
Day Labour	*8*	*8,3*
Free Family Worker	*4*	*4,2*
Length of Stay in Women's Shelter		
Less than 1 Week	*25*	*26*
1 Week to 1 Month	*33*	*34,4*
1 Month to 3 Months	*17*	*17,7*
3 Months to 6 Months	*11*	*11,5*
6 Months and Over	*10*	*10,4*

As can be seen in Table 1, the majority of the participants in the study are individuals between the ages of 25-39 with 58.3%. The majority of the participants in the study are at least high school graduate women with 41.7%. In addition, it is seen that 6 participants are not even literate. The majority of the participants of the study are officially married individuals with 68.8%. The duration of marriage or association of 41.1% of the women participating in the study is 10 years or more. Within the scope of the table, the duration of marriages/unions of women who are already divorced or separated before the divorce/separation is taken as a basis. In addition, it is seen that 6 participants are not married. Six unmarried women were not included in the table. Findings from the table suggest that many women continue their marriage under conditions of violence and oppression for a long time. The vast majority of the participants of the study have only one child with 38.5%. On the other hand, it is seen that there are 8 women who have four or more children. The majority of the participants of the study are women who do not work in any job with 75.0%. 4.2% of the participants who stated that they worked stated that they were unpaid family workers. When women who do not have any income due to being unpaid family workers are added to women who do not work, it is concluded that 79.2% of them do not have economic freedom. The fact that women who do not work are concentrated in the shelter constitutes the idea that women who do not have economic power mostly end up in a deadlock after the violence they experience and turn to the shelter process. The proportion of participants who stated that they had a regular income among all participants was found to be 12.5%. It is seen that 96 women who participated in the study mostly stay in the women's shelter between 1 week or 1 month.

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

Table 2: Distribution According to the Status of Violence of Women

Violence	Number	Percentage
History of violence	*59*	*61,5*
No history of violence	*37*	*38,5*
Total	*96*	*100,0*

As can be seen in Table 2, 59 of the 96 participants of the study had experience of violence and 37 of them did not have experience of violence.

Within the scope of the study, 37 women who stayed in the shelter and had no history of violence participated in the study. When the table is examined, it is seen that women with a history of violence constitute 61.5% of the total number of women interviewed within the scope of the study and 38.5% of women without a history of violence.

Table 3: Type of Violence experienced by Women with a History of Violence (n=59)

Type of violence	Number	Percentage
Physical violence	*53*	*89,8*
Sexual violence	*23*	*39,0*
Psychological violence	*54*	*91,5*
Economic violence	*37*	*62,7*

When Table 3 is evaluated, it is seen that 53 of the 59 women who participated in the study and had a history of violence stated that they experienced physical violence, 23 stated that they experienced sexual violence, 54 stated that they experienced psychological violence and 37 stated that they experienced economic violence. The data obtained show that the violence experienced by women is not limited to a single type of violence.

Table 4: From Whom Do Women Suffer Violence

Violence from whom	Number	Percentage
Spouse-Partner	*54*	*91,5*
Other family member	*5*	*8,5*
Total	*59*	*100,0*

As can be seen in Table 4,91.5% of the 59 women who experienced violence stated that they were exposed to violence from their spouses or partners.

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

Table 5: The Relationship Between Women's Violence Experience and Family Assessment Device Scores

Functions	***Violence***	***Number***	***Rank Aver-age***	***Chi-square***	***P***
Problem solving	*Violence* *No violence*	*59* *37*	64,43 23,09	7,103	,000
Communication	*Violence* *No violence*	*59* *37*	64,78 22,54	7,240	,000
Roles	*Violence* *No violence*	*59* *37*	63,31 24,89	6,583	,000
Ability to Respond Emotionally	*Violence* *No violence*	*59* *37*	63,17 25,11	6,531	,000
Showing the Necessary Interest	*Violence* *No violence*	*59* *37*	60,27 29,73	5,242	,000
Behaviour Control	*Violence* *No violence*	*59* *37*	61,81 27,28	5,921	,000
General Functions	*Violence* *No violence*	*59* *37*	65,26 21,77	7,454	,000

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

Table 6: The Relationship Between The Physical, Sexual, Psychological And Economic Violence Experiences Of Women And The Family Assessment Device Sub-Scores

	Physical violence		Sexual violence		Psychological violence		Economic violence	
	Chi-square	p	Chi-square	p	Chi-square	p	Chi-square	p
Problem solving	*6,622*	*,000*	*4,140*	*,000*	*7,376*	*,000*	*5,191*	*,000*
Communication	*6,252*	*,000*	*4,779*	*,000*	*6,589*	*,000*	*5,778*	*,000*
Roles	*5,823*	*,000*	*4,284*	*,000*	*5,978*	*,000*	*4,665*	*,000*
Ability to Respond Emotionally	*6,145*	*,000*	*3,636*	*,000*	*6,012*	*,000*	*4,566*	*,000*
Showing the Necessary Interest	*4,521*	*,000*	*2,569*	*,010*	*4,417*	*,000*	*2,648*	*,008*
Behaviour Control	*5,263*	*,000*	*2,632*	*,008*	*5,531*	*,000*	*4,386*	*,000*
General Functions	*6,930*	*,000*	*4,598*	*,000*	*7,169*	*,000*	*4,993*	*,000*

As can be seen in Table 6, there is a statistically significant relationship between the physical, sexual, psychological and economic violence experiences of women and almost all of the sub-scores of the Family Assessment Device ($p<0.001$).

