

RESEARCH ARTICLE

The impact of the experience of Sexual Violence on female sexual dysfunction

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Abstract: Purpose: Sexual violence is among the most violent crimes that may occur against individuals. Such crimes have long-term effects on victims and usually cause physical and psychological harm. Accordingly, in the present study, the predictive role of Sexual Violence on Women's sexual dysfunctions was investigated. Methodology: In a descriptive-analytic study through simple random sampling, 140 women were selected. The research instrument was the Female Sexual Dysfunctional Detection Inventory (FSDDI). SPSS-19 software was used to analyze the data. Findings: The results showed that women with sexual violence history had higher mean scores. Moreover, sexual pain disorder and sexual dissatisfaction were predicted by the variable sexual violence history ($P < 0.001$). So, the history of sexual violence in women could lead to sexual dysfunctions in the future and affect the lack of sexual satisfaction.

Keywords: violence against women, Sexual Violence, rape, sexual assault, sexual dysfunctions

1 Introduction

The concept of violence against women and girls is considered as a major type of violence in the area of human rights and in international discourse on "Elimination of Violence". This type of violence includes various forms of sexual, psychological, physical and economic abuse. The United Nations (1993) defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" and Sexual violence is "any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object" [1]. Therefore, the issue of violence has no racial, social, cultural and geographical boundaries, and it is possible to occur in different places and situations such as home, schools, workplaces, etc., and at any place or time [2]. According to statistics [3], it is estimated that 35 per cent of women worldwide have experienced either physical and/or sexual intimate partner violence or sexual violence by a non-partner at some point in their lives. However, some national studies [4], show that up to 70 per cent of women have experienced physical and/or sexual violence from an intimate partner in their lifetime.

Although little data is available-and great variation in how psychological violence is measured across countries and cultures-existing evidence shows high prevalence rates. Forty-three per cent of women in the 28 European Union Member States have experienced some form of psychological violence by an intimate partner in their lifetime [5]. More than 1 in 4 women in Washington DC, United States, have experienced some form of sexual harassment on public transportation, according to a survey conducted [6]. Worldwide, almost 750 million women and girls alive today were married before their 18th birthday. Child marriage is more common in West and Central Africa, where over 4 in 10 girls were married before age 18, and about 1 in 7 were married or in union before age 15. Child marriage often results in early pregnancy and social isolation, interrupts schooling, limits the girl's opportunities and increases her risk of experiencing domestic violence [7]. Around 120 million girls worldwide (slightly more than 1 in 10) have experienced forced intercourse or other forced sexual acts at some point in their lives. By far the most common perpetrators of sexual violence against girls are current or former husbands, partners or boyfriends [8].

Sexual assault is one of the most violent crimes that may occur against individuals. The effects of such crimes on the victims will last for a long time and, in some occasions, will never be wiped out. Sexual assault is defined as penetration of a child or an adult (vaginal, oral, or anal) that is done with the penis, finger or any object. Sexual assault occurs when the victim's

consent is due to fear of death or injury; or through drug injecting [9]; or it can be done under coercion, threat or deception. In other words, it can be said that sexual assault is an act of rape which is not merely intended for sexual intercourse and is done by physical strength or physical force and is an attempt to dominate or humiliate the person to be raped; and it is to be said that it is a violent action rather than a sexual intercourse. Sexual abuse is a product of a personality disorder in childhood or adolescence period; that, in fact, is somehow created during person's mental development stages and become apparent in adolescence or adulthood. Although sexual assault may be affected by sexual disorders, an exception should be considered; occasionally, such behavior is not necessarily a sexual disorder, but an outbreak of anger [1]. A person committing such deeds can have personality disorders and the violence on his part may occur in other forms in addition to rape. In sum, the occurrence of rape against women and children in society can have various causes, including the social context individuals live in, cultural or social issues and lack of education and so on. However, no phenomenon occurs in a society out of the blue, and it does not disappear overnight since many factors are involved in a social phenomenon occurrence and it does not happen by one specific cause [10]. Street harassment of women and the similar crimes as well as sexual deprivation, unemployment, and mental or psychological complexes ultimately results in emergence of "anomy" in the society; that is an unusual condition that ethical issues and social norms have diminished, self-control and social control of individuals have been minimized and spirituality has faded in the society [1, 11].

