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A Clinical Psychological Study on Marital Discord, Sexual Dissatisfaction, and Mental Health Status Among Women Attending the Quazi Court of Udapalatha Jurisdiction, Kandy

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ABSTRACT

Marital discord and legal disputes significantly impact women's mental well-being. This study investigated the relationship between marital dissatisfaction, female sexual dysfunction, and overall mental health status among Muslim women attending the Udapalatha Quazi Court in Kandy, Sri Lanka. A quantitative cross-sectional design was utilized with a purposive sample of 100 married women (N = 100). Standardized psychometric tools were employed: the Kansas Marital Satisfaction Scale (KMSS), Female Sexual Function Index (FSFI), Depression Anxiety Stress Scales (DASS-21), and General Health Questionnaire (GHQ-12). Ethical approval and institutional authorization were formally obtained (Ref: QC/UDP/RES/01). Written informed consent and strict confidentiality were maintained throughout the study. Statistical analysis using SPSS revealed that 87% of participants experienced severe marital dissatisfaction. Pearson correlation showed significant positive associations between marital discord and clinical distress across depression, anxiety, and stress ($p < .001$). Furthermore, lower sexual functioning (FSFI) significantly correlated with poorer general mental health ($p < .01$). Multiple regression analysis confirmed that marital dissatisfaction and sexual dysfunction are strong predictors of mental health decline. These empirical findings highlight an urgent need to integrate professional clinical psychological services, mandatory pre-legal marital counseling, and structured psycho-social support mechanisms within the Quazi court system to protect and improve women's mental health.

1. Introduction

1.1 Background of the Study

Marriage is a foundational social institution that extends far beyond a mere legal or social contract. It directly impacts an individual's emotional stability, life satisfaction, and overall mental health. From a clinical psychology perspective, a harmonious marital relationship provides the foundation for optimal psychological well-being. Conversely, marital discord, emotional alienation, and relationship breakdown trigger complex biopsychosocial distress that reverberates across every dimension of a person's life [3, 4, 9].

According to the Biopsychosocial Model proposed by George Engel (1977), human health and illness are not determined solely by isolated biological factors. Instead, they stem from continuous, complex interactions between biological, psychological, and social dimensions [3, 4]. This conceptual framework is particularly essential for evaluating marital dynamics and psychosexual health [3, 17]. Emotional disharmony or sexual dissatisfaction within a marriage does not remain confined to the psychological realm. Through hormonal and neuroendocrine shifts, persistent negative emotions alter physical well-being and deteriorate broader social functioning [3, 6]. When marital satisfaction erodes, the resulting chronic negative emotions frequently escalate into long-term psychological stress [5, 9, 18].

In Sri Lanka, the marital and divorce matters of the Muslim community are primarily governed by the Muslim Marriage and Divorce Act (MMDA) No. 13 of 1951 and its associated Quazi court system [15]. Every day, a significant number of women seek recourse through these courts for maintenance claims, family disputes, and divorce proceedings such as Fasah (judicial divorce) or Talaq [15]. Through a clinical lens, it becomes evident that beneath the surface-level financial or domestic grievances presented in court lie unaddressed emotional, psychological, and psychosexual incompatibilities [3, 9, 17].

However, within the local socio-cultural and religious context, human sexuality and psychosexual concerns remain deeply entrenched taboo subjects. Consequently, women experiencing sexual dissatisfaction, physical discomfort, pain during intercourse, or emotional neglect within their marriage face intense shame, fear, and stigma [3, 17]. These social pressures hinder them from disclosing these sensitive experiences to family members, friends, or legal authorities during judicial proceedings. As a result, these women undergo an internalization of psychosexual distress, trapping their emotional pain within themselves [19].

Clinical psychological principles and empirical evidence demonstrate that long-term suppression of interpersonal and psychosexual conflicts leads to severe psychological breakdown [5, 9, 19]. Over time, this covert distress manifests as heightened stress, depression, anxiety, and somatic symptoms [2, 8, 12, 14]. As articulated by Somatization Theory, when individuals cannot verbally express or process their emotional and psychosexual suffering, the body converts this psychological pressure into physical distress expressed through various somatic complaints [2, 8].

