Intimate partner violence and sexual dysfunction in women admitted to psychiatry outpatient clinic

Does culture affect outcomes?

Burcu Kok Kendirlioglu[1], Gozde Gundogdu Meydaneri[2]
[1]Assist. Prof., Department of Psychiatry, Maltepe University Faculty of Medicine, Istanbul, Turkey https://orcid.org/0000-0003-0632-1617
[2]Assist. Prof., Topkapı University Faculty of Economics, Administrative and Social Sciences Department of Psychology, Istanbul, Turkey https://orcid.org/0000-0001-5943-950X

SUMMARY

Objective: Intimate partner violence (IPV) not only affects women's physical and mental health, but also affects their sexual health and causes various sexual dysfunctions. It was aimed to reveal the relationship between possible IPV and mental and sexual health in Turkish and Arabic women.

Method: The study was designed as cross-sectional and observational. The study included 105 (50 Arabic and 55 Turkish) women between the ages of 18-50 years old. Domestic Violence Against Women Scale, Golombok- Rust Inventory of Sexual Satisfaction Scale, Beck Depression and Anxiety Inventory were applied.

Results: All women participating in the study were exposed to at least one of the subtypes of violence. A significant positive correlation was observed between Golombok-Rust total score and physical ($p=0.003$), emotional ($p=0.006$), verbal ($p=0.027$), sexual violence ($p<0.001$), and the total violence score ($p=0.001$). A significant positive correlation was observed between the total violence score and the infrequency ($p=0.004$), non-communication ($p=0.024$), avoidance ($p=0.003$), non-sensuality ($p<0.001$) scores. The scores of sexual communication, satisfaction, and anorgasmia were significantly higher and the score of sexual avoidance, non-sensuality and vaginismus was significantly lower in the Arabic women than in the Turkish women.

Discussion: IPV and cultural differences are related to sexual functions. The possibility of IPV exposure should be considered and questioned in women applying to psychiatric outpatient clinics, taking into account the effects of different cultures.

Key Words: Culture, domestic violence, intimate partner violence, sexual dysfunctions, women's mental health

INTRODUCTION

A major global health issue is violence against women. Violence against women is one of the most important global health problems. Worldwide, 35% of women have been subjected to physical or sexual violence at the hands of an intimate partner (1). Intimate partner violence (IPV) has an impact on the sexual, reproductive, emotional and physical health of women. Compared to non-victims of violence, victims endure more health issues, spend much higher health care costs, visit doctors and hospitals more frequently, and stay in hospitals for longer periods of time (1).

In Turkey, 38% of women have been exposed to physical and/or sexual violence at some point in their lives (2). Almost half of married women reported that their husbands or partners had been emotionally abusive to them in the form of intimidation, threats, verbal abuse, insults and humiliation (2). In Turkey, 70.1% of the women who applied to the psychiatry outpatient clinic stated that they had experienced verbal violence in their

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marriage and 49.0% of the women reported that they had experienced physical violence. The most common complaints were depressive symptoms. The level of women's psychiatric symptoms who were exposed to physical and verbal violence was found to be significantly higher than those of the women who were not exposed to violence (3).

IPV not only affects women's physical and mental health, but also affects their sexual health and causes various sexual dysfunctions. Multiaxial problem-oriented systems, including partner's physical abuse and severe marital stress, have also been proposed in the past to classify sexual dysfunction (4). The deterioration of the romantic relationship due to violence, and as a result, the addition of depressive and anxious symptoms at various intensities is among the causes of women's sexual dysfunction. Studies have shown that there is a relationship between violence and the sexual functions of women (5). Women who have been exposed to domestic violence are 6.95 times more likely to experience sexual dysfunction than those who have not been exposed to domestic violence (6). According to the results of the other study, there is a statistically significant difference between non-abused and abused women in terms of various categories of sexual function. These categories include desire, arousal, lubrication, orgasm, sexual satisfaction and pain experienced during sexual activity (7). According to a study from Iran, women who had been sexually assaulted felt less sexually aroused than the non-assaulted group. There was a statistically significant difference between the groups exposed to violence and those not exposed to violence in terms of sexual orgasm (8). Women who suffered from sexual violence, often had painful intercourse (9).