Sexual crimes are of the most important issues in forensic medicine and are problems of contemporary civilized societies [13], and is a common and important public health problem in developed and developing countries. The phenomenon also has serious consequences for women physically and psychologically. In fact, sexual assault is a complicated problem and it has consequences in various aspects such as medical, psychological and legal aspects. The prevalence of this problem in the world varies from 13% to 39% in women, and this is 3% in men. The National Center for Women reports 680 thousand to 1.5 million women are raped every year in the United States [14]. The highest rates of sexual assault are reported in the Congo, and in Iran, the Judiciary has reported 1313 cases of rape per year on average [15]. According to [16], one woman is raped in every five minutes and compared to non-raped women they are more likely to have depression, suicide attempts, chronic anxiety, aggression, drug abuse problems, fatigue, low self-esteem, feelings of guilt, self-blame and sleep disorders. A series of symptoms are observed in these people including fear, innocence, shock, feelings of guilt, feelings of humiliation, embarrassment, aggression, and self-blame [17, 18]. Having various emotional pressures increases the risk of mental breakdown and affects mental health, as a result, a person is not able to behave well and in harmony with the community and maintain his mental health. Since sexual assault is accompanied with force it usually leads to physical and psychological harm. Women who have experienced rape and other forms of sexual assault are likely to experience chronic pelvic inflammatory disease, abdominal pain, irritable bowel syndrome, and sexual dysfunction in the future [19]. Therefore, one of the implications of sexual assault is sexual malfunction or sexual dysfunction.

Sexual dysfunction is malfunction or disorder in desire, arousal or orgasm. Dysfunctions are usually considered as normal sexual problems and are different from sexual deviations or sexual abnormalities, and they are considered separately as clinical dependencies. Sexual dysfunction in women is a complicated and common disease, and is usually related to their quality of life. Several factors affect female sexual function including physiological and psychological factors [20]. In fact, sexual function is influenced by biological, psychological and sociological factors. Disruption in one or more of the above areas will cause sexual dysfunction and severe sexual dysfunction will cause anxiety over sexual function, and anxiety, in turn, will exacerbate and prolong dysfunction. Sexual dysfunction may be of lifelong or acquired types that occur after a period of normal function; or of situational type that is limited to a particular sexual partner or situation; or the result of physiological, psychological or compound factors [21]. According to DSM-5, sexual dysfunction in one person is a severe discomfort and individual stress that lasts for at least 6 months (excluding drug use or drug-induced sexual dysfunction). Sexual problems can have a profound impact on the quality of a person's sexual life. Full sexual history and the examination of general health and other sexual problems (if any) are important and the assessment (function) of anxiety, feeling of guilt, stress and strain is very important in optimal management of sexual dysfunction. Individual sexual dysfunction is usually defined in terms of intimate relationships and in the context of cultural expectations and values that form normal sexual activity norms. Clinical experts point out a number of major distinctions to determine the nature of sexual dysfunction. First, is sexual dysfunction caused by psychological factors such as depression or communication problems, or is due to the combination of psychological and physical factors such as a disease or substance abuse? Furthermore, as stated, they distinguish lifelong, acquired, situational, and general sexual dysfunction. Lifelong dysfunctions have

existed since the onset of sexual activity while acquired dysfunctions existed after a period of natural activity. Situational dysfunctions occur only through certain types of sexual stimulation, situations, or sexual partners while general dysfunctions have no restriction [22].