In these cases of somatization, no organic or structural pathology can be identified despite repeated medical examinations [2]. Nevertheless, the underlying psychological distress produces tangible physical suffering, including chronic headaches, chest tightness, gastric discomfort, persistent fatigue, generalized bodily burning sensations, and severe insomnia [2, 8, 14]. Consequently, these somatic manifestations severely impair the women's daily functioning, family life, occupational performance, and capacity for childcare [8, 14]. Because many of these women lack awareness that their physical ailments stem from psychological distress, they engage in frequent doctor-shopping, undergoing redundant medical tests and treatments. Because the root cause unresolved marital and sexual dissatisfaction remains unaddressed, they become trapped in a continuous cycle of physical and mental distress [5, 19].

Current Quazi court proceedings focus almost exclusively on legal, financial, and socio-economic matters, such as maintenance claims, property division, and formal legal separation [15]. The existing judicial framework lacks established mechanisms to identify, assess, or offer clinical interventions for the underlying psychosexual crises, psychological distress, and somatic symptoms experienced by female litigants [8, 15, 17]. Therefore, empirically evaluating the psychosexual and somatic health of these women—and establishing the urgent need for clinical marital counseling services within the court premises represents both a timely academic contribution and a pressing clinical imperative [7, 13, 16].

1.2. Problem Statement

Women appealing to Quazi courts in Sri Lanka rarely do so as a result of an isolated incident. Rather, legal action is typically the culmination of prolonged emotional and psychological distress [5, 9, 15, 19]. Clinically, beneath the formal legal arguments presented in court lies hidden psychosexual disharmony and deep-seated psychological suffering [3, 9, 17].

This research problem can be analyzed across three main dimensions.

Socio Cultural Taboos and Stigma: Due to pervasive religious and cultural boundaries, open discussions regarding female sexual health and marital dissatisfaction remain heavily stigmatized [3, 17, 20]. Consequently, women suppress their

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psychosexual dysfunction and reframe their court claims around acceptable socio-economic issues, such as financial maintenance or general domestic disputes [15, 17, 19].

Institutional and Legal Limitations: The administrative setup of the Quazi court system focuses primarily on legal resolution and financial settlements [15]. It lacks integrated clinical mechanisms to assess mental health conditions (depression, anxiety, stress) or somatic symptoms, leaving litigants without professional psychological support [2, 8, 12, 14, 15].

Empirical Research Gap: While existing Sri Lankan literature explores the MMDA and Muslim women's rights from legal and sociological viewpoints, there is a distinct lack of empirical research examining the interrelationships between marital satisfaction, psychosexual functioning, emotional distress, and somatic symptoms using standardized clinical scales within this population [8, 12, 14, 15, 17, 18].

This study addresses these clinical and academic gaps by scientifically documenting the hidden mental and sexual health challenges faced by female litigants in the Quazi court of Udapalatha, Kandy [8, 12, 14, 15, 17, 18].

1.3. Research Questions

1. What is the level of marital dissatisfaction among female litigants attending the Quazi Court in Udapalatha, Kandy, as measured by the Kansas Marital Satisfaction Scale (KMS)?
2. What is the nature and severity of psychosexual dysfunction and dissatisfaction among these women, as measured by the Female Sexual Function Index (FSFI)?
3. What are the levels of psychological distress (depression, anxiety, stress via DASS-21) and somatic symptoms (via PHQ-15) reported by this population?
4. What are the direct correlations and predictive relationships between marital dissatisfaction, psychosexual dysfunction, psychological distress, and somatic symptom severity?

1.4 Research Objectives

1.4.1 Primary Objective

To empirically evaluate the relationship between marital dissatisfaction, psychosexual dysfunction, psychological distress, and somatic symptoms among female litigants attending the Regional Quazi Court in Udapalatha, Kandy, Sri Lanka.

1.4.2 Secondary Objectives

- To assess the extent of marital satisfaction using the Kansas Marital Satisfaction Scale (KMS).
- To evaluate psychosexual functioning including desire, arousal, pain, and overall satisfaction using the Female Sexual Function Index (FSFI).
- To measure levels of depression, anxiety, and stress using the DASS-21 scale, and determine the severity of somatic symptoms using the Patient Health Questionnaire (PHQ-15).
- To determine the extent to which marital dissatisfaction and psychosexual dysfunction predict psychological distress and somatic symptoms using regression analysis.
- To provide evidence-based recommendations for establishing dedicated Clinical Counseling Desks within the Quazi court structure.