DISCUSSION

Looking at the ages of the women interviewed within the scope of the study, it is seen that 58.3% of the participants are individuals between the ages of 25-39 years, this majority is followed by women 22.9% between the ages of 18-25 years, 15.6% between the ages of 40-49 and 3.1% between the ages of 50 and over, and the women staying in the shelter are concentrated at ages that can be defined as young. The number of women staying in the shelter in the age group of 50 and over is quite low compared to other age groups. Urhan (2013) found the mean age of the participants as 31.9 (SD = 9.49, December 14-67) in his study, which aimed to examine the frequency of post-traumatic stress and depressive symptoms in women who were exposed to domestic violence (spouse/partner, parent, brother, etc.) and the relationship between demographic and personal factors, relationship characteristics, trauma factors and post-traumatic social support and resource loss in women's shelters affiliated with ASPIM and some municipalities in Istanbul, Izmir and Eskişehir provinces. The findings of these researches support the age group data of the women participating in our study, which focuses on the age group of 25-39 years.

The majority of the women participating in the study are officially married individuals with 68.8%. This rate is followed by divorced or separated women with 16.7%, unofficial women with 8.3% and single women with 6.3%, respectively. Urhan (2013) found that 71.7% of the participants were married or living together in a study aiming to examine the frequency of post-traumatic stress and depressive symptoms in women who were exposed to domestic violence (spouse/partner, parent, brother, etc.) and the relationship between demographic and personal factors, relationship characteristics, trauma factors and post-traumatic social support and resource loss and applied them in women's shelters affiliated to ASPIM and some municipalities in Istanbul, Izmir and Eskişehir provinces. The proportion of women who stated that they divorced or separated in the study was 14.7%. In Urhan's research, the data obtained on the marital status of women show rates close to the data of our research.

The vast majority of the participants of the study have only one child with 38.5%. It was determined that 28.1% of the women had 2 children and 6.3% had 3 children. On the other hand, it is seen that there are 8 women (8.3%) with four or more children. In the 2017 data of the Address-Based Population Registration System, the average household size in Turkey was found to be 3.4 (http://www.tuik.gov.tr/PreHaberBultenleri.do?id=27597). TurkStat 2016 birth statistics show that the total

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

birth rate is 2.10 children. It should not be forgotten that the child of a woman who is a victim of violence is also a victim of abuse, at least because of witnessing violence, and the issue of child treatment should not be ignored while planning services for women.

When their educational status is examined, it is seen that 6.3% of the women are not even literate, 5.2% are literate, 24.0% are primary school graduates, 22.9% are secondary school graduates, 34.4% are high school graduates and 7.3% are college or university graduates.

The majority of the participants of the study are individuals who do not work in any job with 75.0%. 12.5% of the women stated that they had a job with regular income, 8.3% of them stated that they worked in daily jobs, and 4.2% of them stated that they were unpaid family workers. When women who do not have any income due to being unpaid family workers are added to women who do not work, it is concluded that 79.2% of them do not have economic freedom.

Looking at the data on how long the women included in the study stayed in the shelter, 26.0% of them were staying in the shelter for less than 1 week, 34.4% were staying between 1 week and 1 month, 17.7% were staying between 1 month and 3 months, 11.5% were staying between 3 months and 6 months and 10.4% were staying in the shelter for more than 6 months.

It is seen that 59 of the 96 participants of the study had experienced violence and 37 of them did not. 89.8% of the participants who stated that they had a history of violence stated that they were exposed to physical violence, 39.0% to sexual violence, 91.5% to psychological violence and 62.7% to economic violence.

91.5% of 59 participants stated that they were subjected to violence from their spouses or partners. 8.5% of women with a history of violence stated that they were exposed to violence from other family members. As a result of a face-to-face study conducted by the EU Agency for Fundamental Rights (FRA) in 28 EU member states in 2014, it was determined that two out of every five women (43%) were subjected to psychological violence from their current or former spouse/partner and 42% of women subjected to violence from their spouses or partners continued to be subjected to violence while pregnant. (http://fra.europa.eu/sites/default/files/fra-2014-vaw-survey-main-results-apr14_en.pdf, Accessed on 19.08.2018). The fact that the vast majority of the perpetrators of violence against women are women's own spouses shows that the marriage union is not established in a healthy way. Therefore, the availability of pre-marital education and counseling and family counseling services during the marriage process will be an important preventive and protective service in terms of family health and protection from violence.

There is a statistically significant relationship between women's experiences of violence and all of the sub-scores of the Family Assessment Device ($p<0.05$). Women who are subjected to violence experience self-harm, loss of self-confidence, depression, post-traumatic stress disorder as well as various psychological problems. Although women experience the psychological consequences of violence in the first degree, the extensive effects of the trauma they experience extend to both their families and children, their social circles, if any, their workplace and job performances (Fraim 2012).

There is a statistically significant relationship between the physical violence experiences of women and all of the sub-scores of the Family Assessment Device ($p<0.001$). Physical violence is the type of violence that has severe consequences that can reach death for women and is the most reacted by the society. It was determined that 25-40% of the injuries in women occurred due to domestic violence. 7.1% of women who are beaten accept this situation quietly. 80% of women who are exposed to violence think that nothing can be done about violence (Uysal 2006).

There is a statistically significant relationship between the sexual violence experiences of women and all of the sub-scores of the Family Assessment Device ($p<0.05$). In sexual violence, there is an attack on the body and sexual identity. Sexual assault is usually accompanied by physical and psychological violence (Atan 2006).

There is a statistically significant relationship between the psychological violence experiences of women and all of the sub-scores of the Family Assessment Device ($p<0.05$). As a result of exposure to psychological violence, a reduced human profile occurs in the family, in the society, inside and outside the work life and the determination to fight decreases (Keskin 2012).

There is a statistically significant relationship between the economic violence status of women and all of the sub-scores of the Family Assessment Device ($p<0.05$). Economic violence is an important obstacle for women to develop themselves and hold on to life as individuals in social life. Economic violence, which is a violation of rights, impoverished women and sets a barrier to democratization. In order to eliminate all these, improvements need to be made both individually and socially (Bilican Gökkaya, 2011:129-145).