Intimate partner violence affects especially women from different ethnic groups and immigrants. Studies have shown that IPV leads to more suicide attempts and causes more depression, posttraumatic stress disorder (PTSD), and sexual dysfunction in African - American, Latino, American Indian / Alaska Native, and South Asian immigrant women (10). African-American women experience 35% more spousal violence than white women, this inequality is greatly reduced when economic and neighborhood factors are controlled (11). The geographical location is one of the many factors that affects the IPV experience for victims. It has been reported that the rate of exposure to IPV among women in small rural towns is higher than that of women living in metropolitan areas (12).

Studies of the prevalence of sexual dysfunction and IPV have been conducted in many different countries and cultures, but there are also some differences based on cultural and social circumstances (13). Despite having comparable characteristics in countries that are geographically adjacent to one another, sexual difficulties vary depending on various social, cultural, religious, and political aspects. Today, there is a migration from the east to the west so it is crucial to introduce customs and behaviors of various civilizations to the new area. When people start to live in a new society, the cultural diffe-rences in that society can play a significant role in the development of health issues as a result of difficulty adjusting. Contrary to men, women are more impacted by social and cultural pressure. Both women's mental health and sexual health may be impacted by this factor.

Sexuality and intimate partner violence are two intimate topics for women. In Turkey, especially in the peripheral regions, the violence and sexual dysfunction that women are exposed to is ignored. Our aim is to help make these problems visible. Asking about these issues in the outpatient clinic can be difficult for healthcare professionals in different cultures. In this study, we tried to determine the frequency of possible intimate partner violence in women primarily admitted to the psychiatric outpatient clinic and to evaluate its relationship with culture. Secondly, the possible relationship between this exposure and the effect of culture on sexual function was investigated. We hypothesized that IPV causes different sexual function problems in Turkish and Arab women.

METHODS

This is a cross-sectional, observational study. The research was carried out in Istanbul Sancaktepe Training and Research Hospital and Sanliurfa Akcakale State Hospital. A hundred and five women between the ages of 18-50 years old, 50

from Sanliurfa and 55 from Istanbul, participated in the study.

While Istanbul is Turkey's most inhabited metropolitan area, Akcakale is a small city located on the Syrian border in Sanliurfa (Urfa) and it is inhabited by Turkish citizens of Arab ethnicity. This is the region with the highest fertility rate in Turkey, and it is a small city where the influence of Arabic culture is observed in every area, including family life and women's traditional clothing. Although polygamy is illegal in Turkey, this situation is seen in Akcakale. According to the data of the Turkish Statistical Institute (TUIK), the literacy rate reached 97.42% in 2020. Sanliurfa was the second province with the lowest literacy rate with 93.42%. In the report, which evaluates the socioeconomic development of the districts in Turkey, it is seen that Istanbul-Sancaktepe ranks 95th among the districts, with an index score of 1.275, and is in the second level. On the other hand, Sanliurfa - Akcakale is considered to be in the 964th rank among the districts, with an index score of -1.258 and in the sixth level. Although all of this puts the cultural difference between the two cities, the participants were asked about their ethnicity and those living in Akcakale defined themselves as "Arab" and those living in Sancaktepe defined themselves as "Turkish". These two cities were chosen considering that the direct effect of cultural difference on violence against women and sexual functions can be noticed.

Participants and Procedure

The participants in the study were women who presented to the psychiatric outpatient clinics of the two hospitals with any psychiatric complaint. Among these women, those who presented for the first time and who received a diagnosis other than 'depressive disorder' or 'anxiety disorder' after psychiatric assessment were not included in the study. The inclusion criteria were: being aged between 18-50, being married or having a partner (having active sexual life), apply in psychiatry outpatient clinics, and having signed the informed consent form. The exclusion criteria were: having any psychotic symptoms after the examination by a psychiatrist, not having a regular partner relationship. Individuals were evaluated according to Diagnostic and Statistical Manual of Mental Disorders 5 (DSM diagnostic criteria by conducting a psychiatric interview. All participants - including Arab women - spoke Turkish.

