Revista Iberoamericana de Psicología y Salud (2023), 14(1), 10-17

Revista Iberoamericana de Psicología y Salud

Latin-American Journal of Psychology and Health

https://www.rips.cop.es/ • ISSN: 2171-2069

Revista Oficial de la Federación Iberoamericana de Asociaciones de Psicología (FIAP) - Official Journal of the Latin-American Federation of Psychological Associations

Article

Future health-professionals: Attitudes, perceived severity, and willingness to intervene in intimate partner violence cases

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ARTICLE INFO

Received: 03/05/2022
Accepted: 14/10/2022

Keywords:
Violence against women
Barriers to response
Sexism
Acceptance
Health professionals' role

ABSTRACT

Background/objective: Intimate partner violence (IPV) is a public health problem for which many victims attend to healthcare centers to alleviate the results of violence. The present study aimed to explore the relation between IPV attitudes and willingness to intervene in cases of IPV by future health professionals, considering the influence of perceived severity of IPV in this relation. **Method:** The sample was composed of 432 students (M = 22.89, SD = 6.36) of psychology (52.60%), nursing (26.20%), and medicine (21.20%). Sexism, IPV acceptance, perceived severity, and willingness to intervene in IPV cases were assessed. **Results:** The results displayed low sexism (M = 0.61, SD = 0.59) and acceptance of IPV (M = 1.05, SD = 0.06), high perceived severity (M = 9.62, SD = 0.60), and moderate willingness to intervene in cases of IPV (M = 5.20, SD = 1.16). Moreover, a conceptual model showed that more sexist attitudes were related to more acceptance of IPV, decreased perceived severity of IPV, and consequently, the willingness to intervene in cases of IPV. **Conclusions:** These findings highlight the importance of addressing the attitudinal and perceptive barriers of future healthcare professionals to detect and attend early to IPV from healthcare centers.

Futuros profesionales sanitarios: Actitudes, gravedad percibida y voluntad de intervención en casos de violencia de género

Palabras clave:
Violencia hacia las mujeres
Barreras de respuesta
Sexismo
Aceptación
Rol de los profesionales sanitarios

RESUMEN

Antecedentes/objetivos: La violencia de género (VG) es un problema de salud pública por el que muchas víctimas acuden a los centros de salud para aliviar las consecuencias de la violencia. El presente estudio tuvo como objetivo explorar la relación entre las actitudes hacia la VG y la voluntad de intervención en casos de VG por parte de futuros profesionales sanitarios, considerando la influencia de la gravedad percibida de la VG en esta relación. **Método:** La muestra estuvo compuesta por 432 estudiantes (M = 22,89, DT = 6,36) de psicología (52,60%), enfermería (26,20%) y medicina (21,20%). Se evaluaron el sexismo, la aceptación de la VG, la gravedad percibida y la voluntad de intervención en casos de VG. **Resultados:** Los resultados mostraron bajo sexismo (M = 0,61, DT = 0,59) y aceptación de la VG (M = 1,05, DT = 0,06), así como alta percepción de gravedad (M = 9,62, DT = 0,60) y moderada voluntad de intervención en casos de VG (M = 5,20, DT = 1,16). Además, el modelo conceptual testado mostró que a más actitudes sexistas, mayor aceptación de la VG, menor percepción de la gravedad de la VG y, en consecuencia, menor voluntad de intervención en casos de VG. **Conclusiones:** Estos hallazgos destacan la importancia de abordar las barreras actitudinales y perceptivas de los futuros profesionales sanitarios para detectar y atender la VG precozmente desde los centros sanitarios.

Cite as: Badenes-Sastre, M., Lorente, M., & Expósito, F. (2023). Future health-professionals: Attitudes, perceived severity, and willingness to intervene in intimate partner violence cases. *Revista Iberoamericana de Psicología y Salud, 14*(1), 10-17. https://doi.org/10.23923/j.rips.2023.01.061