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

CONCLUSION

As a result of this research, it is seen that not only women who are victims of violence but also women who have accommodation problems due to social and economic deprivation stay in women's shelters. For this reason, specialization of women's shelters according to different needs will provide better services to women. In addition, it has been observed that women who are victims of violence are exposed to more than one type of violence and this violence affects women's perception of family functions in an unhealthy way.

Violence against women, which is the most common form of violence as a human rights violation, is one of the most important problems in the whole world regardless of race, religion, geography and economic development. Despite the steps and developments taken at national and international levels, the problem of violence against women remains an obstacle to women's fundamental rights and freedoms.

When considered within the framework of the General System Approach, the problem of violence against women, which is a multifaceted problem, affects not only the woman who has been subjected to violence, but also her family, children, close environment and society negatively. As emphasized in this research, it is clear that violence disrupts the functions of the family and damages basic family requirements such as problem solving, communication, fulfilment of roles, emotional sharing, and mutual trust. Legal measures to be taken only after violence has occurred and women have suffered victimization will not constitute adequate measures to combat violence against women. A long process and path that requires the realization of measures and social enlightenment to prevent the emergence of violence should be planned and implemented. It will not be possible to prevent violence against women unless legal regulations remain only on paper and protective and preventive models are developed. In this context, it is important to review and work over and over all the factors that cause gender inequality and violence against women.

It is clear that it is necessary to combat domestic violence and violence against women in order to protect and improve the health of the family and society. One of the most important steps to be taken to prevent violence will be to change the silent attitude of women towards violence. For this purpose, women should be enlighten regarding the Law No. 6284 on the Protection of the Family and the Prevention of Violence Against Women and the authorities they can apply to when they encounter violence as well as about women's rights. Also, promotional campaigns and trainings should be organized for this purpose. With the family trainings to be organized, the damages caused by violence to individuals and the disadvantages of children growing up in violent environments should be emphasized at the individual and social level, and personal social work and counselling activities related to anger control should be carried out. Women's having a registered and regular income in employment will be effective in finding solutions and developing coping methods when they encounter violence.

INVESTIGATION OF THE EFFECT OF DOMESTIC VIOLENCE ON WOMEN'S PERCEPTION OF FAMILY FUNCTIONS

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TURKISH JOURNAL OF APPLIED SOCIAL WORK
Volume: 4 Number: 2 Year: 2021

Research Article
Makale Gönderim Tarihi: 08.12.2021
Makale Kabul Tarihi: 31.12.2021

THE EFFECT OF SEXUAL PROBLEMS IN DIVORCE PROCESS: CASES OF MEN (TURKEY)

BOŞANMA SÜRECİNE CİNSEL PROBLEMLERİN ETKİSİ: ERKEK VAKALARI (TÜRKİYE)

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Çetinkaya, D. and Aydemir, İ. (2021). The Effect of Sexual Problems In Divorce Process: Cases Of Men (Turkey). Turkish Journal Of Applied Social Work. 4(2). Pp:157-168. : https://doi.org/ 10.54467/trjasw.1034206

ABSTRACT

This research aims to shed light on the perspective of men towards the divorce process in Turkey and the effect of sexual problems on the decision to divorce. According to the men who participated in the study, the two most important problems leading to divorce is indifference by their wives and not meeting their expectations (emotional, sexual vs.). The next most important problem is jealousy/pressure by wife, and the final is sexual problems. Significant differences were detected in the breakdown of the scale among men who believe sexual problems affect marriage and sexuality is regarded as a problem in marriage as well as seeing it as a reason for divorce. Consequently, the report concludes that men who are in the process of divorce experience sexual problems as revealing in most of the sub-factors of sexual satisfaction level.

Keywords: Divorce, premature ejaculation, impotence, family therapy, sexual problem

ÖZET

Bu çalışmanın amacı, boşanma sürecindeki erkeklere göre cinsel sorunların boşanmaya etkisinin Türkiye örnekleminde incelemektir. Çalışmaya katılan erkeklere göre, boşanmaya yol açan en önemli iki sorun eşlerinin ilgisizliği ve beklentilerini karşılayamama (duygusal, cinsel vs.) dir. Diğer önemli sorun ise, eşin baskısı veya kıskançlığı ve son olarak da cinsel sorunlardır. Erkekler cinsel sorunların evliliği etkilediğine ve cinselliğin evlilikte hem bir sorun hem de boşanma nedeni olarak görmekte ve ölçeğin alt faktörleri arasında anlamlı bir fark belirlenmiştir. Sonuç olarak, çalışmanın sonuçları boşanma sürecindeki erkelerde cinsel doyumun düşük olmasının boşanma ile ilişkisi olduğunu ortaya koymaktadır.

Anahtar kelimeler; Boşanma, erken boşalma, iktidarsızlık, aile terapisi, cinsel sorunlar

TURKISH JOURNAL OF
APPLIED SOCIAL WORK

THE EFFECT OF SEXUAL PROBLEMS IN DIVORCE PROCESS: CASES OF MEN (TURKEY)

INTRODUCTION

Family is the primary social institution of socialization, the role of which is to build social order and balance. The concept of this primary institution has changed throughout history, in line with social changes, and has undertaken new functions at different times. Particularly, problems emerging during industrialization (in industrialized countries) and its associated, rapid social changes had and continue to exert a strong and direct effect on the family structure. In this context, family structure is composed of behavioral patterns accepted and continuously repeated by its members which ensure and regulate interaction among these family members. Family structure differs depending on many variables such as family bonds, social attitudes in the region where they live, reaction to social change, financial conditions and cultural features (Gottman & Levenson, 2000). The most important functions provided by family and marriage relations are emotional, social, psychical, sexual, economic benefits and providing continuance to lineage (Gülsün, Ak, & Bozkurt, 2009).