The scales were given to the women who agreed to take part in the study. They were asked to complete them after the examination. All scales are also in Turkish. The Arab women participating in the study are Turkish citizens, not immigrants. Those who were educated went to school in Turkey. The first psychiatric admission was evaluated according to the women's statements. Women who stated that they had previously taken psychiatric medication were excluded from the study at the onset. The women participating in the study were not using any psychotropic medication. The study was conducted between October 2019 and December 2019. It was not possible to perform a power analysis to determine the number of participants. The sociodemographic data form prepared by the researcher was given to the eligible patients to be included in the study. Then, the patients were given to fill in on their own or with the researcher the Beck Depression, Beck Anxiety, Golombok-Rust Sexual Satisfaction Scale and Psychological Maltreatment of Women Inventory Short Form.

The self-report scales were asked to be completed by the women themselves, except for women who were not be able to read or write. These women were completed by the researcher at the outpatient clinic and outside working hours, with the researcher reading the scales. Women who reported experiencing violence were informed of their rights and those who needed support were referred to the appropriate services. None of the women asked for help. The fact that the self-scales were filled together with the researcher in Sanliurfa, because the women can not be able to read, may have caused the problems to be minimized.

All subjects participating in the study were given an informed consent form approved by the Maltepe University Clinical Research Ethics Committee (number: 2019/900/54 and date: 18/09/2019). Before the clinical interview and application, detailed information about the study was given, and

then the signed consent of all participants was obtained.

Instruments

Sociodemographic Data Form: It is an 18-item form prepared to obtain information about the demographic characteristics of the participants. Questions were asked about the participants' level of education, their spouse's level of education, their parents' level of education, the number of children they had, and the place or people they would seek help from if they were subjected to intimate partner violence.

Psychological Maltreatment of Women Inventory Short Form (PMWI) - Turkish adaptation: It was developed by Tolman (14). The Turkish validity-reliability was made by Ersoy, Hünler, and Namer in 2017 (15). PMWI has Restriction/Blaming/Threat, Emotional/Verbal Violence and Responsibility subscales. It consists of a total of 18 items in the short form. Higher scores indicate higher exposure to psychological violence and the inventory does not have a cut-off point. Internal consistency coefficient (Cronbach-Alpha) was found to be .93; split half reliability was found to be .90 and .87 for the first and second halves, respectively, and the correlation between the two halves were found to be .71. The Cronbach-Alpha value of the current study is 0.83.

Golombok-Rust Inventory of Sexual Satisfaction (GRISS): It is a measurement tool for evaluating the quality of sexuality and sexual dysfunctions. There are two separate forms prepared for men and women, each consisting of 28 items. In female and male forms, there are 7 sub-dimensions, 5 of which are common (avoidance, satisfaction, communication, sensuality and frequency of intercourse). In addition, there are vaginismus and orgasmic disorder (anorgasmia) in the female form, and premature ejaculation and impotence (erectile dysfunction) in the male form (16). The Turkish adaptation of the inventory was made by Tuğrul et al. and evidence regarding its validity and reliability was obtained (17). The Cronbach alpha internal consistency coefficient of Golombok-Rust Sexual Satisfaction Scale was calculated as 0.83 for men and 0.94 for women. According to the data obtained from this sample, Cronbach's alpha values for all sub-dimensions were found to vary between 0.59 and 0.88 in the female form and between 0.42 and 0.85 in the male form. The Cronbach-Alpha value of the current study is 0.88.

Domestic Violence Against Women Scale: The reliability study of the scale, which was developed by Betul Ciler Kilic was conducted, and the total score gives the score for the level of violence against women (18). The reliability study of the scale, which was developed by Betul Ciler Kilic was conducted, and the total score gives the score for the level of violence against women (17). In the first stage, the scale created by the researcher was submitted to an expert opinion for concept validity and necessary corrections were made. In the second stage, item analysis was carried out to determine the reliability of the items in the scale. This procedure checked the correlations between the item scores and determined whether each item measured the variable it was intended to measure. In the third step, the Kuder-Richardson coefficient of 20 was determined for internal consistency. The reliability coefficients of the total scores of the items determine the relationship between the variance of each item and the variance of the total score. The r values for the Domestic Violence Against Women Scale vary between 0.25 and 0.77. The r value for all questions was greater than 0.20 and was considered significant. In this analysis, which examined the internal consistency and homogeneity of the scale, the alpha values for the Domestic Violence Against Women Scale and its sub-groups ranged from 0.73 to 0.94. The Cronbach-Alpha value of the current study is 0.84. The scale, which consists of 50 items in total, has 5 subgroups: physical violence, emotional violence, verbal violence, economic violence and sexual violence. In a 3-point Likert-type scale, the "never" response is scored as 1, the "sometimes" response as 2, and the "always" response as 3, and the score range is between 50 and 150 points. High scores indicate higher levels of violence.