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Introduction

Intimate partner violence (IPV) is a major public health problem that involves behaviors by partner or former partners that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors (World Health Organization [WHO], 2022). Specifically, one in three women in the world suffered IPV, which causes physical and mental health deterioration, including fractures and other injuries, gastrointestinal issues, chronic pain, depression, or anxiety (Campbell, 2002; Wang, 2016, WHO, 2022). Consequently, victims of IPV frequently visit healthcare centers such as primary care, mental health, or emergency services with a covert reason for consultation, and health professionals' roles are essential in detecting IPV (Campbell, 2002; Coll-Vinent et al., 2008; Ruiz-Pérez et al., 2004; WHO, 2022). However, health professionals may encounter barriers to identifying and responding to IPV, such as time constraints, lack of information, attitudes toward IPV (e.g., not considering IPV a health problem), or failing to identify IPV as the origin of the patient's signs and symptoms (Blanco et al., 2004; Coll-Vinent et al., 2008; Goicolea et al., 2019). In this regard, it is necessary to examine the variables involved in health professionals' responses to IPV to direct intervention and prevention efforts.

Theoretical framework

Feminist theory is focused on exploring gender relations based on the social construction of gender, describing IPV as a consequence of gender inequality on the societal level (Bograd, 1988; West & Zimmerman, 1987). In this theoretical context, gender-related norms and attitudes such as acceptance and justification of violence are the main causes of IPV and impact public and professional responses to it (Ferrer et al., 2020; Flood & Pease, 2009). Likewise, attitudes toward IPV could influence its perceived severity as well as help-seeking and reporting behaviors (Herrera et al., 2014; Kuijpers et al., 2021). To mitigate the issue, it is necessary to explore the relation between attitudes and perceptions of IPV as well as their effect on responses to IPV.

Attitudes, perceived severity, and willingness to intervene in cases of IPV

Attitudes toward IPV reveal social norms regarding the acceptance or non-acceptance of IPV and influence professionals who attend victims of violence such as health professionals (Gracia et al., 2020). Specifically, sexism is an ideology that involves attitudes and stereotypes of a gender, considering specific roles appropriate or not depending on gender (Expósito et al., 1998). According to the theory of ambivalent sexism (Glick & Fiske, 1996), sexism is multidimensional and encompasses ambivalence between genders; it can be divided into hostile sexism and benevolent sexism. Sexism has been positively related to attitudes of acceptance of IPV, and both types, have been negatively linked to the perceived severity of IPV (Martín-Fernández et al., 2018; Sánchez-Hernández et al., 2020; Yamawaki et al., 2009), which reflects the significance or magnitude assigned to IPV threats (Riddle & Di, 2020; Witte, 1994). In this regard, attitudes toward IPV may mean that some perceive IPV as normal, determining the social response to this problem (Waltermaurer, 2012).

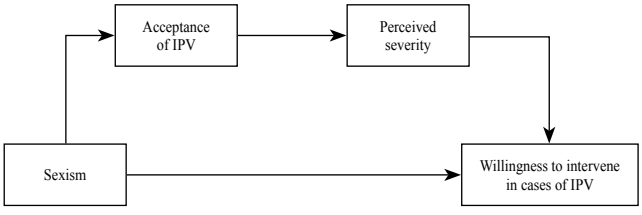
In general, tolerant attitudes toward IPV as well as victim blaming continue to be present in Spanish society (Centro de Investigaciones Sociológicas, 2012; 2013; Rodríguez et al., 2021), also reflected in healthcare professionals. In particular, health professionals' willingness to intervene in cases of IPV decreases when they display more sexist attitudes (Noriega et al., 2020). Also, Torrecilla (2016) founded that more than 28% of health professionals justified physical violence, blaming women and minimizing IPV, more than 17% did not strongly refuse psychological violence, and more than 5% did not totally reject sexual violence. Likewise, highly sexist attitudes and tolerance of IPV were found among students intending to work as health professionals caring for potential IPV victims (Diéguez et al., 2020; García-Díaz et al., 2020). This highlights the urgency of considering multiple factors, such as perceptions and attitudes toward IPV, to minimize this problem (Ming et al., 2020).

In general, some researchers have explored health professionals' knowledge, opinions, attitudes, and perceptions of IPV (Badenes-Sastre & Expósito, 2021; Cann et al., 2001; Follingstad & DeHart, 2000; Follingstad et al., 2004; Goicolea et al., 2019; Noriega et al., 2020) pointed out the influence of health professional's perceptions and attitudes in their response to IPV (Leung et al., 2018). Because IPV is a public health problem, and many victims attend to healthcare centers to alleviate the results of violence (WHO, 2022), it is necessary analyze the influence of these variables in future health professionals. However, no studies have explored the influence of attitudes and perceptions of severity of IPV on future health professionals' willingness to intervene in cases of IPV. Hence, addressing this gap will be essential for understanding the influence of these variables in future health professionals' responses to IPV, as they will have to detect IPV and care for potential victims when they complete their training and work in healthcare centers.