One of the basic functions of spousal relations in the family is fulfilling the sexual needs of each. Humankind is born with sexual drive and basically lives by instincts of love and sexual drive. Therefore, it is necessary to satisfy these instincts. Love and sexuality are the most important factors that bind spouses together and ensure the continuity of the family unit. However, love and sexuality are not the only factors that continue the marriage and other factors must accompany to ensure satisfaction (Kayser, 1993).

The primary physical and psychological need for individuals is love and physical intimacy (sexual intercourse). It is believed that the most important source of motivation for building and sustaining a relationship is love and sexuality (Morokoff & Gillilland, 1993). In this regard, love and sexuality are complementary values gaining meaning when they are present together in marriage. Therefore, love and sexuality in marriage mutually and proportionately satisfy emotional needs (Kayser, 1993).

Sexual satisfaction by spouses creates the need for assuring their marriage relations. (Kersten, 1990). Furthermore, problems in a couple's sexual intercourse (sexual incompatibility and sexual dysfunctions) have consequences. They lower expectations of the marriage, damage the skills used in the struggle against and resolution of family problems, and they reduce the pleasure in marriage and the peace and quality of whatever sexual intercourse does take place (Öztürk & Arkar, 2014). Although there are many factors leading to divorce, low sexual satisfaction is considered to be an important one, and it is therefore significant to investigate sexual satisfaction in depth.

Divorce risk factors include teenage marriage, premarital cohabitation, poverty, unemployment, parental divorce, infidelity, alcohol and drug abuse, weak marital commitment, high levels of conflict, and domestic violence (Bahr, 2016). And though there is relatively scant mention of it in the literature, sexual problems are also a risk factor for divorce. For instance, it has been estimated that 50% of American marriages have some sexual problems (Glick, et al., 2016).

While it is true that there are few studies investigating in general the effect of sexual problems on divorce, it is also significant – and should be noted separately – that there is also limited research on the specific issue of sexual problems and marriage from the perspective of men. Thus, the main objective of this study is to understand the divorce process from the perspective of men as well as the factors contributing to this process.

Severe sexual problems in marriage affect the relationship between spouses and directly or indirectly lead to divorce in modern families. Sexual problems are considered to be a significant reason behind divorces. Since sexual issues and problems, and sexuality in general, are taboos in our social structure, there is an inclination to avoid questioning these issu es. Sexuality always presents as a private issue. Therefore, its effect on divorce is not precisely known. Moreover, there is not any study in the literature focusing on this area from the perspective of men. This study, thus, is essential since it will reveal the effect of sexuality, sexual life and sexual problems on divorce particularly with regard to men. Results of the study will constitute a significant source of light shed on this area.

THE EFFECT OF SEXUAL PROBLEMS IN DIVORCE PROCESS: CASES OF MEN (TURKEY)

MATERIALS AND METHODS

Data and Samples

This research is designed on the basis of the relational screening model. Approximately 300 men in the divorce process were interviewed. In these interviews, most of the participants chose not fill out the interview form since they felt the topic was private, they were shy, or they did not want to share their ideas in this regard. Uncompleted interview forms were excluded, leaving 70 participants with full forms to complete the study. In line with the purpose of the study, participants were required to fill out interview forms. The first section of the form included socio-demographic data (age, educational level, year of marriage, number of children, place of residence, social security, number of past marriages, etc.), the second section included questions on the participants' opinions on sexual life in their marriage, and the third section applied the Golombok Rust Inventory of Sexual Satisfaction (GRISS

Golombok-Rust Inventory of Sexual Satisfaction (GRISS)

The GRISS is a short 28□item questionnaire for assessing the existence and severity of sexual problems. The design, construction, and item analysis of the GRISS are described in this study. It is shown to have high reliability and good validity for both the overall scales and the sub-scales (Rust &, Glombok 1983).

The GRISS male form is a measuring tool for assessing the nature of sexual relations and sexual dysfunctions which is used in this study. Under the 28 items of the GRISS male form, there are 7 sub-scales which are the frequency of sexual intercourse, communication, satisfaction, avoidance and sensuality, premature ejaculation and impotence (erectile dysfunction). While high scores indicate sexual dysfunction and deterioration in the quality of intercourse, raw scores may be later turned into standard scores between 1 and 9 (5 is the breakpoint) and since scores of 5 or above are defined as sexual dysfunction or deterioration of the intercourse, participants receiving 5 and above are referred to as the "problematic group" while others receiving less scores lower than 5 are referred to as the "problem-free group".

Data was obtained in May- August, 2017. Data obtained in the study was analyzed by SPSS 21.00. In addition, descriptive statistical analyses (frequency, percentage distribution, average values, standard deviation) and correlation analyses were conducted in line with the purpose of the study.

RESULTS

Demographic Characteristics

It was determined that 42.9% of the men participating in the study, who are divorced or in the divorce process, completed undergraduate education, while 10% received master's degree and 81.5% live in urban areas. 87.1% of the males live in nuclear families, and 40% of them were not married with children, 28.6% have 1 child, and 22.9% of the males have 2 children. In addition, it is detected that they stayed married for minimum 1 year and maximum 35 years with an average of 8 years.

61.4% of the males married after flirting/companion period, while 17.1% had arranged marriage (without coercion), and 8.6% got married after premarital cohabitation, 4.3% had a consanguineous marriage, 4.3% married without permission from their parents and 4.3% had an arranged marriage due to social pressure or pressure from relatives. 11.4% of the males have consanguineous marriage, while the rest 88.6% did not prefer consanguineous marriage. Indeed, consanguineous marriage is an on-going phenomenon in rural areas. Yet, it is gradually losing its effect in urban areas.

