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Researching Sexual Abuse in Societies in Which Sexuality Is Regarded as Taboo: Difficulties and Proposed Solutions

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1. Introduction

Sexual violence is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work (1). In many countries a substantial proportion of women experiencing physical violence also experience sexual abuse. The term intimate partner abuse refers to the physical, sexual, and/or psychological abuse of an individual perpetrated by a current or former intimate partner. While this term is gender-neutral, women are more likely to experience physical injuries and incur psychological consequences of intimate partner abuse (2).

Sexual abuse of women is commonly recognized as an important public health problem because of its attendant morbidity, mortality, and long-term impact on women's health (3-8).

2. Social and women associated characteristics

The features of societies determine women's responsibilities within those societies and represent the key to attitudes toward them. For example, the image of the child as representing the future of the community developed very early in Turkish society. Understanding of and sympathy towards motherhood and children are therefore among the factors that shaped Turkish traditions and customs (9). The elevated position ascribed to motherhood is even more apparent in the saying "*Paradise lies under [one's] mothers' feet.*" However, there are other perspectives that also judge a woman's position in society. For instance, the traditional Turkish saying "you must always keep a rod to a woman's back and a child in her belly" expresses a way of thinking that regards physical or sexual abuse of women as something quite natural.

Ninety-nine percent of the population of Turkey is Muslim. Islam recognizes that both men and women have sexual drives and rights to sexual fulfillment and affirms heterosexual relations within marriage and lawful relationships. But explicit discussion of sexuality is

taboo in Turkey (10). Severe restrictions are imposed on sexuality under Islam, however. It is sometimes believed that if unsatisfied or uncontrolled, female sexuality might lead to social chaos (*fitna*), and that social order thus necessitates male control of women's bodies (9). Extramarital relations are forbidden in Islam. The woman has a duty to meet the sexual needs of the man to whom she is married. Although monogamy is common in Turkey in the strictly legal sense, the fact that society regards it as normal for a man to have extramarital relations outside religious laws, and that it is the man's wishes that play the determining role in the quantity, time, quality and form of sexual relations in marriage, makes the perception of the concept of sexual abuse difficult, for which reason it becomes a supposedly natural state of affairs for a woman to be exposed to sexual abuse.

The concept of approach to risk in terms of public health entails the principle of some service provision for all, but more for those at risk. In that light, all women may be at risk of sexual abuse, but some are at greater risk than others. These factors increase women's vulnerability. One of the most common forms of sexual violence around the world is that which is perpetrated by an intimate partner, suggesting that one of the most important risk factors for women - in terms of vulnerability to sexual assault - is being married or cohabiting with a partner. Other factors influencing the risk of sexual violence include:

- being young,
- consuming alcohol or drugs,
- having previously being raped or sexually abused,
- having many sexual partners,
- involvement in the sex trade,
- becoming more educated or economically empowered, at least where sexual violence perpetrated by an intimate partner is concerned and
- poverty.

Identification of women meeting these criteria will constitute the main objective for both research and for solving the problem.

3. Sources of data

The main sources of data for sexual abuse are police records, medical records, nongovernmental organization activities and survey research. The relationship between these sources and the global magnitude of the problem of sexual violence may be compared to an iceberg floating in water (11). The small visible tip represents cases reported to the police. A large part may be elucidated through survey research and the work of nongovernmental organizations. But beneath the surface remains a substantial although unquantified component of the problem.

Generally, sexual abuse has been a neglected area of research. The available data are scanty and fragmented. For example, police data are often incomplete and limited. Many women do not report sexual violence to the police because of shame, or from a fear of being blamed, not believed or otherwise mistreated. Data from medicolegal clinics may be biased towards the more violent incidents of sexual abuse. The proportion of women who seek medical services for immediate problems associated with sexual violence is also relatively small (1).

In addition to research aimed at determining the scale of the phenomenon in different societies, studies by nongovernmental organizations represent a further source of information. There is no screening program for abuse or violence towards women in Turkey. All that exists are the refuges or shelters known as "Purple Roofs," intended for women, or men, who seek their help and which provide judicial, social and psychological support for women exposed to violence.

4. Characteristics of existing studies

This section is intended to elicit conclusions by examining research on sexual abuse in terms of

- Method
- Aim and
- Study groups.

In terms of methodology, existing studies are mainly cross-sectional surveys based on an observational approach, while there may be a few case studies performed from patient presentations and fewer still of the quantitative focus group and in-depth interview type.

A simple description of the health status of a community, based on routinely available data or on data obtained in special surveys, is often the first step in an epidemiological investigation. In many countries this type of study is undertaken by a national centre for health statistics. Pure descriptive studies make no attempt to analyze the links between exposure and effect. They are usually based on mortality statistics and may examine patterns of death by age, sex or ethnicity during specified time periods or in various countries.

Cross-sectional studies measure the prevalence of disease and thus are often called prevalence studies. In a cross-sectional study the measurements of exposure and effect are made at the same time. It is not easy to assess the reasons for associations shown in cross-sectional studies. The key question to be asked is whether the exposure precedes or follows the effect. If the exposure data are known to represent exposure before any effect occurred, the data from a cross-sectional study can be treated like data generated from a cohort study.