The Physical Violence subgroup measures the level of physical violence such as beating, slapping and similar physical violence done to the woman by the partner. The Emotional Violence subgroup mea-

sures the level of emotional violence such as whether the woman is loved; her family and friends are humiliated by her partner and frightened by her partner. The Verbal Violence subgroup measures the level of verbal violence such as insults and threats addresses to the woman by her partner. The Economic Violence subgroup measures situations such as whether a woman restricts her work because of her partner who controls her expenditures. The Sexual Violence subgroup evaluates situations such as whether the woman is forced to have sexual intercourse against her will and her partner mocks her about her sexual desire or avoidance.

Beck Depression Inventory (BDI): Developed by Beck et al. (19) and adapted into Turkish by Hisli (20). It was determined that the scale had sufficient reliability and validity. Two-half test correlation was r=.74 and internal consistency coefficient (Cronbach Alpha) reported as .80. The Cronbach-Alpha value of the current study is 0.78.

Beck Anxiety Inventory (BAI): Developed by Beck et al.(21) and adapted to Turkish by Ulusoy, Sahin, and Erkmen (22). It was determined that the scale had sufficient reliability and validity. As a result of the validity and reliability study of the Turkish version, the Cronbach alpha value was found to be 0.93. The Cronbach-Alpha value of the current study is 0.89.

Statistical Analysis

In the descriptive statistics of the data, mean, standard deviation, median minimum, maximum, frequency and ratio values were used. The distribution of variables was assessed with the Kolmogorov Smirnov test. The independent-sample t-test and Mann- Whitney U test were used in the analysis of quantitative independent data. Chi-square test was used in the analysis of qualitative independent data, and Fisher Test was used when the Chi-square test conditions were not met. Spearman correlation analysis was used in the correlation analysis. SPSS 28.0 program was used in the analysis. Subscales with a significant difference between the two groups were evaluated one by one in the linear regression model in which age, education period, number of children, marriage duration, BA and BD score were evaluated as predictors.

RESULTS

The mean age of the 105 women participating in the study was 33.7±7.3 years old, and a total of 25 participants were not be able to read or write (3 Turkish, 22 Arabic women). The sociodemographic characteristics including their marrige history of participants were given in Table 1.

No significant difference was found between the total score of the Domestic Violence Against Women Scale and the sub-scores of physical violence, emotional violence, verbal violence, economic violence, and sexual violence in the Turkish or Arabic groups ($p>0.05$). The comparison of domestic violence against women scores of Turkish or Arabic women is given in Table 2. 41.9% of women reported that they have not been exposed to physical violence, 3.8% have not been exposed to economic violence, and 2.8% have not been exposed to sexual violence when the scale score is under 10 in each sub-dimension. There was no significant difference between BDI score and BDI score distribution, BAI score and BAI score distribution among the Turkish and the Arabic women ($p >0.05$). The BDI and BAI scores were given in Table 2.

There was no significant difference between GRISS total score and sexual frequency scores in both groups ($p >0.05$). The scores of sexual communication, satisfaction, and anorgasmia were significantly higher in Arabic women than in Turkish women ($p<0.05$). In the Arabic women, the score of sexual avoidance, non-sensuality and vaginismus was significantly lower than in the Turkish women ($p<0.05$). The comparison of GRISS scores of Turkish and Arabic women is given in Table 2. Sexual dysfunction (GRISS>33) was found in 78% in Turkish women and in 68% in Arabic women. This rate corresponds to 73.3% of all participants.