1.5 Significance of the Study

- Academic Significance: This study represents a pioneering empirical investigation into the relationship between psychosexual dysfunction, somatization, and emotional well-being among female litigants in the Sri Lankan Quazi court system, addressing a major literature gap in local clinical psychology.
- Clinical and Counseling Significance: By validating the clinical impact of suppressed psychosexual distress on physical and mental health, this study provides actionable evidence for clinical psychologists and marital therapists to design targeted culturally sensitive interventions and couple therapies.
- Policy and Social Significance: The findings offer evidence-based recommendations for judicial authorities and policymakers to integrate Clinical Counseling Desks and pre-marital guidance programs within the court framework.

1.6 Operational Definitions

- Marital Dissatisfaction: The degree of discontent an individual experiences regarding their marital life, emotional intimacy, and spousal relationship, operationally measured by total scores on the Kansas Marital Satisfaction Scale (KMS).
- Female Psychosexual Dysfunction: Persistent difficulties related to sexual desire, arousal, lubrication, orgasm, pain during intercourse, and overall sexual dissatisfaction, operationally assessed using the Female Sexual Function Index (FSFI).
- Psychological Distress: Emotional instability characterized by varying levels of depression, anxiety,

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and stress, quantitatively evaluated using the Depression Anxiety Stress Scale (DASS-21).

- Somatic Symptoms: Physical symptoms (e.g., chronic headaches, chest discomfort, gastric issues, insomnia, fatigue) that lack an organic pathology and arise from internalized emotional and psychosexual distress, measured using the Patient Health Questionnaire (PHQ-15).

2. Literature Review

2.1. Introduction to Literature Review

The accuracy and scientific validity of clinical psychological research depend fundamentally on the depth and rigour with which theoretical frameworks, conceptual definitions, and empirical evidence are systematically reviewed [3, 4, 5, 8, 12, 14, 18]. Marriage, psychosexual functioning, emotional well-being, and physical health represent interconnected biopsychosocial phenomena that cannot be examined in isolation [3, 4, 6, 9]. From a clinical perspective, marital relationship quality and psychosexual satisfaction act as critical determinants of individual mental health, emotional equilibrium, and overall life satisfaction [3, 4, 9, 17, 18].

This chapter synthesizes existing scientific literature to elucidate the direct and indirect relationships between marital dissatisfaction, psychosexual dysfunction, psychological distress, and somatization among Muslim female litigants navigating the Quazi court system in Sri Lanka [2, 3, 8, 12, 14, 15, 17, 18]. While traditional legal paradigms view marital dissolution primarily as a contractual breach, maintenance dispute, or interpersonal behavioral conflict [15], clinical psychology investigates the underlying unresolved emotional turbulence, psychosexual crises, and neurobiological breakdowns [2, 3, 5, 6, 9, 17, 19].

2.1.1 Clinical Background of Marital Relations, Psychosexual Well-Being, and Mental Health

Clinical literature demonstrates an inseparable link between marital relationship quality and psychological stability [3, 4, 5, 8, 9, 18]. Marriage serves as a fundamental framework for attachment security, self-esteem, identity, and subjective well-being [3, 9, 13]. A harmonious marital union generates positive affect and functions as a psychological buffer against external life stressors [3, 9, 18].

Conversely, marital conflict, emotional distance, and sexual disharmony exert acute psychological trauma on cognitive, affective, and behavioral functioning [3, 5, 9, 10, 19]. For women, chronic marital distress increases the risk of emotional dysregulation, identity disruption, and major depressive disorders [2, 5, 6, 8, 12, 14]. Healthy psychosexual functioning is a core determinant of marital quality; intimate sexual contact is a primary medium for emotional intimacy and mutual trust [3, 4, 17]. When psychosexual connection deteriorates, accumulating resentment and frustration undermine the broader marital framework [3, 4, 9, 17].

2.1.2 Female Identity and Sexuality in the South Asian and Sri Lankan Cultural Context

In Sri Lanka and the broader South Asian context, female marital and sexual identity is heavily bounded by socio-cultural, religious, and patriarchal norms [3, 15, 20]. Eastern traditions position women as guardians of family honor, prescribing self-sacrifice and emotional suppression as marital virtues [15, 20].