Cross-sectional studies are relatively easy and inexpensive to conduct and are useful for investigating exposures that are fixed characteristics of individuals, such as ethnicity or blood group. In sudden outbreaks of disease, a cross-sectional study to measure several exposures can be the most convenient first step in investigating the cause.

Data from cross-sectional studies are helpful in assessing the health care needs of populations. Data from repeated cross-sectional surveys using independent random samples with standardized definitions and survey methods provide useful indications of trends. Each survey should have a clear purpose. Valid surveys need well-designed questionnaires, an appropriate sample of sufficient size, and a good response rate. Cross sectional studies are generally conducted "door to door" or "face to face" following appropriate sampling. The numerical data obtained are presented as prevalence and percentages.

Many countries conduct regular cross-sectional surveys on representative samples of their populations, focusing on personal and demographic characteristics, illnesses and health-related habits. Frequency of disease and risk factors can then be examined in relation to age, sex and ethnicity. Cross-sectional studies of risk factors for chronic diseases have been performed in a wide range of countries (12).

In these observational-type studies a “memory factor” problem, such as recalling or confusing past events, may arise when eliciting information from the interviewee. The memory factor does not represent a very significant drawback in terms of subject characteristics. But the characteristics of the person conducting the interview may affect study participation. The character of the interviewer is important in terms of subject confidentiality. Women may decline to participate in a study, for reasons such as the involvement of matters too private to be shared with someone encountered for the first time for the purpose of questionnaire administration or fear of her partner or partner’s family, and this is important in terms of sources of error in observational-type studies.

One limitation of such studies is that only a small number of communities can be included, and random allocation of communities is usually not practicable; other methods are required to ensure that any differences found at the end of the study can be attributed to the intervention rather than to inherent differences between communities. Furthermore, it is difficult to isolate the communities where intervention is taking place from general social changes that may be occurring. Design limitations, especially in the face of unexpectedly large, favorable risk factor changes in control sites, are difficult to overcome. As a result, definitive conclusions about the overall effectiveness of community-wide efforts are not always possible.

Random and systematic errors are significant sources of error in epidemiological studies. There are three major sources of random error; individual biological variation, sampling error and measurement error. Systematic error (bias) comprises selection bias and measurement (or classification) bias. Selection bias occurs when there is a systematic difference between the characteristics of the people selected for a study and the characteristics of those who are not. Sample size and participation or refusal to take part represent a risk in terms of sources of error in studies of sexual abuse. While errors regarding sample size apply to all studies, an unwillingness to speak out because of the subject matter involved may hinder participation, and this may represent a more significant source of error.

Although there have been considerable advances over the past decade in measuring the phenomenon through survey research, the definition used have varied considerably across studies. There are also significant differences across cultures in the willingness to disclose sexual violence to researchers. Caution is therefore needed when making global comparisons of the prevalence of sexual violence (1).

With multi-factorial topics, the inability to control elements other than the factor investigated represents a significant limitation of cross-sectional studies. Because of the subject matter it is important for attention to be paid to this in cross-sectional surveys.

The number of studies regarding domestic violence and physical and sexual abuse is also limited. One of the main reasons for this is women’s family loyalty and the fact that they ignore the physical and sexual abuse they suffer, a reluctance to apply to any legal or health

institution, which stems from regarding such abuse as normal or at least putting up with it, and, in particular, the idea that even if they were to resort to such measures, abuse within the family is a purely domestic issue. This contradictory situation stems from changes in the nature of relations between men and women in Turkey in historical and social terms. However, its ancestral nature is particular to the Turks, and manifests deep psychological roots that need to be considered when evaluating Turkish group behavior (10).

Evaluated in terms of aims, existing research consists predominantly of prevalence studies aimed at determining the current situation. Studies provide analyses aimed at the scale of the subject representing narrow fields with small or large sample sizes. This approach is important as it will guide the subsequent cause, effect and intervention phases. Fewer case studies and qualitative studies are intended to provide information about causes.

In terms of study groups, cross-sectional survey studies are performed with married or pregnant women or with physicians. Participation levels for all groups constitute a significant problem. As explained above, this represents one of the sources of error in epidemiological studies. Eliciting information and discussing unmarried women's sex lives may be a problem, especially in societies in which sexuality is a taboo subject.

A participation level of 69% was reported in one cross-sectional study on the subject of sexual abuse with a study group made up of physicians. Physicians have also been shown to face severe problems in identifying relevant situations. Major barriers to physician identification of intimate partner abuse and referral of patients include patient-related barriers such as fear of retaliation, lack of disclosure, fear of police involvement and lack of follow up, mutual barriers such as cultural differences, lack of privacy and language differences, and provider-related barriers such as lack of training, lack of time, lack of resources/referrals and a sense of inefficacy (2).