The present research

Based on the aforementioned considerations the purpose of the present study was to explore the relation between IPV attitudes and willingness to intervene in cases of IPV by future health professionals such as physicians, nurses, and psychologists, considering the influence of perceived severity of IPV in this relation. A conceptual model (Figure 1) analyzing the mediating effect of IPV acceptance and perceived severity in the relationship between health professionals' sexism and willingness to intervene in cases of IPV was tested. Initially, scores and correlations among future health professionals' sexist attitudes, acceptance of IPV, perceived severity, and willingness to intervene in cases of IPV were explored.

Figure 1.
Conceptual Model Showing the Proposed Relationship Between Sexism and Willingness to Intervene in cases of IPV Mediated by Acceptance of IPV and Perceived Severity.



Specifically, we estimated that the willingness to intervene in cases of IPV would correlate negatively with sexism (Hypothesis 1a) and acceptance of IPV (Hypothesis 1b) and positively with perceived severity (Hypothesis 1c). Then, we expected that more sexist attitudes would be related to more acceptance of IPV, decreasing the perception of severity of IPV and, consequently, the willingness to intervene in cases of IPV (Hypothesis 2).

Method

Participants

The sample was composed of 432 participants (88% women); 52.6% were psychology students, 26.2% were in nursing, and 21.2% in medicine. The age of the participants ranged from 18 to 65 years (M = 22.89, SD = 6.36). Of the total sample, 75.7% had received training in IPV and 24.3% had not. Specifically, 53.7% of them had specific training in attending victims of IPV from a healthcare center. Concerning previous IPV experiences, 78.0% of the participants reported experiencing or knowing about IPV cases.

Instruments

Ambivalent Sexism Inventory (ASI; Glick & Fiske, 1996). The Spanish version of the ASI was applied (Expósito et al., 1998). It assesses ambivalent sexism and was composed of 22 items rated in a 6-point response format ranging from 0 (*totally disagree*) to 5 (*totally agree*). Of the 22 items, 11 were related to hostile sexism (e.g., "Women are very easily offended"), and 11 were related to benevolent sexism (e.g., "The man is incomplete without the woman"). Higher scores revealed more sexist attitudes. In the present study, the alpha coefficient of ambivalent sexism was .89.

Acceptability of IPV against Women (A-IPVAW; Martín-Fernández et al., 2018). The A-IPVAW measured the acceptability of a set of men's behaviors towards their female partners. This scale includes 20 items (e. g., "I think it is acceptable for a man to control where their partner goes"), with a response format range from 1 (*not acceptable*) to 4 (*very acceptable*). High scores on the scale indicated more acceptability of IPV. In this study, the Cronbach's alpha for the scale was .53.

Perceived Severity of IPV (PS-IPV; Gracia et al., 2009). The scale presents eight hypothetical scenarios (e.g., "A couple is fighting; he insults her and threatens to hit her") to assess the perceived severity of IPV incidents. The participants had to rate the scenarios on a 10-point response scale (ranging from 1, *not severe at all*, to 10, *extremely severe*). In this study, the scale showed good internal consistency (α = .83).

Willingness to Intervene in Cases of Intimate Partner Violence against Women (WI-IPVAW short version; Gracia et al., 2018). A shorter version of the initial WI-IPVAW scale (five items) was created, including five items that assess *calling the police* (e.g., "If I found out that a woman neighbor of mine had been beaten by her husband, I would advise her to report it"), *personal involvement* (e.g., "In a bar, if a man started screaming at his partner, I would stand between them to help the woman"), and *not my business* (e.g., "If an immigrant couple or a couple from another culture were fighting on the street, I would ignore it and keep walking"). The participants responded in a 7-point response format from 1 (*not likely*) to 7 (*extremely likely*) to rate the probability that they would intervene in the situation presented. The Cronbach's alpha for this study was .79.

