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The invisible pain of women: sexual coercion, psychological distress and somatic symptoms

Il dolore invisibile delle donne: coercizione sessuale, disagio psicologico e sintomi somatici

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SUMMARY. Introduction. Sexual coercion among married women is a widely concealed and a serious public health concern that may impede physical, sexual and psychological health of women. **Purpose.** We aimed to investigate the associations between sexual coercion, psychological distress and somatic symptoms among married women. **Methods.** This cross-sectional study was carried out from September 2018 to March 2019 at the International Islamic University, Pakistan. A sample of 200 married women with equal proportion of working and home bound women was selected whilst using non-probability purposive sampling technique from the cities of Rawalpindi and Islamabad (Pakistan). Information about study variables were gathered through Sexual Coercion in Intimate Relationship Scale, Kessler Psychological Distress Scale and Somatic Symptoms Scale. Linear regression analysis, a moderation analysis and a *t*-test was carried out using SPSS 23. **Results.** Sexual coercion was positively related to psychological distress and somatic symptoms among married women (p<.001). As a predictor variable, sexual coercion explained a variance of 53% in psychological distress and 35% in somatic symptoms. Additionally, home bound married women were more prone to suffer from sexual coercion, distress of psychological nature and somatic symptoms than married working women (p<.001). **Discussion.** Overall, women who experience sexual coercion have poorer psychological health. Study findings support the notion that husbands may act coercively to acquire or retain an impersonal sense of control and power more on home bound women. Additionally, working status might be a reason that work will positively contribute to the mental health of working women that needs further exploring.

KEY WORDS: sexual coercion, psychological distress, somatic symptoms.

RIASSUNTO. Introduzione. La coercizione sessuale tra le donne sposate è un grave problema di salute pubblica ampiamente tenuto nascosto e che può ostacolare la salute fisica, sessuale e psicologica delle donne. **Scopo.** Abbiamo mirato a indagare le associazioni tra coercizione sessuale, disagio psicologico e sintomi somatici tra le donne sposate. **Metodi.** Questo studio trasversale è stato condotto da settembre 2018 a marzo 2019 presso l'Università islamica internazionale, in Pakistan. È stato selezionato un campione di 200 donne sposate con la stessa proporzione di donne lavoratrici e costrette a casa utilizzando una tecnica di campionamento intenzionale non probabilistica delle città di Rawalpindi e Islamabad (Pakistan). Le informazioni sulle variabili dello studio sono state raccolte tramite la Scala Kessler del disagio psicologico e la Scala dei sintomi somatici. L'analisi di regressione lineare, un'analisi di moderazione e un t-test sono stati effettuati utilizzando SPSS 23. **Risultati.** La coercizione sessuale era correlata positivamente al disagio psicologico e ai sintomi somatici tra le donne sposate (p<,001). Come variabile predittiva, la coercizione sessuale spiegava una varianza del 53% nel disagio psicologico e del 35% nei sintomi somatici. Inoltre, le donne sposate costrette a casa erano più inclini a subire coercizione sessuale a soffrire di disagio di natura psicologica e sintomi somatici rispetto alle donne lavoratrici sposate (p<.001). **Discussione e conclusioni.** Nel complesso, le donne che subiscono la coercizione sessuale hanno una salute psicologica peggiore. I risultati dello studio supportano l'idea che i mariti possano agire in modo coercitivo per acquisire o mantenere un senso impersonale di controllo e di potere sulle donne costrette a casa. Inoltre, lo stato lavorativo potrebbe essere un motivo per cui il lavoro contribuirà positivamente alla salute mentale delle donne lavoratrici, aspetto che necessita di ulteriori approfondimenti.

PAROLE CHIAVE: coercizione sessuale, disagio psicologico, sintomi somatici.