Views on Divorce and Sexuality

It was observed that 77.1% of the males did not attempt to current divorce, while 22.9% did. Accordingly, 58.6% of the males stated they were the one to initiate the divorce, while it is also stated that this rate is close to the rate of their wives. In addition, 54.3% of those who applied to court for divorce were males while the rate of application by their partners was 45.7%. According to the males who decided to divorce themselves, 27.1% of the partners reacted with anger, 11.4% remained unresponsive, 8.6% rejected divorce, and 4.3% reacted by threatening their husbands. In case where the wife was the one to decide to divorce, the reactions of

THE EFFECT OF SEXUAL PROBLEMS IN DIVORCE PROCESS: CASES OF MEN (TURKEY)

the males were also scrutinized. In this regard, 10% of the males sought help from their close relatives and friends, 7.1% left home and remained unresponsive at the same rate, while 5.7% rejected divorce. 58.3% of the males, on the other hand, did not want to answer this question.

The factors affecting the decision to divorce according to men were analyzed, and it was observed that 67.1% said the reason was their partner's indifference and failure in fulfilling their expectations, 40% held that the reason for divorce was jealousy/pressure from the partner, 37% stated sexual problems, 35.7% pointed to the existence of someone outside the nuclear family at home, 32.9% stated financial problems (poverty, unemployment, etc.), 27.1% mentioned interference by parents, 11.4% mentioned alcohol, gambling and other harmful habits, and 7.1% referred to other reasons for their divorce (Table 1).

Table 1: Reasons for Divorce according to Males

Reasons	*n*	*%*
Indifference and failure in fulfilling expectations	*47*	*67.1*
Jealousy/pressure from the partner	*28*	*40.0*
Sexual problems	*26*	*37.1*
Having someone outside the nuclear family at home	*25*	*35.7*
Financial problems, unemployment	*23*	*32.9*
Interference by parents	*19*	*27.1*
Alcohol, gambling and other harmful habits	*8*	*11.4*
Other	*5*	*7.1*

Note: Multiple options are marked.

18.6% of the males stated that sexual problems had a negative effect on their marriage, while 41.1% said these problems had a partially negative effect on their marriage, 11.4 were not sure and 24.3% said that their marriage was not affected at all. 22.9% of the males found their sexual life satisfactory, 34.3% partially satisfactory and 18.6% found that their sexual life in marriage was not satisfactory at all. 11.4% of the males said that they forced their partners to perform sexual intercourse, 51.4% stated their partners rejected sexual intercourse and 81.4%, on the other hand, uttered that they rejected their partners' desire for sexual intercourse.

22.9% of the males stated that problems of sexual compatibility in their marriage completely disrupted their marital adjustment, 44.3% said these problems partially damaged marital adjustment, and 28.6% said problems of sexual compatibility did not have any negative effect in their marital adjustment (Table 2).

Analyzing the responses with regard to the factors that have a negative effect on sexual life in marriage, it was observed that 57.1% of the males marked falling out of love, 30% partner's unattractiveness, 22.9% physical incapacity, 25.7% cheating, 25.7% partner's poor-groomed appearance, 20% sexual incompatibility and ignorance with regard to sexuality, and 4.3% marked violence as one of the factors affecting their sexual life (Table 2).

12.9% of the males regarded sexual problems as a reason for divorce, while 31.4% stated that they deemed sexual problems partially responsible for divorce, 11.4% were not sure, and 41.4% stated they they absolutely do not see sexual problems as a reason for divorce (Table 2).

When analyzing the feelings of men, whose marriage is over or about to end, towards their partners, it is observed that they are disappointed, nervous, shocked, regretful, angry, hateful, and fearful (Table 3).

When evaluating their feelings towards the divorce process or ending the marriage, 50% of the males stated that they are disappointed, 32.9% are happy, 32.9% are nervous, 25.7% are angry, 24.3% are regretful, 21.4% are shocked, 15.7% are hateful, and 5.7% are fearful (Table 3).

THE EFFECT OF SEXUAL PROBLEMS IN DIVORCE PROCESS: CASES OF MEN (TURKEY)

Table 3: Distribution by feelings towards the partner and divorce/ending marriage		
General feelings towards the partner	*n*	*%*
Disappointment	*43*	*61.4*
Nervousness	*25*	*35.7*
Shock	*21*	*30.0*
Regret	*20*	*28.6*
Anger	*19*	*27.1*
Hate	*10*	*14.3*
Happiness	*10*	*14.3*
Fear	*3*	*4.3*
Feelings towards divorce or ending marriage		
Disappointment	*35*	*50.0*
Nervousness	*23*	*32.9*
Happiness	*23*	*32.9*
Anger	*18*	*25.7*
Regret	*17*	*24.3*
Shock	*15*	*21.4*
Hate	*11*	*15.7*
Fear	*4*	*5.7*

91.4% of the males participating in the study stated that they did not receive any sexual education in the premarital period or during marriage. In addition, 65.7% stated that marriage age does not affect sexuality. It was determined that 27.1% of the males believed that divorce is a negative incident, while 22.9% believed it is good, 25.7% were at ease, and 20% felt positive after divorce.

Results of Sexual Satisfaction Levels

When the sub-factors of the GRISS are scrutinized in terms of the males within the scope of this research, it is observed that they do not experience problems with regard to the frequency of sexual intercourse mean value (M= 3.81, SD= 1.31) or communication problems according to communication sub-factor mean value (M= 4.62, SD= 2.12). However, it is determined that they have low level of sexual satisfaction since the sexual satisfaction sub-factor mean value is high (M= 7.82, SD= 1.73). According to the avoidance sub-factor mean value (M= 3.32, SD= 2.60), the rate of avoidance by the males from sexual life is low. Since the sensuality sub-factor mean value (M= 9.91, SD= 2.17) is high, it is observed that level of sensuality is low in their sexual life. Finally, it was determined that the males experienced premature ejaculation problems in their sexual intercourse according to the premature ejaculation sub-factor mean value (M= 6.21, SD= 1.74) as well as experiencing the problem of impotence as a result of high impotence sub-factor mean value (M= 7.77, SD= 2.08).