When the study group is made up of physicians, the specialization of the group involved may also have an effect. Primary care physicians, internal disease specialists and obstetricians may produce different situation analyses. Obstetricians generally have a greater predisposition toward the subject, or may identify more cases. Generally speaking, primary care physicians tend not to add asking patients about sexual abuse to their routine procedures. Failure to identify patients at this stage represents a major missed opportunity. Standardization of protocols to be drawn up and procedures, as well as physician training, will increase interest and support on the subject (13,14).

5. Recommended solutions

Scientists with an interest in the subject in Turkey are aware that women are subjected to sexual abuse, but they face very great difficulties in conducting research intended to reveal the true position. The problems we envisaged prior to one study in which we investigated whether or not pregnancy had any effect on physical and sexual abuse, and the problems that arose during that research, are listed below. Our recommendations for Turkey and countries/societies resembling it in religious and social terms are also discussed:

1. Turkish society and Turkish women are unaware of and unable to fully comprehend the concept of sexual abuse. For that reason, awareness should be established before such studies, particularly using written and visual media, and research performed only afterward.

2. We observed in our research that even when women were forced to engage in sexual relations, or did so against their will, they put up with the situation, making no protest against it. Underlying this is the role of “satisfying the husband” that society imposes on women. However, this attitude changes as levels of education rise. This perspective declines if the woman is educated, is in paid employment and enjoys high status. Stratification should therefore be performed according to women’s status when research is performed.
3. It is very difficult to perform screening / cross sectional studies / society-based research on the subject of sexual abuse. It is just about impossible to ask individuals or families identified for sampling in cross-sectional, cohort or descriptive studies questions about sexual abuse. In order to obtain more significant results from cross-sectional studies, given the difficulty in asking questions by way of questionnaires, research could be conducted on the basis of meetings with physicians at hospitals and clinics to which individuals apply and receive health services for any reason, with the security provided by the patient-doctor relationship.
4. Because of the difficulties involved in conducting descriptive, cross-sectional and cohort studies, it might be of greater benefit to perform quantitative research, such as focus group encounters, to reveal women’s exposure to sexual abuse.
5. People who participate as project directors or interviewers in future research into such a sensitive subject must instill a sense of security in those taking part. The study team, and particularly those who will be involved in speaking to women, must be very well trained. That training must stress verbal communication, body language and general communication.
6. It is just about impossible to investigate extramarital sexual relations. For that reason, in planning research the study population should consist of women of reproductive age, 15-49, and married women only should be used, if possible.
7. It is effectively impossible in societies such as Turkey to ask about even a married woman’s relations with different partners. The scale and nature of abuse in these relationships cannot therefore be established.
8. In Turkey, a woman’s most important role in marriage is child-bearing. There is a strong preference for the child to be born to be male. Exposure to sexual abuse is therefore generally hidden because of that pressure. For that reason, questions should be asked investigating men and women’s birth preferences and the results analyzed.
9. Sexual abuse is generally correlated with exposure to physical violence and emotional stress. Questions regarding physical and emotional abuse should therefore be asked before turning to sexual abuse. A second interview within the scope of the research should even be conducted if necessary because of the likelihood of sexual abuse in those responding positively to questions about those other forms of abuse.
10. It may be difficult to perform descriptive and/or cross-sectional studies in order to establish the nature, frequency and nature of and figures for sexual abuse. Studies should therefore be planned on the basis of more than one interview. This may help the woman taking part establish confidence in the study team and make it easier for her to provide more information about herself.
11. The person to conduct the interview coming from the local area may be either a positive or a negative factor. It may be positive in assisting women to establish a sense of trust, but negative in that women may be reluctant to share their secrets with a local.

12. Men should also perform studies. This will help educate men on an individual basis and also assist debate among men when the subject is raised, as well as establishing sensitivity/awareness.
13. Interview / questionnaire/data forms used must not be too long. Initial interview/scanning forms in particular must not be highly detailed for quantitative studies.

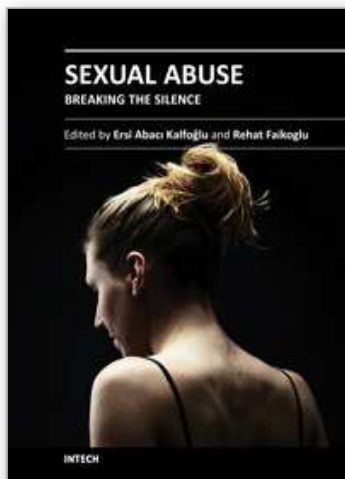
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Sexual assault can be considered as expression of aggression through sex. This, in turn, can have serious negative effects on a survivor's social and occupational functioning. This book has been organized towards that specific approach, by compiling the scientific work of very well-known scientists from all over the world. The psychological victimization of sexual assault, the physiological aspect of sexual abuse and the different attitudes in coping with sexual assault based on different cultural backgrounds are analyzed. Having in mind that one solution may not necessarily be suitable for all cases, we hope that this book will open a debate on sexual assault for future practice and policy and that it will be a step forward to 'break the silence'.

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