INTRODUCTION

Over a past few decades, mental health issues have escalated in Pakistan, i.e., a relatively newly developed country[1]. Both in rural and urban population, common mental health problems have been identified among both men as well as women, whether working or non-working[2]. However, due to the patriarchal social structure such prevalence of common

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mental disorders is largely unreported especially among women. Two of the leading health problems among married women are features of depression and anxiety due to emotional distress (psychological distress)[3] and unexplained bodily symptoms without much physical evidence (somatic).[4] Studies suggest that married women have an increased vulnerability to sexual coercion that is possibly associated with mental health problems such as depression, anxiety and somatic symptoms[5,6]. Sexual coercion has been widely described in literature by definition, sexual coercion is an act of forcing (or attempting to force) another individual through means such as; violence, threats, verbal insistence, deception, imposed cultural expectations, or economic circumstances to engage in sexual activity against her/his will. Globally, the most common categories of violence/offences against women, undertaken by their husbands, are physical and sexual abuse. Around the world, men interpret monogamy as an unconditional bond for their wives to perform sexual activity and also the capacity to force the wives into the act, if need be[7].

Similarly, in Pakistan, there are cultural norms, beliefs and traditions that obstruct women's autonomy and consent to contribute into a gender-based ferocity. Women are more prone to sexual coercion with some studies indicating as much as 20% of the women being affected by the phenomenon[8]. A total of 50 surveys (population-based) were analysed, revealed around 10-50% of married women to have undergone assault of a physical nature at the hands of their husbands at some point in their lives[9]. A further research, conducted on working women, revealed that 1 in 10 had been sexually coerced[10]. In 15 countries a qualitative study was carried out that reported women having troubling experiences with regards to intercourse after marriage. Periodically mentioned by these women was the physical pressure to have intercourse as well as some being forced to perform endeavours during sex which, to them were both derogatory and insulting[7].

Sexual coercion has been found to have extensive mental, emotional, societal, bodily and health consequences which may appear immediately or at a later stage in life. Fear of being intimate, forced marriages, reduced sexual pleasure, mental and physical reservations regarding sexual performance are problems more likely faced by women report to have been sexually coerced[8,11]. These women have been reported to have a declined physical health, somatic symptoms, higher psychological distress, and greater health service consumption[12]. Moreover, sexually coerced women may feel a sense of powerlessness whilst insisting their sexual companion to wear a condom, thus, fear of unwanted pregnancy adds to a psychological distress. Unintended pregnancies[13] and abortions[14] are more likely found among sexually coerced women. Women are also likely to experience a complex multitude of gynaecological problems like bleeding and discharge from vagina, pain during sex and menstruation, and in more complicated cases pelvic inflammatory disease[7,15]. It is, therefore, apparent that the consequences are significant and long-lasting for married women experiencing sexual coercion.

Furthermore, the correlation of sexual coercion and mental health issues are insignificant due to dearth of indigenous literature regarding the subject matter i.e. psychological distress and somatic symptoms among working and home bound married women. Almost half of Pakistan's population is comprised of women but they lack a reputable social status due to several issues including but not limited to lack of employment opportunities and health services, lack of access to basic education, injustices and patriarchal structure of families to mention a few. greater acceptance for strong and orthodox masculine norms and patriarchal structure in Pakistan contribute towards increased violent behaviour against women[16]. According to Aurat Foundation's (2013) annual report; total 48023 violence cases against women (year, 2008-2013) were reported. From these around 726 were cases of sexual assault or coercion reported by women[17]. Additionally, Browne's and Finkelhor model (1985)[18] suggests that outcomes as well depend upon the characteristics of women's' experiences of sexual coercion. Hence, it is of utmost importance to examine whether particular experiences of sexual coercion contribute into impaired mental and physical health conditions.

Furthermore, robust mental health is the foundation for well-being and effective functioning for an individual, their community and that of women for their own health. Thus, the very aim of the present study was to investigate the relationship between sexual coercion, psychological distress and somatic symptoms among married women. Additionally, the study also aimed to investigate and compare differences, if any, among working and home bound married women with regards to sexual coercion, psychological distress and somatic symptoms. If the differences are identified, mental health professionals can move forward towards the development of more effective services and interventions for mental health issues among sexually coerced women. Present study can also aid policy makers and relevant government departments to promote policies and guidelines to improve experiences of married women with their intimate partners in terms of sexual coercion.