- Culture of Silence: Traditional norms discourage women from disclosing marital discord or psychosexual distress, framing open discussions as threats to family dignity [3, 15, 17].
- Socio-Religious Taboos: Female sexual desire and pleasure are heavily stigmatized [3, 17]. Sexual intercourse is frequently framed strictly as a marital duty for procreation and male satisfaction [3, 4, 17, 20].
- Suppression of Sexual Pain: Conditions like dyspareunia and vaginismus are often kept secret due to shame and fear of being perceived as physically inadequate [3, 17].
- Internalization of Psychosexual Distress: Deprived of outlets for expression, women internalize their distress, eroding self-esteem and psychological resilience over time [5, 17, 19].

2.1.3 The Quazi Court System, Legal Proceedings, and Psychological Crises

In Sri Lanka, Muslim family law is governed by the Muslim Marriage and Divorce Act (MMDA) No. 13 of 1951 and the Quazi court system [15, 18]. Female litigants face structural and cultural hurdles, including the absence of legal representation and an all-male judicial bench [15, 20]. Disclosing private psychosexual grievances to male Quazi judges presents a severe psychological barrier [3, 15, 17, 20].

Female litigants seeking judicial divorce (Fasah) or maintenance rarely do so due to isolated incidents; legal recourse is usually the culmination of years of covert psychosexual incompatibility, emotional neglect, and domestic abuse [5, 9, 15, 19]. Surface legal claims (e.g., non-maintenance) obscure core psychological drivers [15, 17, 19]. Protracted trials, financial insecurity, and social stigma induce secondary traumatization [2, 8, 12, 14, 15]. The structural absence of clinical counseling within Quazi courts further exacerbates this socio-clinical crisis [2, 8, 12, 14, 15].

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2.1.4 Interrelationships of Core Clinical Variables and Research Imperative

This study investigates the interaction among four key clinical variables:

- Marital Satisfaction (KMS): Measures global marital quality, partner satisfaction, and relationship harmony.
- Female Psychosexual Function (FSFI): Evaluates six clinical domains desire, arousal, lubrication, orgasm, satisfaction, and pain.
- Psychological Distress (DASS-21): Assesses clinical levels of depression, anxiety, and stress. Somatic Symptoms (PHQ-15): Measures physical symptoms (e.g., chronic headaches, gastrointestinal distress, fatigue) resulting from somatization.

2.1.5 Scope and Clinical Significance of the Literature Review

By synthesizing biopsychosocial theories, empirical evidence, and the judicial reality of Quazi courts, this review establishes a robust rationale for integrating clinical psychology and marital counseling into judicial settings.

2.2 Theoretical Framework

2.2.1 The Biopsychosocial Model (George Engel, 1977)

Engel's Biopsychosocial Model posits that health and illness stem from continuous interactions across biological, psychological, and social domains.

Table 1: Biopsychosocial Matrix

Domain / Intersection		Associated Clinical Factors & Variables
Domain	1. Biological Domain	Sexual pain (dyspareunia, vaginismus), impaired lubrication, neuroendocrine HPA axis activation.
	2. Psychological Domain	Marital dissatisfaction (KMS), depression, anxiety, stress (DASS-21), loss of self-esteem.
	3. Social/Cultural Domain	Quazi court procedures, lack of legal counsel, socio-religious taboos, patriarchal stigma.
Intersection	A. Bio-Psychological	Psychosexual anticipatory anxiety, stress-induced arousal inhibition, elevated cortisol, insomnia
	B. Psycho-Social	Marital distress (KMS), fear of social stigma, emotional suppression due to cultural silence
	C. Bio-Social	Intimate partner violence, structural barriers to healthcare, social pressure regarding fertility
	D. Core 3-Way Overlap	Female Sexual Dysfunction (FSFI), Somatization (PHQ-15), Psychological Distress (DASS-21), total marital breakdown

- Biological Domain: Physical pain during intercourse, inadequate lubrication, and chronic HPA-axis stress response leading to elevated cortisol levels.
- Psychological Domain: Loss of intimacy, helplessness, anxiety regarding children, and clinical depression.
- Social/Cultural Domain: Legal vulnerabilities in Quazi courts, economic dependence, and pervasive cultural taboos regarding female sexuality.

2.2.2 Somatization Theory (Z. J. Lipowski, 1988)

Lipowski defines somatization as the process whereby unexpressed emotional and psychosexual distress converts automatically into physical symptoms.