Socio-demographic information. Data regarding participants' sex, age, degree, IPV training, specific training to attend IPV from healthcare centers, and previous experiences with IPV victims were measured at the end of the questionnaire.

Design and Procedure

A no-experimental associative study was performed.

Through intentional sampling, the participants were included in the study if they were studying for a degree in psychology, nursing, or medicine in Spain. First, an online survey was developed using the LimeSurvey research platform. Next, the survey was disseminated on social networks (Instagram, Facebook, WhatsApp, and institutional mail). All of the participants were informed about study's purpose and volunteered to participate, providing their informed consent in accordance with the Helsinki Declaration, and the anonymity and confidentiality of their responses was guaranteed. No monetary incentives were provided for participation. The study was developed with the approval of the ethics committee of the University of Granada.

Data analysis

The data were analyzed using the SPSS Program, version 23. First, descriptive statistics (mean and standard deviation) were conducted to explore the participants' scores on sexism, acceptance of IPV, perceived severity, and willingness to intervene in cases of IPV. Then, a Pearson correlation analysis was carried out to analyze how the willingness to intervene in cases of IPV is related to the attitudes and perceptions assessed. Last, a multiple serial mediation analysis was performed using model 6 of the PROCESS program described by Hayes (2013). This analysis was intended to explore an explanatory model in which the acceptance of IPV and the perceived severity of IPV mediated the relationship between sexism and willingness to intervene in cases of IPV. The analyses were controlled for age, sex, degree, IPV training, specific training to attend IPV victims from healthcare centers, and previous IPV experience.

Results

Sexism, Acceptance of IPV, Perceived Severity, and Willingness to Intervene in Cases of IPV

Table 1 shows descriptive statistics regarding the main variables used in this study according to degree and the correlations between variables. The results obtained in the descriptive analysis show that future health professionals present low sexist attitudes (M = 0.61, SD = 0.59) and acceptance of IPV (M = 1.05, SD = 0.06), as well as high perception of severity of IPV (M = 9.62, SD = 0.60). However, participants' willingness to intervene in cases of IPV was moderate (M = 5.20, SD = 1.16). The Pearson correlation analysis revealed significant correlations between willingness to intervene in cases of IPV and the rest of variables analyzed: sexism (r = -.170, p < .001), acceptance of IPV (r = -.276, p < .001), and perceived severity (r = .249, p < .001). These results confirm Hypotheses 1a, 1b, and 1c.

Table 1.
Correlation Analysis among Willingness to Intervene in Cases of IPV, Attitudes and Perceptions and Means According to degree.

					Psychology (*n* = 228)	Nursing (*n* = 113)	Medicine (*n* = 91)
	1	**2**	**3**	**4**	***M(SD)***	***M(SD)***	***M(SD)***
1. Willingness to Intervene in cases of IPV	-				5.16(1.13)	5.47(1.10)	4.95(1.21)
2. Sexism	-.170***	-			0.58(0.57)	0.59(0.59)	0.69(0.62)
3. Acceptance of IPV	-.276***	.248***	-		1.05(0.07)	1.04(0.06)	1.04(0.06)
4. Perceived severity	.249***	-.223***	-.302***	-	9.60(0.64)	9.71(0.47)	9.60(0.65)

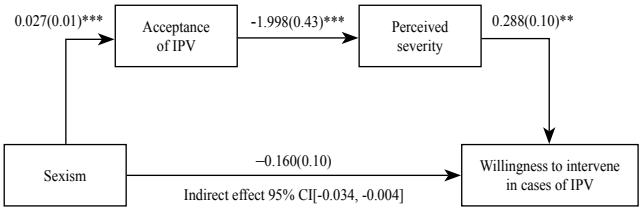
Note. IPV = intimate partner violence; *p < .05; **p < .01; ***p < .001.

Mediating Effect of Acceptance of IPV and Perceived Severity on the Relationship between Sexism and Willingness to Intervene in Cases of IPV

To test Hypothesis 2 ("More sexist attitudes would be related to more acceptance of IPV, decreasing the perception of severity of IPV and consequently, the willingness to intervene in cases of IPV"), model 6 of a multiple serial mediation of the PROCESS macro (Hayes, 2013) was applied.