MATERIAL AND METHODS

Subjects and study design

Subsequent to cross-sectional study design, a purposive sample, comprised of 200 married women (n=100 working married women, n=100 home bound married women), with the age range of 18 to 40 (M=28.5; SD=6.98) years was obtained for data collection from the areas of twin cities i.e. Rawalpindi and Islamabad, Pakistan. Duration of the study was from September 2018 to March 2019. Home bound married women were approached at gyms (n=10, 5%), salons (n=10, 5%), hospital outpatient departments/clinics (n=50, 25%), non-working married students (n=30, 15%) and working married women at their working areas (University faculty members (n=40, 20%), Corporate sector (n=20, 10%), Bankers (n=20, 10%) and NGOs (n=20, 10%)) and were guided about the purpose of study.

Inclusion criteria

Working and home-bound women having education of at least intermediate, married once, willing to answer questions, understand English language and without any psychiatric illness were included in study.

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Exclusion criteria

Divorced, widow, remarried women and women suffering from any neurological ailment were excluded.

Instruments

Information related to sexual coercion, psychological distress and somatic symptoms was collected through sexual coercion in intimate relationship scale (SCIRS)[19], Kessler psychological distress scale (KPDS)[20] and somatic symptom scale (SSS-8)[21].

The sexual coercion in intimate relationship scale was formulated to measure the use of psycho-behavioural actions or strategies of sexual coercion, for instance, menaces, withholding of facilities, and violence. SCIRS comprised of 34 items utilizing a six-point likert type scale and the range of score was 34 to 170. Basically, it is a measure of women's own reports of their husband's sexually coercive acts, developed and validated in 2004 by Shackelford and Goetz[19].

Kessler psychological distress scale was developed by Kessler et al.[20] in 2003 with a score range of 10 to 50. KPDS, a 10-item validated scale proposed to provide a universal measure of distress. Items are related to symptoms of anxiety and depression which are experienced by a person in the past four weeks.

Somatic symptom scale (SSS-8), a short self-report scale, was formulated by Gierk et al.[21] in 2014 in order to assess somatic symptoms. Score on this five-point scale ranges from 0-32 and the participant's rate about their somatic symptoms which they experience in previous week.

Ethical aspects

Ethical approval letter (Letter # 36DPEC) was obtained from International Islamic University, Psychology department ethics committee. Considering the sensitivity of present research respondents were informed regarding the confidentiality of the stated information and they were made clear that their participation was entirely voluntary and they have the right to withdraw from study if they experience severe distressing symptoms. Additionally, they were guided that the sought data would solely be used for study purpose.

Statistical analysis

For statistical analysis, SPSS-23 was used.

RESULTS

Frequency tabulation (Table 1) reveals equal distribution of home bound (*f*=100, 50%) and working (*f*=100, 50%) married women. Most of the participants fall in the age range of 24-29 (65, 32.5%) as compared to 30-34 (53, 26.5%), 18-23 (47, 24.5%) and 35-45 (35, 17.5%).

The educational level of most married women is Mphill 68(34.0%), MSC 57(28.5%), BS 48(24.0%) and PhD 27(13.5%). Women from middle socio-economic status 84(42.0%) were particularly higher in number then the upper 62(31.5%) and lower ones 53 (26.5%). 151 (75.5%) married women were married by their parent's choice and 49 (24.5%) did love marriage. Data also indicates that 53(29.0%) women had only child, 93(46.5%) have 2-3, 49 (24.5%) had 4-5 number of children.

Table 1. Percentage and frequency distribution of demographics (n=200).