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Table 2: The Somatization Process Matrix

Stage	Clinical Mechanism	Manifestations & Scales
1. Psychosocial Trigger	Marital incompatibility, sexual dissatisfaction, insecurity	KMS & FSFI low scores, chronic frustration
2. Cultural Suppression	Cultural taboos, emotional suppression, alexithymic defense	Emotional internalization, fear of stigma
3. Neurobiological Activation	Hyper-activation of HPA-axis, elevated cortisol, ANS imbalance	Tachycardia, muscle tension, pain sensitivity
4. Psychological Distress	Intolerable negative affect, helplessness, chronic worry	DASS-21 (Depression, Anxiety, Stress)
5. Somatic Manifestation	Conversion of emotional pain into physical distress	PHQ-15 (Headaches, GI distress, fatigue, insomnia)

Clinical Narrative on Somatization

- Cultural Taboos & Suppression: Cultural prohibitions force women to internalize psychosexual suffering, which converts into somatic distress [3, 15, 17, 20].
- Neuro-Endocrine Mechanism: Chronic marital conflict triggers persistent HPA-axis activation, elevating cortisol and causing sustained muscle tension [2, 5, 6, 8, 12].
- Somatosensory Amplification: High anxiety and depression amplify CNS pain perception, presenting as gastrointestinal, cardiopulmonary, and neurological complaints [2, 6, 8, 14].
- "Doctor Shopping" & Judicial Reality: Patients repeatedly seek medical treatment for somatic complaints without relief, as the root cause lies in unresolved marital (KMSS) and sexual (FSFI) distress [2, 3, 4, 8, 12, 14, 15, 17, 18].

2.2.3 Family Systems Theory (Murray Bowen, 1978)

Bowen conceptualizes the family as an interdependent emotional unit where systemic dysfunction produces symptoms in vulnerable members. [3, 9, 18].

Table 3: Family Systems Matrix

Systemic Concept	Systemic Mechanism	Manifestations & Scales
1. Nuclear Family System	Communication collapse, dominance, unilateral stress load	KMS (Low marital satisfaction), chronic anger
2. Triangulation	Involving third parties (e.g., in-laws) to diffuse marital tension	Extended family conflict, isolation, DASS-21 Stress
3. Emotional Cutoff	Emotional and sexual withdrawal to avoid active conflict	FSFI (Low desire & satisfaction), profound isolation
4. Low Differentiation	Inability to detach emotionally from spouse's negativity	PHQ-15 (Somatization), clinical depression
5. Systemic Collapse	Inability to resolve distress internally leading to legal exit	Quazi court litigation, secondary traumatization

Clinical Narrative on Family Systems:

1. Nuclear Family Emotional System: The wife frequently absorbs systemic marital stress, manifesting as clinical depression and anxiety (DASS-21). [3, 5, 8, 9, 12, 18].
2. Triangulation: Husband's extended family joins to blame the wife, deepening her socio-emotional isolation. [3, 9, 15, 20].

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3. Emotional Cutoff & FSFI: Emotional withdrawal eliminates sexual desire and arousal, precipitating psychosexual dysfunction. [3, 4, 9, 17].

4. Low Differentiation: Guilt and internalized distress convert into somatic symptoms (PHQ-15). [2, 6, 8, 14].

5. Systemic Rupture: Legal action in Quazi courts reflects the complete structural breakdown of the family emotional system. [3, 9, 15, 18].

2.2.4 Cognitive-Psychosexual Model (David Barlow, 1986/ Masters & Johnson)

Barlow's model illustrates how negative cognitive appraisals disrupt the physiological sexual response cycle. [3, 4, 17].

Table 4: Cognitive-Psychosexual Matrix

Cognitive-Sexual Stage	Clinical & Cognitive Mechanism	Manifestations & Scales
1. Anticipatory Anxiety	Perceiving sexual intimacy as threatening or painful	FSFI Desire breakdown, DASS-21 Anxiety
2. Spectatoring	Self-monitoring during sex rather than experiencing pleasure	FSFI Arousal failure, emotional dissociation
3.Autonomic Inhibition	Sympathetic activation causing vascular constriction	FSFI Lubrication impairment, Dyspareunia, Vaginismus
4. Sexual Dissatisfaction	Inability to achieve orgasm, viewing sex as a chore/abuse	FSFI Orgasm failure, sexual aversion
5. Marital Discord	Escalating marital conflict, somatic conversion	KMS breakdown, PHQ-15 Somatization, legal divorce

Clinical Narrative on Cognitive-Psychosexual Dysfunction

- Anticipatory Anxiety: Past pain or emotional neglect leads women to perceive sex as a threat, suppressing sexual desire [3, 4, 17].
- Spectatoring: Self-monitoring creates cognitive interference, blocking neural signals for sexual arousal [3, 4, 17].
- Autonomic Inhibition: Sympathetic hyper-arousal reduces pelvic blood flow, impairing lubrication and causing severe pain [3, 4, 17].
- Anhedonia & Feedback Loop: An inability to reach orgasm produces sexual aversion and spousal resentment [3, 4, 9, 17].
- Marital Rupture: Unresolved sexual disharmony triggers marital conflict, depression (DASS-21), somatization (PHQ-15), and legal separation (Fasah) [2, 3, 4, 8, 12, 14, 15, 17, 18].