No significant difference was found in both groups in terms of the Female Psychological Maltreatment Inventory Restriction/Blame/Threat, Emotional/Verbal Violence sub-scores and Total

Table-1: Comparison of sociodemographic characteristics of the Turkish and the Arabic women

	Turk Mean – SD / %	Arab Mean – SD / %	p	t / Z
Age (years)	34.8 – 9.6	31.5 – 6.1	0.037* t	2.121
Number of siblings	4.0 – 1.7	7.2 – 2.9	<0.001* *m	-6.055
Educational Level (years)	8.9–3.8	4.2 –3.6	<0.001** t	6.458
Partner s Educational Level (years)	9.6 –3.6	7.6 –3.7	0.007* t	2.740
Mother s Educational Level (years)	4.8–3.2	1.4–1.3	<0.001** t	72.207
Father s Educational Level (years)	7.4–3.2	4.1–2.3	<0.001** t	98.346
Working Status				
Working	18.2%	30.0%	0.156 x†	2.016
Not working	81.8%	70.0%		
Family income level				
Low	25.5%	68.0%	<0.001** x2	19.107
Middle	47.3%	20.0%		
High	27.3%	12.0%		
Duration of Marriage (years)	13.3–9.0	13.1–7.1	0.956 m	-.055
Partner s Age (years)	40.5–9.0	38.9–9.9	0.364 t	.913
Number of Children	1.9–1.0	4.2–2.2	<0.001** m	-5.672
Way of forming marriage				
Arranged and non-consensual	29.1%	76.0%	<0.001* x2	23.079
Consensual	58.2%	20.0%		
Arranged and consensual	12.7%	4.0%		
Who Do You Ask for Help If Your Partner Treats You Badly?				
Friends	21.8%	8.0%	<0.001* x2	38.616
Police	25.5%	0.0%		
Family	43.6%	32.0%		
Relatives	9.1%	38.0%		
No one	0.0%	22.0%		
Does Your Partner Have Another Partner?				
No	100%	76.0%	<0.001* x2	14.903
Yes	0	24.0%		

t: Independent-sample t-test, m : Mann-Whitney U test, x^2 : Chi-square test, **: p<0.01, *: p<0.05

Score (p>0.05). The Female Psychological Maltreatment Inventory Responsibility score in the Arabic group was found to be significantly lower than the Turkish group (p<0.05). The comparison of PMWI scores of Turkish and Arabic women is given in Table 2.

Correlations of GRISS Total Score and Violence Scores (with sub-scores) were shown in Table 3. Correlations of Violence Total Score and GRISS Scores (with subscrores) were shown in Table 4. Correlations were shown for both total participants and groups separately.

Table-2: Comparisons of domestic violence against women scale, Golombok-Rust inventory of sexual satisfaction, psychological maltreatment of women inventory short form, Beck Depression, and Beck Anxiety Inventory between Turkish and Arabic women

Scale	Sub-scales	Turk Mean – SD	Median	Arab Mean – SD	Median	p	t / Z
Domestic Violence Against Women Scale	Physical Violence	11.2– 1.5	11.0	11.7–2.2	11.0	0.576 m	.559
	Emotional Violence	17.2–2.6	17.0	17.8–2.7	17.0	0.713 m	-.368
	Verbal Violence	16.2 –2.6	16.0	16.7–4.4	15.0	0.504 t	-.687
	Economic Violence	15.4 –2.6	16.0	15.6–2.9	16.0	0.818 t	-.230
	Sexual Violence	14.1 –2.4	14.0	13.9–2.6	14.0	0.667 t	.431
	Total Violence Score	74.2 –7.8	74.0	75.7–12.7	72.0	0.865 m	-.170
GRISS	Frequency	3.7–1.6	4.0	3.9–2.2	4.0	0.514 m	.653
	Communication	3.5–1.6	3.0	5.8–2.6	7.0	<0.001** m	4.549
	Satisfaction	6.4–3.7	7.0	9.4–5.5	11.0	0.001* m	3.435
	Avoidance	5.6–3.8	6.0	4.0–3.9	3.0	0.034* t	2.144
	Sensuality	6.3–2.9	7.0	4.9–4.2	4.0	0.012* m	-2.501
	Anorgasmia	5.7–2.6	5.0	8.2–4.8	7.0	0.001* t	-3.418
	Vaginismus	6.0–2.9	7.0	4.3–2.7	4.0	0.002* t	3.101
	Golombok Total Score	45.2–14.5	48.0	46.2–22.8	50.0	0.626 m	.488
PMWI	Restriction/Blaming/Threat	18.3–5.6	19.0	17.5–7.0	18.0	0.483 t	.704
	Emotional/Verbal Violence	17.1–4.8	17.0	18.4–6.8	18.0	0.304 m	1.029
	Responsibility	10.3–3.5	11.0	9.3–3.4	8.5	0.046* m	-1.996
	Total PMWI Score	45.7–10.7	48.0	45.2–15.3	45.0	0.829 t	.217
BD Score		21.5–9.9	21.0	23.4–11.8	22.5	0.378 t	-.885
BA Score		22.3–7.7	22.0	22.9–9.6	23.0	0.729 t	-.347