Variables	*f*	%
Work status		
Working married women	100	50
Home bound married women	100	50
Age		
18-23	47	23.5
24-29	65	32.5
30-34	53	26.5
35-40	35	17.5
Educational level		
BS	48	24.0
MSC	57	28.5
MPHILL	68	34.0
PhD	27	13.5
Socio economic status		
Lower class	53	26.5
Middle class	84	42.0
Upper class	63	31.5
Marriage type		
Arrange	151	75.5
Love	49	24.5
N. of children		
Only child	58	29.0
2-3	93	46.5
4-5	49	24.5

Linear regression and *t*-test analysis (Tables 2 & 3) was computed to obtain study results. Sexual coercion was found to be positively associated with psychological distress and somatic symptoms among married women ($p<.001$, $r=.53$). Table 2 shows results of Linear Regression analysis of predictor sexual coercion to outcome psychological distress. Sexual coercion significantly and positively predicted Psychological distress among married women ($\beta=.73$, $p<0.001$). The R^2 value shows that the predictor i.e. sexual coercion, explained 53% of the variance in psychological distress (F (1,198)=226.74, $p<.001$).

Table 4 shows that sexual coercion as a predictor variable, positively contributed in somatic symptoms of married women ($\beta=.59$, $p<0.001$, $r=.35$). The R^2 value shows that the predictor i.e. sexual coercion, explained 35% of the variance in outcome i.e. somatic symptoms (F (1,198)=109.12, $p<.001$).

Table 4 shows that, working women experience less sexual coercion (M=62.49, SD=13.57) than home bound married women (M=84.12, SD=27.19). Home bound married women encounter more psychological distress (M=76.16, SD=26.30) than working married women (M=60.98, SD=10.88) ($p<.001$). Working married women have low somatic symptoms (M=4.88, SD=1.59) than home bound married women (M=6.58, SD=3.21) ($p<.001$).

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Table 2. Linear regression analysis indicating sexual coercion as the predictor of psychological distress and sexual coercion predicting somatic symptoms.

	Outcome (*Psychological distress*)						
						95% CI	
Predictor (*s*)	*B*	*SEB*		*t*	*P*	*UL*	*LL*
Constant	20.69	3.34		6.18	.000	14.09	27.28
Sexual coercion	.65	.043	.73	15.05	.000	0.56	0.73
R=.73; R^2=.53							
	Outcome (*Somatic symptoms*)						
Constant	.879	.489		1.799	.074	-.085	1.842
Sexual coercion	.066	.006	.596	10.446	.000	.054	.079
R=.60; R^2=.35							

Table 3. Means, standard deviations, and t values for sexual coercion, psychological distress and somatic symptoms among married working and home bound women.

Variables	Working women (n=100, M±SD)	Home Bound women (n=100, M±SD)	t(198)	p	Cohen's d
Sexual coercion	62.49±13.57	84.12±27.19	7.17	.001	1.00
Psychological distress	60.98±10.88	76.16±26.30	5.33	.001	.75
Somatic symptoms	4.88±1.59	6.58±3.21	4.74	.001	.67

Table 4. Moderating Role of working status of women in Relationship between Sexual Coercion and psychological distress (n=220).

					95%CI	
	B	*SEB*	*t*	*p*	*LL*	*UL*
Constant	-2.68	-.22	0.81		-25.77	20.39
Sexual coercion	1.01	6.70	0.15	.000	0.71	1.31
Working status of women	19.67	8.34	2.35	.010	3.22	36.13
Sexual coercion * Working status of women	-0.31	0.12	-2.61	.009	-.55	-.07

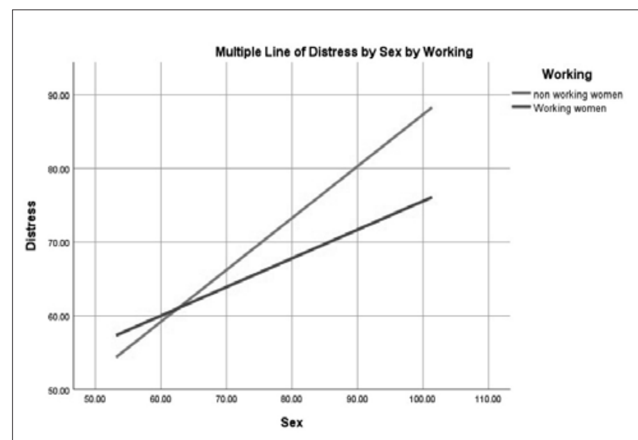

Figure 1. Mode graph indicating working status of a women moderating the relationship betweenperceived sexual coercion and psychological distress among married women.