In general, sexual dysfunction can be attributed to a variety of factors including physical diseases, psychological disorders, substance abuse, age, cultural and moral factors, masturbation, couples' sexual compatibility including the proper and adequate foreplay by the sexual partner, life satisfaction, sexual partner behavior, fear and anxiety, rape, *etc.* [23, 24]. Given that female sexual dysfunction is a common problem in the public society and has not been studied much compared to men sexual dysfunction and has always been one of the main issues in young women's quality of life [25, 26], therefore, the study of the effective factors in the occurrence of this dysfunction are of significant importance. On the other hand, and according to what is stated in relation to victims of rape, a person who has been raped feels bad about sexual intercourse in the long run and hates it. Sexual hatred and male hatred and being pessimistic about the opposite sex are other implications of sexual assault, and in the long run, the sexual capabilities of the individual might be lost [27], and these implications provide evidence for the need to investigate sexual assault or violence against women and its effects on their sexual function. The study also seeks to study the predictive role of sexual violence on women's sexual dysfunctions.

2 Methodology

2.1 Population and sample selection criteria

This descriptive-analytic study evaluates the sexual dysfunctions of women with prior Sexual Violence history.

The statistical population includes all women with a sexual dysfunction (disorder in: Desire, Arousal, Orgasm, Pain, and dissatisfaction) and have had a sustained sexual activity for at least the last four weeks (since they attended the clinics). The study samples of the research were selected randomly and included 140 women that attended two sexual health clinics in Tehran due to sexual dysfunction from March, 2016 to the end of March, 2017.

Exclusion criteria included: women with a history of hormonal diseases such as PCO, neurological diseases such as multiple sclerosis or MS, slipped disk, pelvic surgery, spinal fusion, gynecological surgery, perineal surgery, and women with endocrine disorders such as diabetes, history of infertility, and psychotic disorder and neuropsychiatric condition, as well as drug addiction and postmenopausal women.

2.2 Research instrument

The research instrument was The Female Sexual Dysfunctional Inventory (FSDDI) questionnaire. This questionnaire was designed by Naderi (2012) based on DSM-5 criteria and socio-cultural factors and then its psychometric properties were evaluated [21].

2.2.1 Scoring

The above questionnaire assesses six areas of female sexual dysfunction; sexual desire disorder (questions 1, 2, 4, 5, 8, 17, 18, 19, 23, 32); female sexual arousal disorder (questions 6, 7, 22, 27); female orgasmic disorder (9, 20, 28); genitor-pelvic pain-penetration disorder (questions 10, 21, 24, 25, 29, 30); sexual dissatisfaction (questions 3, 11, 12, 13, 14); and other related factors (questions 15, 16, 26, 31); that in total have 32 items and each item (question) has six options. Also the grading method follows Likert's management system (0-5). The high score in the questionnaire is a sign of sexual dysfunction.

2.2.2 Reliability and validity

The reliability coefficient of the whole questionnaire with 32 items estimated 0.95 via Cronbach alpha. Furthermore, the correlation of each question with the whole questionnaire showed that the questionnaire had a good internal consistency. Regarding the detection coefficient of the questionnaire, and according to the findings, using this instrument one can distinguish between individuals with and without sexual dysfunction. In terms of face and content validity of the questionnaire, the degree of agreement among experts and specialists was 0.89. Moreover, the results of the standard validity of both researcher-made questionnaire and Female Sexual Function Index-FSFI [28] showed a high correlation of each domain with the total scale in both questionnaires that totaled 0.77. Factor analysis was used to determine the structural validity of the questionnaire and the main factors were validated.

2.3 Method of analysis

In this study, to analyze the obtained data, independent t-test was used to determine the significant difference between the mean scores obtained from sexual dysfunctions in two groups of women with and without prior sexual violence history. Then, multiple linear regressions were used stepwise to determine the role of sexual violence in prediction of female sexual dysfunctions. Data were analyzed using SPSS-19 software.

3 Results

Independent t-test was used to examine the significant difference between sexual functions of women with and without prior sexual violence history. According to the results, there is a significant difference between the sexual functions of women with prior sexual violence history and women with no prior sexual violence history; and women prior sexual violence history have a higher mean score in all subscales than women with no prior sexual violence history (Table 1)

Table 1 Independent t test between sexual functions of women with and without prior sexual violence history