t: Independent-sample t-test, m: Mann-Whitney U test, **: p<0.01, *: p<0.05, BD: Beck depression, BA: Beck Anxiety, PMWI: Psychological Maltreatment of Women Inventory Short Form, GRISS: Golombok-Rust Inventory of Sexual Satisfaction

Table-3: Correlations of GRISS Total Score and Violence Scores

		Physical Violence	Emotional Violence	Verbal Violence	Economical Violence	Sexual Violence	Total Violence Score
All Participants GRISS	r	0.286	0.266	0.215	0.168	0.339	0.328
Total Score	p	0.003*	0.006*	0.027*	0.087	<0.001**	0.001**
Turkish GRISS Total	r	0.080	0.320	0.246	0.163	0.450	0.381
Score	p	0.562	0.017*	0.071	0.234	0.001**	0.004*
Arabic GRISS Total	r	0.446	0.287	0.268	0.254	0.315	0.341
Score	p	0.001**	0.043*	0.060	0.075	0.026*	0.015*

*: p<0.05, **: p?0.001, Spearman Correlation, GRISS: Golombok-Rust Inventory of Sexual Satisfaction

Subscales with a significant difference between the two groups were evaluated one by one in the linear regression model in which age, education period, number of children, marriage duration, BA and BD score were evaluated as predictors. For sexual communication, which is the sucscale of GRISS; It was observed that BA score (B = 0.093, β = 0.328, t = 3.539, p = 0.001) and ethnicity (B = 1.831, β = 0.378, t = 3.221, p = 0.002) had a significant effect. For sexual satisfaction, significant effects of BA score (B = 0.131, β = 0.233, t = 2.292, p = 0.024) and ethnicity (B = 2.730, β = 0.282, t = 2.201, p = 0.030) were found. For sexual avoidance; a significant effect of BD score (B = 0.105, β = 0.290, t = 2.722, p = 0.008) was observed, but no significant effect of ethnicity was detected. For sexual sensuality; Significant effects of BD score (B = 0.094, β = 0.281, t = 2.688, p = 0.008) and ethnicity (B =-2.227, β =-0.309, t =-2.307, p = 0.023) were observed. For anorgasmia, only the number of children (B = 0.673, β = 0.269, t = 2.496, p = 0.014) had a significant effect. For vaginismus, only ethnic origin (B =-2.376, β = 0.408, t =-3.012, p = 0.003) was found to be significant. In the Responsibility subscale of PMWI, only the effect of age (B =-0.170, β =-0.407, t =-2.651, p = 009) was found to be significant.

DISCUSSION

In this study, we concluded that sexual functions are affected by intimate partner violence. Additionally, this impact may differ across cultures. The Arabic women whose father, mother and husband have lower education level, have significantly lower education level and more children than the Turkish women. The fact that arranged marriages are more common among in Arabic women and 22% of these women do not even think of going to any authority, when they are subjected to violence, can be seen as a reflection of the culture they live in.

It is understood that all women participating in the study were exposed to at least one of the subtypes of violence. However, there is no difference between these two groups about IPV. In a study investigating physical and sexual intimate partner violence in 15 countries, the lifetime prevalence of violence was reported as 15% to 71%. It was reported that drastic variations in the prevalence of IPV were observed across different geographic regions (23). According to this study, we can interpret that the geographical difference has no effect on IPV. This may be related to the mental state of women. Although there is no difference the severity of depression and anxiety scores between the two groups, violence may have been definable more in women seeking treatment. According to one study, women who suffer from mental disorders such as post-traumatic stress disorder, anxiety or depression are more likely to be exposed to violent behaviour (24).