Moderation analysis

We also tested whether working status of a women moderates the relationship between their perceived sexual coercion and a psychological distress (Figure 1).

Main effect of Sexual Coercion (X=predictor). Sexual coercion is a significant positive predictor of psychological distress β=1.01, *t*= 0.15, p<.001, 95% BCaCI [0.71, 1.31].

Main effect of the moderator (M=Moderator). Results indicate that working status of a women significantly predicts psychological distress β=19.67, *t*=2.35, p<.05, 95% BCaCI [3.22, 36.13].

Interaction effect. There is a significant interaction between perceived sexual coercion and working status of women in predicting psychological distress β=-.31, *t*=-2.61, p<.01, 95%BCa CI [-.14, -.01].This indicates that relationship between self-efficacy and quality of life is conditional upon resilience.

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Slope analysis of moderation

Results of slope analysis indicates among non-working women a stronger significant positive relationship between perceived sexual coercion and psychological distress $\beta=.70$, $t=13.11$, $p<.001$, 95% BCaCI [.59, .80], whereas among working women the similar relation is albeit significant, however not as strong as it is evident among non-working women $\beta=.39$, $t=3.62$, $p<.001$, 95% BCaCI [0.17, 0.60]. Therefore, we can conclude that working status of a women significantly moderates the relationship between perceived sexual coercion and psychological. Following mod-graph visually demonstrates this moderating role of working status of a women and its impact upon their perceived sexual coercion and psychological distress.

DISCUSSION

This study findings are in line with the previous studies indicating that sexual coercion as perceived by women is one of the most significant contributing factors into their mental distress and related somatic symptoms. According to the Pakistani perspective, incidence of coercive behaviour between intimate partners was reported to be in the range of 30% to 79%[22]. Three fifth of married women in Pakistan, as reported, experienced coercion by their husbands. This percentage is higher than that of other countries like Australian women (21%), American (20%-46%), Ethiopian (46%) and Bangladeshi (46%)[7]. However, it is not clear whether poorer psychological health among married women is linked to a particular incident of sexual coercion. Thus, this research aimed to inquire about the association between sexual coercion with psychological distress and somatic symptoms among married women.

Sexual coercion is a relatively less explored and less researched topic in Pakistan in comparison to Western countries. Recent studies on an issue as sensitive as sexual coercion shows that although it is under-reporting, the coercion phenomenon is greatly and positively linked to psychological distress with a large variance of 53% among married women. In consistence with prior research, women who experience sexual coercion multiple times are more prone to have elevated mental distress[23]. Furthermore, the likelihood of mental distress was found to be directly related to an increased number of coercive episodes[11].

There is an alarming increment in the number of incidences of mental health problems such as somatic symptoms as a result of persistent wave of intimate sexual coercion. A display of present study indicates a significant and positive relationship between sexual coercion and somatic symptoms and shows that as a predictor variable, sexual coercion explained a variance of 35% among married women. Previous studies revealed that women experiencing sexual coercion are at a greater risk to suffer from somatic symptoms[24,25]. Another study investigated the correlation of sexual coercion with mental health issues and concluded that sexual coercion was associated with depression, hostility, anxiety, dissociation, somatic symptoms and PTSD[5]. This study compliments the previous research by showing that a single episode of sexual coercion has negative impact on the psychological health of a married women.