As shown in Figure 2 and Table 2, higher scores in acceptance of IPV and lower scores in perceived severity predicted less willingness to intervene in cases of IPV in people with more

Figure 2.
Conceptual Model Showing the Relationship Between Sexism and Willingness to Intervene in cases of IPV Mediated by Acceptance of IPV and Perceived Severity.



Note. Unstandardized beta coefficients reported, with standard errors within parentheses; *p < .05; **p <.01; ***p < .001.

Table 2.
Mediating Effect of Acceptance of IPV and Perceived Severity on the Relationship Between Sexism and Willingness to Intervene in Cases of IPV.

	Acceptance of IPV		Perceived Severity		Willingness to Intervene in Cases of IPV	
Background	***Coeff.***	**Symmetric BCI**	***Coeff.***	**Symmetric BCI**	***Coeff.***	**Symmetric BCI**
Constant	1.064***	[1.001, 1.118]	10.924***	[9.895, 11.952]	6.493***	[3.625, 9.362]
Sexism	0.027***	[0.017, 0.038]	–0.137*	[-0.231, –0.042]	-0.160	[–0.247, 0.027]
Acceptance of IPV			–1.998***	[–2.852, -1.145]	–3.370***	[–5.081, –1.659]
Perceived Severity					0.288**	[0.101, 0.476]
Age	–0.002***	[–0.003, –0.001]	0.011**	[0.003, 0.020]	0.006	[–0.011, 0.023]
Sex	–0.020*	[–0.039, –0.001]	0.343***	[0.173, 0.512]	–0.099	[–0.437, 0.067]
Degree 1	–0.018*	[–0.034, –0.003]	–0.012	[–0.150, 0.127]	–0.203	[–0.473, 0.067]
Degree 2	–0.003	[–0.018, 0.012]	0.096	[–0.041, 0.232]	0.256	[–0.377, 0.210]
IPV training	0.012	[–0.005, 0.028]	0.117	[–0.032, 0.266]	–0.082	[–0.243, 0.281]
Specific training to attend IPV from healthcare centers	0.012	[–0.003, 0.026]	–0.021	[–0.155, 0.113]	0.019	[–0.243, 0.281]
Having previous IPV experiences	0.016*	[0.001, 0.030]	–0.126	[–0.256, 0.001]	–0.274	[–0.527, 0.021]
	R^2 = .137		R^2 = .177		R^2 = .143	
	$F(8, 423) = 8.45$, p < .001		$F(9, 422) = 10.09$, p < .001		$F(10, 421) = 7.06$, p < .001	

Indirect Effects	**Effects**	**Symmetric BCI**
Total	–0.147	[–0.239, –0.074]
I1	–0.092	[–0.165, – 0.037]
I2	–0.039	[–0.087, –0.006]
I3	–0.016	[–0.034, –0.004]

Note. IPV = intimate partner violence against women; Degree 1 = condition 1 medicine; condition 0 = nursing and psychology; Degree 2 = condition 1 nursing; condition 0 = medicine and psychology; I1 = Sexism → Acceptance of IPV → Willingness to Intervene in Cases of IPV; I2 = Sexism → Perceived Severity → Willingness to Intervene in Cases of IPV; I3 = Sexism → Acceptance of IPV → Perceived Severity → Willingness to Intervene in Cases of IPV; Symmetric BCI: Symmetric Bootstrapping Confidence Interval. The indirect effects are significant where the Bootstrap Confidence Interval does not include the value 0. *p < .05, **p < .01, ***p < .001.

sexist attitudes (indirect effect = -0.016, *SE* = 0.01, 95% CI[-0.034, -0.004]), confirming Hypothesis 2. Finally, the variance explained by acceptance of IPV and perceived severity variables included in the model predicted a total of 14.36% of the willingness to intervene in cases of IPV according to sexism attitudes.

Discussion

Addressing IPV in healthcare centers is critical to detect this problem and support victims. Knowing about future health professionals' attitudes and perceptions about IPV is the first step in understanding how they respond to it. In this regard, changing the perspective of IPV from a private issue to a social problem has involved better knowledge of the problem and legislative changes to address IPV (Bosch & Ferrer, 2000). Likewise, IPV is recognized as a major public health problem (WHO, 2022), however, it is not always addressed as such. In particular, sexist ideology can influence attitudes and perceptions toward IPV and determine responses to this issue, which may cause health professionals to underestimate the severity of IPV in consultation, interfering in their willingness to intervene.