In the correlation analysis of the GRISS sub-factors, it is determined that there is a negative and significant relation between the sub-factors of avoidance and communication as well as a negative and significant relation between the sub-factors of avoidance and sensuality. On the other hand, there is a positive and significant relation between he sub-factors of premature ejaculation and frequency of sexual intercourse in addition to the positive and significant relation between impotence and frequency of sexual intercourse. Furthermore, positive and significant relation is detected between the sub-factors of impotence and avoidance as well as impotence and sensuality (Table 4).

THE EFFECT OF SEXUAL PROBLEMS IN DIVORCE PROCESS: CASES OF MEN (TURKEY)

Table 4: Correlations Among the GRISS Variables

		GRISS 1	GRISS 2	GRISS 3	GRISS 4	GRISS 5	GRISS 6	GRISS 7	
GRISS 1	*Correlation*	*1*							
	P value								
GRISS 2	*Correlation*	*,209*	*1*						
	P value	*,082*		*1*					
GRISS 3	*Correlation*	*-,008*	*,199*						
	P value	*,949*	*,099*	*-,173*					
GRISS 4	*Correlation*	*-,054*	*-,415***	*,152*	*1*				
	P value	*,657*	*,000*	*,100*					
GRISS 5	*Correlation*	*,228*	*,115*	*,412*	*-,265**	*1*			
	P value	*,058*	*,342*	*-,012*	*,026*				
GRISS 6	*Correlation*	*,246**	*,194*	*,924*	*-,178*	*,226*		*1*	
	P value	*,040*	*,107*	*-,023*	*,140*	*,060*			
GRISS 7	*Correlation*	*,302**	*-,098*	*,850*	*,310***	*,334***		,169	1
		,011	*,419*		*,009*	*,005*		*,162*	

Note: GRISS 1: Frequency of sexual intercourse, GRISS 2: Communication, GRSS 3: Satisfaction, GRISS 4: Avoidance, GRISS 5 Sensuality, GRISS 6: Premature Ejaculation, GRISS 7: Erectile dysfunction

*. Correlation is significant at the 0.05 level (2-tailed), **. Correlation is significant at the 0.01 level (2-tailed).

DISCUSSION AND CONCLUSION

Divorce is a process these stages are respectively: the emotional divorce, legal divorce, economic divorce, family divorce, social divorce, and finally psychological divorce (Bohannan, 1973). The first stage is emotional divorce, followed by legal divorce. Therefore, it is believed that professional support in these first two steps may ease the resolution of problems.

Most of the participants did not receive professional help (family therapist) in the divorce process, and those who did receive professional help preferred to apply to a family therapist. Family therapy services in Turkey are provided by private centers or local governments and public institutions in Turkey. Local governments and particularly the Ministry of Family and Social Services provide this service free of charge. Nevertheless, it is observed that families experiencing problems are not sufficiently benefiting from these services.

The majority of the males (58.6%) in this study stated that they decided to divorce and filed the divorce application. It is not surprising in our country, which is endowed with a patriarchal gender-based cultural structure, that it is the males who first decide to divorce and apply to the judicial authorities. From this perspective, it is observed from the responses given to the question, "What was your reaction when (if) your wife decided to divorce?" that the majority of the males sought help from their friends or close relatives followed respectively by leaving home, remaining unresponsive, and rejecting the divorce. In another study, almost all cases (98.7%) revealed that it was the males who decided to divorce and 51.3% of their spouses reacted by 'resisting divorce' (Morokoff & Gilliland, 1993). According to the men who decided to divorce, their spouses reacted with anger, frustration and crying, leaving home, remaining unresponsive, rejecting the divorce, and threatening their husbands. These men indicated that the reasons for divorce were respectively as follows: indifference by the spouse and failure to meet their expectations, jealousy/pressure, sexual problems, having somebody else at home, financial problems, interference by parents,

THE EFFECT OF SEXUAL PROBLEMS IN DIVORCE PROCESS: CASES OF MEN (TURKEY)

and harmful habits such as alcohol abuse or gambling. According to the males participating in the research, sexual problems were the third leading factor resulting in divorce. Furthermore, among the reasons for divorce stated by men who participated in Kaya's (2016) study was end of enthusiasm, which is understood as reluctance due to repeated use of the same sexual object.

Although the concept of divorce is still seen as taboo in Turkey and divorce proceedings are rather challenging, many couples apply to family courts for divorce. As is purported in a study conducted by Sevim (et al., 2016), as divorce rates are increasing year by year, it is commonly observed that families do not respond to divorce as harshly as before, and some families even support their children in divorce. As a matter of fact, the number of families contributing to the decision to divorce is very high. Furthermore, the new legal regulation allows divorced people to write "single" under the 'marital status' section in their identity cards. In this context, a significant increase has been observed in divorce rates in recent years.

Analyzing the factors affecting sexual life in marriage according to men, it is found that quarrels between spouses are the first reason for negative impact on sexual life, which are followed respectively by falling out of love, unattractiveness of the spouse, his own or his wife's physical incapacity, cheating, poorly groomed spouse, sexual incompatibility, violence, and lack of information about sexuality (Table 2). One of the primary factors having a negative impact on the sexual life of spouses is quarrels and falling out of love. In other words, it may well be argued that continuous quarrels and falling out of love bring along sexual problems and a negative impact on sexual intercourse. Similarly, sexual problems, in turn, might lead to more quarrels between the spouses as well as falling out of love.