	Groups	M	SD	F	t
Sexual Desire Disorder	1	3.59	0.81	18.7	-3.10*
	2	3.07	1.13		
Female Sexual Arousal Disorder	1	3.76	1.15	6.75	-2.97*
	2	3.12	1.38		
Genito-Pelvic Pain-Penetration Disorder	1	4.23	0.73	118.32	-5.09*
	2	3.18	1.55		
Female Orgasmic Disorder	1	3.44	0.98	4.46	-2.31*
	2	3.01	1.22		
Sexual Dissatisfaction	1	3.72	0.5	19.54	-3.30*
	2	3.35	0.78		
Other Related Factors (Religion, culture and ...)	1	2.57	0.91	0.06	-3.76*
	2	2.01	0.88		
Total Score	1	3.55	0.4	62.77	-5.50*
	2	2.95	0.81		

Note: Group 1: Women with prior Sexual Violence history (n = 70); Group 2: Women without Sexual Violence history (n=70). * The significant difference between the mean of sexual dysfunctions of Women with and without prior Sexual Violence history in all subscales is significant (p < 0.01).

Then, multiple stepwise regressions were used to measure the predictive power of the variable sexual violence in prediction of the variable female sexual dysfunction and its domains (Table 2)

Table 2 The results of regression analysis and correlation coefficients

	Model	Sum of Squares	df	F	Standardized Coefficients			t
					Model	B	Beta	
1	Regression	5.53	1	25.93*	(Constant)	0.94		8.04*
	Residual	29.46	138		Model 1	0.15	0.39	5.09*
	Total	35.00	139					
2	Regression	7.19	2	17.7*	(Constant)	0.41		1.88
	Residual	27.81	137		Model 2	0.14	0.37	4.78*
	Total	35.00	139			0.16	0.22	2.85*

Note: Dependent Variable: Sexual Violence; Model 1: Genito-Pelvic Pain-Penetration Disorder; Model 2: Genito-Pelvic Pain-Penetration Disorder; Sexual Dissatisfaction Model 1: (R= 0.39, R square=0.15, Adjusted R square=0.15); Model 2: (R= 0.45, R square=0.20, Adjusted R square=0.19). * Indicates significant (P < 0.01).

Among the variables studied, only the variable sexual pain disorder and Sexual Dissatisfaction in the regression equation could validate 0.19% of equation total variance. The results of the variance analysis for the validity of the regression equation also show that the result is significant (P < 0.01).

According to the results of regression analysis and correlation coefficients of sexual violence and sexual dysfunction of women, it can be said, sexual violence can predict the variable sexual pain disorder and sexual dissatisfaction among sexual dysfunctions Scales (P < 0.01).

4 Discussion

Sexual violence is among the most prominent examples of violence against women and children [29]; and such violence is generally cloaked by the victims because of social sensitivity, reputation maintenance, threats from the assaulter, or reactions of stigma; and there is no precise statistics available about its quality and quantity in the society [30]; and occasionally a sexual violence causes death [1]. On this regard, rape is among crimes with psychological harm no less than murders and even possibly more than that. According to what mentioned, such unfortunate incidents exert a lot of psychological pressure on the victim [2, 31]. This pressure appears in form of various implications and disorders in person. Among the rape consequences on victims are post-traumatic stress disorder (PTSD), reduced self-esteem [32], substance abuse, distrust, depression, loneliness, discomfort, confusion, suicide, fear, anger, physical self-harm, alienation with body, sexual dysfunction, *etc.* Nearly two thirds of those who are abused or raped suffer from sexual repression [33, 34], and many others are fear their sexuality desires, and they think their body is dirty or embarrassing [10].

In this regard, the results of this study indicate that sexual function in all subscales was higher in women with prior sexual violence history than in women with no prior sexual violence history and this is consistent with findings of some other studies in the same area [35, 38], and this indicates the association of sexual violence with sexual dysfunction. In explaining this subject, it can be said, sexual activity is influenced by biological, psychological and social factors. The external and internal genital hormones and neuro-hormones, intrapsychic dynamics, interpersonal communication, social and economic status, dominant culture and customs, and issues such as sexual harassment, sexual abuse and rape, *etc.*, all affect gender expressions. And the disorder in one or more of these cases can cause sexual dysfunction; repeated episodes of sexual dysfunction would create anxiety over doing sexual activity and the created anxiety aggravates sexual dysfunction and results in lifelong dysfunction [39, 40].