This study is one of the first to test a conceptual model assessing the mediating effect of IPV acceptance and perceived severity on the relationship between sexism and willingness to intervene in cases of IPV by future health professionals. The results confirmed Hypothesis 2: "More sexist attitudes would be related to more acceptance of IPV, decreasing the perception of severity of IPV and, consequently, the willingness to intervene in cases of IPV." These novel findings are key to identifying the obstacles presented to attend to IPV victims in healthcare centers as well as directing efforts to raise future health professionals' awareness about IPV. Moreover, although it was not the main objective of the study, IPV training and specific training to attend IPV victims from healthcare centers were controlled to test the conceptual model, with no significant results. In this regard, the despite the fact that a lack of training in IPV is recognized as an obstacle (Coll-Vinent et al., 2008; Shearer et al., 2006), our outcomes may suggest that IPV training is not sufficient to generate willingness to intervene in IPV cases for future health professionals, requiring a focus on attitudinal and perceptual variables. Considering this will be essential so, despite victims frequently going to healthcare centers due to the health problems caused by IPV, the responses from health professionals (e.g., injury reports) reflect only 9.6% of the total number of complaints, showing a possible lack of involvement in helping victims to get out of violent relationships (Consejo General del Poder Judicial, 2019; Lorente-Acosta, 2020).

Other important findings were scores obtained by future health professionals on sexist attitudes, acceptance, perceived severity and willingness to intervene in IPV cases. In general, low levels of sexism and acceptance of IPV were found in our sample, which was composed mainly of women. These outcomes are contrary to that of García-Díaz et al. (2020), who found high tolerance of IPV and sexist attitudes among psychology, nursing, and medicine students. However, although Rodríguez and Ballesteros (2019) also encountered medium or high percentages of acceptance of IPV behaviors among young people as well as low gender equality attitudes, it was more pronounced in men than women. As a result of these differences, considering variables such as gender or universities' commitment will be important to consider in transmitting favorable attitudes toward the IPV approach from healthcare centers.

Otherwise, although previous studies assessed the perceived severity of IPV in the general population, aggressors, victims, or police (e.g., Gilbert & Gordon, 2017; Gracia et al., 2008; Guerrero-Molina et al., 2020; Herzog, 2004), to date, no previous studies have explored it in a sample of future health professionals. In this study, participants showed a high perception of severity of IPV, making an important contribution to the current literature; being aware of the magnitude and severity of IPV is necessary in order to confront it (Badenes-Sastre & Expósito, 2021). Last, our sample had medium scores in willingness to intervene in cases of IPV. This outcome is striking—although IPV is recognized as a public health and social responsibility issue (WHO, 2022), the willingness to intervene helping women victims of IPV might not be enough. In this regard, in addition to adopting a favorable attitude in the fight against IPV, health professionals must take action and help the victims because, according to Parker et al. (2020), when victims of IPV perceive social support, the likelihood of victimization decreases.

In accordance with previous literature (Diéguez et al., 2020; García-Díaz et al., 2020; Martín-Fernández et al., 2018; Noriega et al., 2020; Waltermaurer, 2012; Yamawaki et al., 2009), strong correlations among target variables (attitudes, perceived severity, and willingness to intervene in cases of IPV) were found. Particularly, willingness to intervene in cases of IPV was negatively associated with sexism (Hypothesis 1a) and acceptance of IPV (Hypothesis 1b), while perceived severity was positively related to it (Hypothesis 1c), confirming the initial hypothesis. Findings from the present study gave empirical support to the idea that future health professionals' attitudes and perceptions about IPV influence their willingness to intervene in cases of IPV. It is necessary to work on these aspects during training for psychologists, nurses, and medical physicians, emphasizing the consequences of IPV for women's health.

In sum, given the extent and potential dangerousness of IPV, systematic screening and assessment from healthcare centers should be considered. Specifically, health professionals should be aware that many medical consultations for health problems by women are associated with the presence of IPV (Riggs et al., 2000), and it is essential to adopt an attitude of alertness for the early detection of IPV.