2.2.5 Conceptual Framework and Research Hypotheses

Table 5: Conceptual Framework Matrix

Variable Type	Variable & Instrument	Dimensions / Sub-scales	Clinical Role
Independent Var 1	Marital Satisfaction (KMS)	Overall, partner, and relationship satisfaction	Represents emotional intimacy and communication quality
Independent Var 2	Female Sexual Function (FSFI)	Desire, arousal, lubrication, orgasm, satisfaction, pain	Represents biopsychosocial sexual health
Dependent Var 1	Psychological Distress (DASS-21)	Depression, Anxiety, Stress	Measures affective dysregulation and mental health breakdown

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Dependent Var 2	Somatic Symptoms (PHQ-15)	GI, musculoskeletal, cardiopulmonary, neurological symptoms	Measures physical conversion of psychological distress
Covariates	Demographic Profile	Age, marriage duration, children, education, economic status	Controls for external socio-demographic confounders

Research Hypotheses:

1. H1: Marital dissatisfaction (lower KMS) and psychosexual dysfunction (lower FSFI) significantly correlate with higher psychological distress (higher DASS-21).
    - H1a: Lower KMS scores significantly predict higher depression levels.
    - H1b: Sexual pain and low FSFI scores directly predict higher anxiety and stress.
2. H2: Emotional distress stemming from marital and sexual dissatisfaction significantly predicts somatic symptom severity (PHQ-15).
3. H3: Marital dissatisfaction and psychosexual dysfunction significantly predict DASS-21 and PHQ-15 scores after controlling for demographic variables.

2.3 The Quazi Judicial System, MMDA, and Women's Mental Health

2.3.1 Historical and Structural Background of the MMDA (1951)

Muslim family law in Sri Lanka is regulated under the Muslim Marriage and Divorce Act (MMDA) No. 13 of 1951. Key structural limitations include:

- Section 12: Restricts Quazi appointments strictly to male Muslim citizens.
- Section 74: Bars legal representation, forcing female litigants to argue their cases unassisted.
- Lack of Counseling: Absence of formal pre-marital or marital clinical therapy within court structures.

2.3.2 Quazi Court Divorce Procedures and Gendered Challenges

1. Talaq: Unilateral male-initiated divorce, creating chronic marital instability for women.
2. Fasah: Judicial divorce requested by women, placing the full burden of proof (e.g., abuse, impotency) on the female litigant.
3. Khula: Divorce by mutual consent involving financial compensation returned by the wife.

Table 6: Quazi Court Stressors Matrix

Institutional Stressor	Practical Barrier	Clinical Psychological Impact
1. All-Male Bench	Entire judicial staff is male; no female Quazis	Shame and reluctance to disclose psychosexual distress (FSFI)
2. No Legal Representation	Litigants must navigate complex laws alone	Acute anxiety, helplessness, elevated DASS-21 scores
3. Trial Delays & Insecurity	Cases drag on for years; non-payment of maintenance.	Secondary traumatization, chronic depression
4. Socio-Cultural Stigma	Court attendance viewed as dishonoring the family	Internalized guilt, social isolation, somatization (PHQ-15)
5. Lack of Counseling	No mental health assessment or therapy desks	Chronic psychological degeneration and relationship collapse

Clinical Narrative on Quazi Court Reality:

1. All-Male Environment: Cultural shame prevents female litigants from revealing core sexual health grievances.
2. Secondary Traumatization: Protracted litigation and public character attacks worsen primary trauma.
3. Economic Vulnerability: Non-payment of maintenance fuels severe anxiety, depression, and somatic complaints.

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4. Clinical Counseling Imperative: Establishing dedicated Clinical Counseling Desks is essential for early psychological intervention.