On the other hand, in this research, the results of the data analysis show that being violence or raped in women is directly related to and predicts sexual dysfunction. In other studies, that were consistent with this result, it was shown that sexual assault can lead to sexual dysfunction such as pain disorders in the future [41]. When a woman often experiences pain in the vagina before, during and after sexual intercourse, this condition is called vaginismus. This situation may occur for any woman doing sexual intercourse if not stimulated enough, or in women that have a desire or stimulant-related disorder, or in women who are concerned about their sexual act, or have anxiety and stress [42, 43]. Painful intercourse may trigger an abnormal setting in which the pain and prediction of pain disrupts sexual stimulation and normal discharge. If the pain is felt deep inside the vagina, it is likely that there is a latent disorder in the pelvic organs. This disorder can be endometriosis, pelvic inflammatory disease (PID), abnormal adhesion of the organs, ovarian cancer, cancerous cysts or rupture of the ligaments that protect fetus. Deeper vaginal pain may occur when the male penis, during penetration, touches the cervix (neck of uterus). This situation usually alters with change of position. On the other hand, it can be said that the case of painful vaginismus is a relatively rare form of physical pain disorder that muscles in one third of outer vagina (levator ani-coccygeus muscles) contract abnormally to prevent penetration of male penis and as a result makes the sexual intercourse impossible, difficult, or painful. It seems that body via painful vaginismus avoids sexual intercourse. This pain is very common in women who have experienced sexual abuse, such as rape [21]. Therefore, it can be said that one of the psychological factors of sexual pain disorder and lack of sexual satisfaction is the unpleasant experience of rape or sexual violence, and according to the findings of the study, women with rape, violence and assault history also suffered from sexual pain disorder, that ultimately, it leads to a lack of sexual satisfaction.

In sum, sexual violence is a social harm in countries all around the world, and goes beyond the borders of culture, social and economic class, education, ethnic and nationality and in many cases it is kept hidden behind cultural and social norms and the beliefs. These behavioral abnormalities, according to social, cultural and economic characteristics of societies, have different causes and reasons and faces and are observed in many countries regardless of their ideologies and beliefs. Today, in the most advanced countries in the world, women and children suffer from the implications and consequences of these issues, and the available statistics in this area, as previously mentioned, confirm the countless problems in these countries [44]. Violence against women and sexual assault, in addition to the harmful effects on one's life, e.g. sexual function, have some negative consequences including the feeling of insecurity and disorders in social interactions; moreover, the existence of this harmful phenomenon against the women in the society makes it difficult for women to properly utilize their talent and abilities [45]. Therefore, having proper information about the implications of the sexual violence and assault

helps people treat their problems on time.

5 Conclusion

The results of this study showed that the history of sexual violence in women could lead to sexual dysfunctions in the future and affect the lack of sexual satisfaction. However, studies conducted in Iran show that although, this issue has been studied in various fields including legal and sociological-psychological, but in the legal field, it can be said that the violence against women is of little concern. In the field of criminology, according to the findings, it can be said that victim satisfaction has a great impact on the incidence and the prevention of sexual violence and rape, and the government and the judiciary should pay special attention to the victims of such crimes. Therefore, in prevention of violence and rape against women, first, it is required to build culture and to understand the difference between “women’s victimization and delinquency”; and in the second place, it requires governments to support women who are victimized and to interact internationally. In the psychological field according to findings, sexual violence and rape affect different aspects of a person’s life including sexual function and couple relationship and the inability in proper sexual intercourse causes the intensification of family disputes. Since sexual dysfunctions play an undeniable role in mental health and the lives of individuals, the inability to establish a healthy and enjoyable relationship with the sexual partner has physical, psychological and even social consequences for the couples. According to results of multiple studies that reported a relatively high prevalence of these disorders that shouldn’t be faced with irrational prejudice and have to be considered scientifically and in consistence with patients’ culture and approval and should be taken into account by doctors, psychologists, nurses, midwives and the other health personnel so that to prevent these problems through appropriate training.

Conflicts of interest

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