Moreover, in the present study we also found certain differences between perception of sexual coercion between married women and home bound women. In the present study, it was discovered that home bound married women suffer more from this issue as compared to working married women. Consistent with the previous literature, present research reveals that psychological distress[28] and somatic symptoms[29] are more prevalent in home bound rather than working women. Extensive research on study findings revealed that home bound women are prone to report more sexual coercion or assault from their husbands than working married women[26,27]. Various factors seem to have contributed into differences on perception of sexual coercion among these groups of women, such as working women may experience it less severely in comparison to their home bound counterparts due to a better educational status, employment opportunities, better social and communication platforms, financial independence. Moreover, working women appear to be further self-reliant. Whereas home bound women are more vulnerable to experience rigid culture, submissiveness towards husbands, lack of choice and preferences and joint system of families[16,17]. They are competent enough to function separately without reliance on their husbands. Working married women possess a higher degree of self-differentiation indicating that during episodes of conflict, threat, assault, terror, criticism or rejection, the individual can make sound judgment and discriminate from beliefs the facts that may be clouded with emotions. Hence they are less likely to suffer from sexual coercion[27].

In Pakistan, during the last few decades inflation in the employment of women at workplaces has occurred, especially in urban areas. A parallel change in the Pakistan's culture, in regards to the role and expectations of women, is taking place as more and more women are entering into the work force. However, a working married woman may face difficulties in attempting to fulfil the demands of both the workplace and home. Meanwhile, a house bound married woman may feel psychological distress and somatic symptoms more due to her household chores and financial dependence. It seems that both groups of women strive for a higher level of satisfaction while they try coping up with everyday hassles and interpersonal conflicts[27].

Moreover, home bound women exhibit psychological distress and somatic symptoms because of the amount of mental pressure regarding the brought up of children, maintenance of pleasant relationship with the in-laws and their relatives and, above all, having good compatibility with the husband. In so far as mental health is concerned, these were some of the factors and it is apparent from the outcome that home bound married women suffer more as compared to working married woman[30].

Although, women across the world face challenges however as Pakistan's society is a strict normative society still underway in the process to accept women's rights, and the challenges posed to Pakistan's women are more distinct. Being employed, working women receive extra consideration and support from the family members because of their financial status. As a result of enhanced opportunities of social interactions, mental health issues which these women experienced are found as low as compared to home bound women. Additionally, since majority of the research on sexual coercion and its association with psychological distress and so-

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matic symptoms originate from developed countries, it can be argued that the greater recognition of, and research about, the problem of sexual coercion mirrors the developing freedom afforded to women. Therefore, in settings where women rights are less accepted, one might expect both a higher prevalence of sexual coercion and its association with mental health issues *and* less attention devoted to the research of the problem. Thus, the current study addressed the limitations mentioned in the literature by utilizing a cross sectional design to examine the associations of sexual coercion with mental health issues like psychological distress and somatic symptoms.

Limitations

Despite the cultural taboo of sexual coercion experienced by women the study highlights, this study does have its limitations. Though, the study reported sexual coercion as a predictor of psychological distress and somatic symptoms, it is also plausible that some other psychological issues emerge as a result of sexual coercion. Although we included a limited number of responses for this study, future studies should strive to aim for a higher sample size from all over the Pakistan to achieve a broad aspect to this phenomenon. Moreover, certain psychological therapies should be implemented to ameliorate the major aspects of this issue. Proper education of women before marriage and individual/marital counseling could add as a moderator and tackle these issues before they take root.

CONCLUSIONS

The issue of sexual coercion is soaring globally. Due to the sensitivity of the subject matter in Pakistan, it is an under reported issue. However, many women having experienced sexual coercion are still living with its consequences. Women who have encountered sexual coercion suffer from poor psychological health. Additionally, husbands are more likely to behave coercively with home bound married women to acquire or retain an impersonal sense of control and power. Therefore, work will positively contribute to the mental health of working women with the help of a working status. The identification of sexual coercion by intimate partners is a major obstacle that needs to be reinforced through educational and health awareness programs, for the control and prevention of sexual coercion or assault. Moreover, comprehensive laws and legislations need to be developed, implemented and strengthened. Further extensive research work on this issue is also required by mental health professionals.

Conflitto di interessi: gli autori dichiarano l'assenza di conflitto di interessi.

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