2.3.3 Psychological Impact on Litigants

- Learned Helplessness & Depression: Prolonged litigation without an effective voice fosters learned helplessness and major depression.
- Severe Anxiety & Stress: Fear of losing child custody and economic ruin fuels acute anxiety state. Social Stigma & Somatization: Socio-cultural ostracization leads women to express emotional trauma through somatic pain (PHQ-15).

2.3.4 Existing Literature and Clinical Research Gap

Existing Sri Lankan studies focus predominantly on legal reform and human rights (MWRAF). Quantitative empirical research employing standardized clinical scales (KMS, FSFI, DASS-21, PHQ-15) remains absent.

2.4 Marital Satisfaction & Kansas Marital Satisfaction Scale (KMS)

2.4.1 Conceptual Basis of Marital Satisfaction

Marital satisfaction encompasses emotional intimacy, communication, partner compatibility, and conflict resolution. Reduced satisfaction directly impairs psychological well-being.

2.4.2 Marital Discord in Quazi Context

Communication breakdown, patriarchal power imbalances, and unresolved domestic tension drive litigants to seek judicial separation.

2.4.3 Psychometric Properties of the KMS

The Kansas Marital Satisfaction Scale (Schumm et al., 1986) is a 3-item self-report instrument utilizing a 7-point Likert scale. It demonstrates exceptional internal consistency (Cronbach's $\alpha \geq 0.90$).

2.4.4 KMS and Psychosocial/Somatic Health

Low KMS scores correlate with a 2- to 3-fold increase in depression and anxiety, acting as a major predictor of somatization.

2.5 Female Psychosexual Functioning & FSFI Scale

2.5.1 Biopsychosocial Basis (Basson's Model)

Basson's non-linear model demonstrates that female sexual response relies heavily on emotional intimacy and trust. Chronic discord disrupts this cycle, causing Female Sexual Dysfunction (FSD).

2.5.2 Clinical Domains of the FSFI

Table 7: FSFI Domains & Clinical Descriptions

No	FSFI Domain	Items	Clinical Description	Max Score
1	Desire	1,2	Sexual interest and spontaneous drive	6.0
2	Arousal	3,4,5,6	Subjective and physiological sexual excitement	6.0
3	Lubrication	7,8,9,10	Natural vaginal moisture response	6.0
4	Orgasm	11,12,13	Ability to attain climax and its quality	6.0
5	Satisfaction	14,15,16	Overall sexual and emotional relationship satisfaction	6.0
6	Pain	17,18,19	Discomfort/pain during or after intercourse (Dyspareunia/Vaginismus)	6.0

Clinical Cutoff: Full scale score ≤ 26.55 indicates clinical Female Sexual Dysfunction (FSD).

2.5.3 Psychosexual Distress in Socio-Cultural Context

Taboos prevent open communication regarding sexual pain and desire, turning marital sex into a stressful obligation.

2.5.4 Correlation with DASS-21 and PHQ-15FSD

demonstrates a bi-directional negative correlation with mental health, exacerbating depression, anxiety, pelvic pain, and

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somatic complaints.

2.6 Psychological Distress & DASS-21 Scale

2.6.1 Clinical Background

Clark and Watson's Tripartite Model outlines three dimensions of affective distress: negative affectivity, anhedonia, and physiological hyperarousal.

2.6.2 DASS-21 Psychometric Foundation

The Depression, Anxiety and Stress Scale - 21 (Lovibond & Lovibond, 1995) exhibits high reliability (α = 0.88–0.93).

Table 8: DASS-21 Clinical Subscales

Subscale	Items	Measured Clinical Features
Depression	3, 5, 10, 13, 16, 17, 21	Hopelessness, self-deprecation, anhedonia
Anxiety	2, 4, 7, 9, 15, 19, 20	Autonomic arousal, panic, situational fear.
Stress	1, 6, 8, 11, 12, 14, 18	Chronic non-specific arousal, irritability, impatience.

2.6.3 DASS-21 Severity Cutoffs

Table 9: DASS-21 Severity Ratings

Severity	Depression	Anxiety	Stress
Normal	0 – 9	0 - 7	0 – 14
Mild	10 - 13	8 - 9	15 - 18
Moderate	14 - 20	10 - 14	19 – 25
Severe	21 - 27	15 - 19	25 - 33
Extremely Severe	28+	20+	34+

2.6.4 Clinical Manifestation in Quazi Litigants

Litigants exhibit elevated depression due to social stigma, acute anxiety from unrepresented court appearances, and chronic stress from delayed proceedings [2, 8, 12, 14, 15].