The Turkish and Arabic groups did not differ significantly on the Golombok-Rust total score or sexual frequency score. Sexual avoidance, non-sensuality and vaginismus severity scores were significantly lower in the Arab group than in the Turkish group, although sexual non-communication, dissatisfaction and anorgasmia severity scores were significantly higher in the Arab group than in the Turkish

Table-4: Correlations of Violence Total Score and GRISS Scores

GRISS		Infrequency	Non-communication	Dissatisfaction	Avoidance	Non-sensuality	Vaginismus	Anorgasmia
All Participants	r	0.279	0.220	0.496	0.283	0.335	0.113	0.121
TVS	p	0.004*	0.024*	<0.001**	0.003*	<0.001**	0.251	0.220
Turkish TVS	r	0.322	0.069	0.503	0.214	0.342	0.129	0.117
	p	0.017*	0.619	<0.001**	0.118	0.011*	0.350	0.396
Arabic TVS	r	0.294	0.275	0.496	0.317	0.390	0.124	0.107
	p	0.039*	0.053	<0.001**	0.025*	0.019*	0.390	0.460

*: p<0.05, **: p<0.001, Spearman Correlation, GRISS. Golombok-Rust Inventory of Sexual Satisfaction, TVS: Total Violence Score

group. Compared to white women, African American women engaged in more sexual activity, but Hispanic women reported less physical pleasure and arousal. Japanese and Chinese women, with arousal being the only notable exception, reported lower levels of arousal and desire than white women (25). We can say that in societies where cultural oppression is experienced less, women try to experience their sexuality more. In conservative societies, however, this seems to be difficult. There are significant differences in the prevalence of specific sexual disorders between white, African American and Asian American women, so health professionals should be cautious about generalising about the sexual concerns of women from different ethnic backgrounds (26).

According to the data of sociodemographic variables in China, women of non-Han or ethnic minorities reported sexual dysfunction less frequently than women of Han ethnicity. Ethnic minorities have a reduced likelihood of sexual dysfunction than people of Han ethnicity. In terms of regional variance, female sexual dysfunction was less common in the southern provinces than in the northern provinces. The regional variation and the regional variation in economic development did not correlate. This finding may be due to a cultural difference in Chinese people's reluctance to acknowledge their sexual troubles or seek treatment for sexual dysfunction (27). There is a similar situation in the current study. However, Istanbul is the biggest city in Turkey in all areas escpecially socioeconomic area, the Turkish women have reported more sexual dysfunctions than the Arabic women. This difference may be related to the expectation from sexuality. The empowerment of women in the socio-cultural field also increases their power to take responsibility for their sexuality.

To compare 10% of women in Turkey and 6.7% of women in Greece, 40% of Iranian women never talk about sexual issues with their partners, according to the survey of women's sexual problems in different countries (13). The assumption that women are prevented by social and religious norms from expressing themselves unless their partner does so may explain why this problem is more prevalent in Iran. The 'good girl' model is used in cultures where women are expected to play a traditional sexual role and adhere to the notion that they must 'control all kinds of emotional and behavioural issues, limit sexuality to responding to their partner, and control all kinds of negative emotions and behaviours'. Differently from Turkey and Iran, where there are religious restrictions on sexuality and where sexuality is considered forbidden, it can be argued that religion contributes to the greater sexual freedom of Greek women (13). The effort of being a "good girl" and pleasing her husband due to cultural pressure; women continue to have sexual intercourse even if they have been subjected to violence. All these lead to problems in the mental health of women. Especially in depressed and anxious women, possible intimate partner violence and sexual functions should be questioned. The way of questioning may be different in different ethnicities.

Similar to other women, the majority of Muslim women suffer arousal, desire, and orgasmic disorders linked to physiological and psychologic variables. Given the prevalence of unconsummated marriage in this demographic, sexual pain disorders may be more common there. Maintaining virginity and protecting the hymen before marriage are special issues (28). In our study, the concern of polygamy, especially among the Arabic women, draws attention as a problem specific to this culture. Possible risk factors for female sexual dysfunctions among Beijing women included unhappiness with the partner's sexual ability, low marital affection, the partner's sexual issues, displeasure with the marriage, and rural lifestyle (29). Considering that IPV can affect marital happiness and satisfaction between partners, similar results seem to be achieved.