From this perspective, nearly half of the men regard sexual problems as the cause of divorce, while two-fifths absolutely reject the idea that sexual problems are a reason for divorce (Table 2). And a low rate of them stated that they are not sure about this issue. In their study, Guatam and Batra (1996) revealed that gender-related factors and sexual dysfunctions are associated with divorce-seeking behaviors. The results of this study, as well, express that men have sexual problems in their marriage, and this is an important factor in divorce. In this respect, the study reveals the importance of family therapy and giving adequate information about the management of sex and sexual dysfunctions.

Table 2: Reasons for sexual problems in marriage according to males

Factors	*n*	*%*
Disputes	*48*	*68,6*
Falling out of love	*40*	*57.1*
Partner is not attractive	*21*	*30.0*
Cheating	*18*	*25.7*
Partner is not well-groomed	*18*	*25.7*
Sexual problems (dysfunction)	*16*	*22.9*
Lack of information on sexuality	*14*	*20.0*
Sexual incompatibility	*14*	*20.0*
Pregnancy/Delivery	*11*	*15.7*
Economic Problems	*11*	*15.7*
Incompatible physical conditions at home	*9*	*12.9*

THE EFFECT OF SEXUAL PROBLEMS IN DIVORCE PROCESS: CASES OF MEN (TURKEY)

Crowded family	*8*	*11.4*
Too much care for children	*7*	*10.0*
Alcohol and substance abuse	*7*	*10.0*
Physical illnesses	*6*	*8,6*
Not being an attractive male	*5*	*7.1*
Taboos on sexuality	*5*	*7.1*
Violence	*3*	*4.3*
I do not know	*2*	*2,9*
Other	*2*	*2.9*
Whether sexual problems are seen as disagreements in marriage	*Whether sexual problems are seen as disagreements in marriage*	*Whether sexual problems are seen as disagreements in marriage*
Yes	*8*	*11,4*
Yes, partially	*31*	*44,3*
I am not sure	*8*	*11.4*
No	*20*	*28.6*
Whether sexuality is seen as a reason for divorce	*Whether sexuality is seen as a reason for divorce*	*Whether sexuality is seen as a reason for divorce*
Yes	*9*	*12.9*
Yes, partially	*22*	*31.4*
I am not sure	*8*	*11.4*
No	*29*	

Note: Multiple options are marked.

Results of this study pertaining to the GRISS sub-factor values of the men indicate that the males participating in the study do not experience problems in frequency of sexual intercourse and communication, yet their sexual satisfaction is deduced to be low due to the high mean value of the sexual satisfaction sub-factor. According to a survey conducted in 12 countries including Turkey, 84% of men and 74% of women believe that the most important element of sexual self-confidence for men is to satisfy their wives in sexual terms. In couples with sexual dysfunction, marital adjustment is poor and sexual satisfaction levels are low (Öztürk & Arkar, 2018).

In the correlation analysis of the GRISS sub-factors, a negative and significant relationship was detected between sexuality avoidance and communication sub-factors. Accordingly, the level of avoidance from sexual intercourse increases as communication between spouses on sexuality diminishes. In other words, couples tend communicate less when there are sexual problems and correspondingly, the level of avoidance of sexual intercourse increases or contrarily, the level of communication (verbal, body language, physical contact, and implicit messages) increases to share sexual desires as avoidance of sexual intercourse increases. This fact proves that men are experiencing problems in their sexual life and the above equations may well be interpreted as indicators of men's sexual problems in marriage.

The high mean value of the sensuality sub-factor reveals that the males who participated in the study had a severe

THE EFFECT OF SEXUAL PROBLEMS IN DIVORCE PROCESS: CASES OF MEN (TURKEY)

problem of physical contact in their sexual life. Furthermore, this sub-factor revealed as the highest mean value among all the other sub-factors in the GRIS. As a matter of fact, sensuality is the most important initiating element in sexual intercourse.

In the correlation analysis between sensuality and avoidance sub-factors, a negative and significant relationship was found. In this respect, as men avoid sexual intercourse, the level of physical contact with their spouses decreases as well. In other words, men tend to avoid sexual intercourse as they experience problems in their sexual life (e.g. impotence, premature ejaculation, or infertility which causes the feeling of being insufficient) and as a result, their level of sensuality and physical contact with spouses decreases. Emotional bond as well as sensuality and physical contact are critical in sexual intercourse and these factors constitute the trigger of this process while increasing satisfaction level.

The frequency of sexual intercourse is the most important indicator of satisfaction level in sexual life for men. In this context, the problem of premature ejaculation may result from cognitive or organic reasons. To the same degree as sexual compatibility and satisfaction, premature ejaculation may lead to perception of men as impotent and thus, physically incapable. Henceforth, premature ejaculation must absolutely be examined and treated with either medical therapy or cognitive intervention. In other words, premature ejaculation may lead to a strong feeling of impotence and shame in men and as the problem of premature ejaculation continues, men feel more embarrassed and start to avoid sexual intercourse in order to mask their impotence, which leads to a decrease in the frequency of sexual intercourse.

The fact that the impotence sub-factor mean value is high indicates that men have impotence problems. According to the impotence sub-factor mean value the males participating in this study experienced impotence problems in their sexual intercourse. As a matter of fact, the problem of impotence can be a very serious concern for men. On the other hand, performance anxiety, extramarital relationships accompanied by feelings of guilt, sexual dysfunctions in the partner, various sexual myths, exaggerated expectations and problems between husband and wife may also lead to impotence (Ekmekçioğlu & Demirtaş, 2006). McCabe (2008) refers to the fact that men who have impotence problems often find that their marriage dynamics start to become dysfunctional over time. In other words, as the problem of impotence deeepens, it is reflected in other dynamics of the marriage as well.