Limitations and Future Directions

The findings obtained in the conceptual model allow sequential testing of sexism as related to willingness to intervene in cases of IPV through acceptance of IPV and perceived severity. Notwithstanding, these data must be interpreted with caution. First, significant effects in age, sex, degree, and previous experiences of IPV were founded in some relationships between variables. Given the imbalance of participants in these categories, it was not possible to analyze the differences among them in attitudes, perceptions and willingness to intervene in cases of IPV. In this line, accumulated empirical evidence suggests that men show sexism and acceptance of IPV, as well as

perceiving less severity of IPV than women (Diéguez et al., 2020; Lelaurain, et al., 2018). Further, García-Díaz et al. (2020) studied a sample of health science students, finding higher levels of sexism and tolerance of IPV in psychology students than medicine or nursing students as well as less sexism and IPV tolerance in students in their last courses than those in their first courses. Testing the present conceptual model differentiating according to sex, degree and course would be interesting for future research.

Additionally, due to the low Cronbach's alpha obtained for the acceptability of IPV scale, results should not be generalized, requiring further research. Finally, this study assessed the social response in terms of intervening in cases of IPV by future health professionals, but not specifically the response in their workplace, as they were still students. Other studies should explore their responses and/or willingness to intervene in these cases in consultation settings. In spite of these limitations, the study certainly adds to our understanding of the obstacles to intervening in cases of IPV. It would be interesting for future studies to test this conceptual model with health professionals, taking into account their actions in consultation beyond their willingness to intervene.

Implications for Practice and Policy

The aforementioned findings elucidate important practical and policy implications. First, the conceptual model suggests the need to direct efforts to reduce favorable attitudes toward IPV that make it difficult to perceive the severity of this problem, consequently decreasing willingness to respond to IPV. Preventing IPV through transversal education in gender equality will help generate a social change that does not accept or normalize IPV. Additionally, working IPV attitudes and perceptions in future health professionals during their university training, including gender perspectives, will encourage them to take an active role in the detection of IPV when they are working in healthcare centers. Lastly, health professionals must understand IPV (WHO, 2013). In this regard, health professionals can benefit from the implementation of specific programs to attend IPV victims in consultation to understand the nature of the issue—a public health problem that does not consider political ideologies.

In terms of policy implications, IPV prevention campaigns should continue to be implemented to promote social awareness and the perception of severity of IPV. Likewise, the effectiveness of these campaigns should be evaluated regularly. As this study has shown, perceived severity of IPV and willingness to intervene in cases of IPV, may vary depending on attitudes towards this problem. These data are alarming; the response to IPV, unlike other health problems, will depend on the cultural context including beliefs, attitudes, and laws (Spencer et al., 2020). IPV will need to be depoliticized, and institutions should make efforts to address IPV as a public health problem, adopting general governmental commitments that do not depend on the ideologies of the political group in power.

Finally, health professionals are in a unique position to ask women about IPV during routine or annual consultations and, although there is a general awareness of the importance of IPV screening from healthcare centers, wide variation also exists depending on the site and the way IPV detection is applied (Shearer et al., 2006; Williams et al., 2016). Similarly, based on the results obtained in this study, it can be concluded that attitudinal and perceptual obstacles in future health professionals' responses to IPV require prevention programming and intervention work.

Conclusions

Healthcare centers' responses to IPV are essential, requiring a commitment among health professionals caring for victims. This study concluded that greater sexist attitudes in future health professionals are related to lower willingness to intervene in cases of IPV, and this relationship is mediated by higher attitudes of acceptance of IPV and lower perceived severity. Although the future health professionals showed low levels of sexist attitudes and acceptance of IPV as well as high perceived severity of IPV, their willingness to intervene in IPV cases was not high. In this regard, promoting a cultural and attitudinal change among health science students from early stages at universities will be a crucial element in taking action against IPV.

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Funding: This report was conducted with the support of a research contract awarded to Marta Badenes Sastre by the Spanish Ministry of Science, Innovation, and Universities (reference: FPU17/01279).

Institutional Review Board Statement: The study was developed with the approval of the ethics committee of the University of Granada (Ref.: 1522/CEIH/2020).

Informed Consent Statement: Participants provided informed consent.

Data Availability Statement: The data presented in this study are available on request from the corresponding author.

Conflicts of Interest: The authors declare that there is no conflict of interest.