Significant relationships have been found between sexual dysfunction and IPV, particularly physical and sexual violence (30). The authors commented that in Iranian women, sexuality is based on pleasing the partner. In our study sexual communication, satisfaction, and anorgasmia severity scores were significantly higher in the Arabic group than in the Turkish group. This difference may be due to cultural influences, partner relationships, mood disorders or different perceptions of sexuality. Similar to the aforementioned study, a relationship

was found between Golombok total score and physical, verbal, sexual and emotional violence in the current study. In particular, women's sexual health is affected by emotional and verbal abuse as well as sexual and physical abuse. A woman who has experienced IPV is expected to be less responsive to her partner's sexual demands and desires.

One study found that physical and psychological IPV were present in 56.7% and 10% of cases respectively. Sexual dysfunction, sexual communication and lifetime physical and psychological IPV were all significantly associated with sexual dissatisfaction (31). The perception of the spouse as too directive or too independent, non-violent issues in the marital relationship, may be associated with sexual dysfunction in addition to the identified violence (32). Similar results were reached in the current study. Violence in a relationship is a sign of relationship dysfunction, and it is difficult to have healthy sexuality in a dysfunctional relationship. Sexual miscommunication will cause sexual dysfunctions, including sexual dissatisfaction in women who need more verbal stimuli for arousal. Regardless of culture, IPV is likely to lead to sexual dysfunction.

There was no significant difference in the Restraint/Blame/Threat, Emotional/Verbal Violence and the Total Scores of the Psychological Maltreatment of Women Inventory Short Form in the Turkish and Arabic women. The Responsibility score of the Form was significantly lower in the Arabic women than in the Turkish women. This difference can be explained by the fact that the Arabic women have low expectations from their partners about responsibility with housework. The fact that the items loaded on other factors in the original form of the scale and related to taking responsibility for common life were gathered under a single factor is thought to indicate a difference in Turkish culture. Obtaining a three-factor structure in the Turkish application study of the long form of the scale also supports this explanation (15).

The first limitation was that only women who applied to the psychiatry outpatient clinic and sought help for mental health were included in the study. The inclusion of individuals with psychiatric disorder is insufficient in terms of reflecting the structure of the general society. The lack of a structured interview to diagnose depression or anxiety is also a limiting factor. An important limitation is that sexual functioning was assessed only with a self-report scale. As the diagnosis of sexual dysfunction was not made by psychiatric examination, the data may have been insufficiently analyzed. The fact that the violence scale has only been tested for validity and reliability in Turkey and it is a local scale and not an internationally valid scale may also have reduced its reliability. We think that the questions of the test are effective in revealing violence. There are also statistical limitations due to the use of only univariate analysis.

This is the first study to assess the relationship between IPV and sexual functioning in Turkey. We suggest that the results of the study may be particularly useful for clinicians or health professionals working in the urban areas to understand the women living there. We can suggest that the probability of any subtype of IPV will be very high in women who apply to the psychiatry outpatient clinic. Psychiatrists or mental health professionals should ask about each subtype of violence in women. Again, it seems important to question sexual functions in these women. Sexual dysfunction is strongly associated with violence experienced by women. The fact that there was no difference in intimate partner violence between two different cultures may be related to women's mental health. The fact that the Arabic women had lower avoidance scores due to the threat of polygamy may be the result of cultural influence. It is clear that the treatment of women's mental and sexual health will begin with their protection from partner violence. Strengthening the mental health of women who apply to the psychiatry outpatient clinic is about educating them about their rights and informing them of reliable addresses they can reach when they are exposed to partner violence. As a result, it is suggested that health services may benefit from staff taking a holistic approach to patient care, including women's religious and socio-cultural components before assessing IPV and sexuality issues and offering appropriate coping techniques. For health professionals to have more systematic and standardized access to the cultural information of the society they serve, transcultural models of

care need to be used. In future studies, intimate partner violence should be evaluated in groups without psychiatric disorders. In addition, women who report having been exposed to violence should be interviewed about post-traumatic stress disorder. A psychiatric interview is also recommended for the diagnosis of sexual dysfunction.

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Informed consent was obtained from all individual participants included in the study.

All data generated or analysed during this study are included in this published article

Correspondence address: Assist. Prof. Burcu Kok Kendiroglu, Maltepe University Faculy of Medicine Department of Psychiatry, Istanbul, Turkey kokburcu@gmail.com

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