In the correlation analysis between impotence and frequency of sexual intercourse, a positive and significant relationship was determined. Similarly, men who have impotence problems also suffer from problems in terms of frequency of sexual intercourse. As men suffer more and more from impotence, they tend to feel incompetent, useless and ashamed. To avoid shame and stigmatization, they try to avoid sexual intercourse as much as possible, which gradually reduces the frequency of sexual intercourse. In this regard, the need for sexual intercourse in spousal relations can be satisfied only through mutual contribution. As men avoid sexual intercourse, they are chased by their wives and after a certain period of time, conflicts emerge between the spouses, which turn into a reason for divorce if this problem is not solved. As stated before, the frequency of sexual intercourse decreases as men experience premature ejaculation and impotence problems, while the frequency of sexual intercourse increases as this problem decreases.

In the correlation analysis between impotence and avoidance, a positive and significant relationship was identified in addition to the positive and significant relationship between impotence and sensuality. This result reveals that men avoid sexual intercourse when they experience impotence, and also physical contact – or, in other words, sensuality. Rosenheim and Neuman (1981) point out the fact that men with sexual dysfunction experience more interpersonal anxiety, and anger is rather prominent (Rosenheim and Neuman, 1981), which suggests that depressive symptoms increase in individuals with sexual problems (Quinta Gomes et al., 2011). The importance of professional support appears at this stage.

The results of a study in Iran demonstrated the relatively high prevalence of sexual dysfunction among men, and unfortunately, the fact that most of them did not seek help for their sexual problems (Charandabi et al., 2015). Hisli Şahin et al. (2012) conducted a study which resulted in men with sexual dysfunction having significantly higher scores than all the other sub-scales except for the "sensuality" sub-scale and GRISS total score compared to the control group.

In addition to whether spouses respond to each other's sexual needs in marriage, the way they respond to these needs is also critical for sexual life (Youn, 2009). Shakeriana (et al., 2014) found in their study a significant negative correlation between marital problems and sexual satisfaction. In other words, as sexual satisfaction increases, marital problems decrease in parallel, while decreased sexual satisfaction leads to more problems in marriage. Therefore, it is observed that sexual satisfaction is an important function in preventing marital problems.

THE EFFECT OF SEXUAL PROBLEMS IN DIVORCE PROCESS: CASES OF MEN (TURKEY)

In light of this information, a significant relation is found between seeing sexual problems as a source of disagreement and the sub-factors of communication avoidance and impotence. According to this result, it can be uttered that men see sexual problems as a source of disagreement and problems of impotence, avoidance and communication, indeed, are accepted as reasons for quarrels.

In this line, a significant relation is found between seeing sexual compatibility problems as a source of marital problems and the sub-factors of communication, avoidance, and frequency of sexual intercourse. According to this result, it is possible to argue that men see sexual problems as a source of disagreement in marriage and experience problems of frequency of sexual intercourse, avoidance and communication which they deem as reasons for damaging the marital harmony. In addition to avoidance, lack of communication with regard to sexual life, and too frequent or infrequent sexual intercourse may be argued to cause conflicts in marriage as well.

In summary, the results of this study demonstrate that men who are in the divorce process do not experience problems in terms of frequency of sexual intercourse, however this frequency does not have a positive effect on sexual satisfaction. In other words, their sexual intercourse is not satisfactory since physical contact and sensuality is inadequate, and they face the premature ejaculation problem. Due to these reasons, it is revealed that they experience the problem of impotence. Although men present sexual problems as the third reason for divorce, the results of this scale indicate that their sexual life is not satisfactory, they do not physically contact their wives much, and have premature ejaculation and impotence problems. In other words, it may be argued that low sexual satisfaction and other sexual problems in marriage have an impact on divorce when the sampling of the males in the divorce process who participated in this study are taken into consideration. Recommendations provided in line with these results of the study are given below.

There is a clear need for cooperation between experts from different disciplines (psychiatrist, social worker, psychologist, sexual therapist, divorce lawyer) in the solution of sexual dysfunction and incompatibility problems (Maccabee et al., 2017).

It is of vital importance for judges of family courts to refer divorcing couples to a family therapist and ensure that they decide whether to divorce or not after this therapy. This process must be managed systematically and in a sustainable manner. Furthermore, the Ministry of Family, Labor and Social Services can create funding to cover therapy fees of couples referred to family therapy.

It is important in terms of strengthening the family to train couples via individual and group studies with regard to marriage, sexuality, communication, empathy, and parenthood with micro and mezzo interventions.

There is a need for comprehensive sexuality research (particularly with couples who applied to family courts). Sexual education programs should be provided systematically and regularly to couples with marriage plans by focusing on taboos, views and approaches, deficient or misinformation on marriage and sex. Such training activities should be carried out under government control as an obligation and provided free of charge.

It is further recommended to investigate this issue with a larger study group in order to contribute to the literature and create a source for future studies.

Limitations

It was planned to collect data from the males who had applied for divorce to Istanbul Anatolian Courthouse, however the permission given to carry out the study was later cancelled. Before cancellation, 15 male participants were interviewed. Although the Ministry of Justice authorized this study, it was a significant limitation that authorities at Istanbul Anatolian Courthouse did not grant permission.

Another important limitation was perception of sexuality as a private issue and taboo, which prevented access to men who are divorced or in divorce process. In addition, another limitation was that 230 out of 300 males did not accept to take part in the research.

THE EFFECT OF SEXUAL PROBLEMS IN DIVORCE PROCESS: CASES OF MEN (TURKEY)

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We would like to express our endless gratitude to all academicians who have contributed to this issue as referees.

We would like to thanks for work to **Burcu Ertek**

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