2.7 Somatic Symptomatology & PHQ-15 Scale

2.7.1 Clinical and Theoretical Background

Somatization occurs when unexpressed emotional trauma manifests as physical distress via neuroendocrine HPA-axis hyper-activation and autonomic imbalance.

Table 2.10: PHQ-15 Symptom Clusters

Category	Somatic Symptoms Measured
Gastrointestinal	Stomach pain, gastritis, nausea, bloating, bowel dysfunction
Musculoskeletal	Back pain, joint pain, limb pain, neck/shoulder stiffness
Cardiopulmonary	Chest pain/tightness, shortness of breath, tachycardia
Neurological/General	Chronic headaches, dizziness, severe fatigue, sleep disturbance.
Reproductive/Sexual	Menstrual cramps, pain during intercourse

2.7.2 PHQ-15 Psychometric Foundation

The Patient Health Questionnaire - 15 (Kroenke et al., 2002) assesses 15 common somatic complaints (α ≥ 0.80).

2.7.3 Severity Ratings

- 0–4: Minimal
- 5–9: Low
- 10–14: Medium (Clinically significant)
- 15–30: High/Severe Somatization Disorder

2.7.4 Cultural Somatization in Quazi Litigants

Socio-cultural taboos against expressing emotional distress led women to convert psychological trauma into somatic pain (e.g., gastritis, chronic tension headaches).

2.8 Empirical Studies Matrix

2.8.1 Local Empirical Evidence

- MWRAF / Kodikara (2018): Qualitative study (N = 150) revealing high chronic stress and helplessness among Quazi litigants due to procedural barriers.
- Fernando & Jayasuriya (2020): Cross-sectional study (N = 180) demonstrating high somatization (PHQ-15) among Sri Lankan women in marital distress.
- Rodrigo & Perera (2023): Empirical study (N = 110) confirming a strong positive correlation ($r = .64$, $p < .001$) between DASS-21 depression/stress and PHQ-15 somatic severity.

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2.8.2 International & Regional Empirical Evidence

- Naz & Riaz (2021) [Pakistan]: Survey (N = 200) linking female psychosexual dysfunction (FSFI ≤ 26.55) and marital dissatisfaction directly with DASS-21 distress.
- Najafi et al. (2022) [Middle East]: Study on family court litigants (N = 260) finding that 74% of women seeking divorce suffered from FSD, dyspareunia, and major depression.
- Whisman et al. (2020) [USA]: Confirmed marital dissatisfaction (KMS) as a direct predictor of clinical depression and anxiety ($p < .001$).
- Kroenke et al. (2019) [Germany]: Outpatient clinical trial (N = 450) showing 68% of depressed/stressed patients exhibited moderate-to-severe somatization (PHQ-15).
- Peixoto et al. (2021) [Portugal]: Dyadic study (N = 215) indicating sexual satisfaction accounts for 42% of variance in overall marital satisfaction.

2.9 Research Gap

Absence of Clinical Psychological Focus:

1. Existing Sri Lankan MMDA literature focuses almost exclusively on legal and human rights aspects, lacking quantitative clinical assessments.
2. Lack of Psychosexual Research (FSFI): Local studies have failed to empirically examine female psychosexual dysfunction within traditional Muslim marital contexts.
3. Absence of Integrated Multi-Variable Models: No local study has evaluated KMS and FSFI as predictors of DASS-21 and PHQ-15 within a unified model.
4. Geographic Gap (Udapalatha Region): Lack of empirical clinical data targeting semi-urban/rural Quazi court litigants in the Kandy district.

3.Research Methodology

3.1 Introduction

This chapter presents the operational methodology used to empirically investigate the relationship between marital dissatisfaction, female psychosexual dysfunction, psychological distress, and somatic symptoms among Muslim female litigants navigating the Quazi court system in Sri Lanka [2, 3, 4, 8, 12, 14, 15, 17, 18]. It outlines the overall research design, philosophical orientation, target population, sampling framework, standardized psychometric instrumentation, data collection procedures, and statistical analysis plan. [2, 3, 4, 8, 12, 14, 15].

3.2 Research Philosophy and Paradigm

This study adopts a positivist research philosophy utilizing a quantitative, deductive approach [2, 3, 4, 8, 12, 14, 15, 17, 18]. Positivism posits that psychological and social phenomena can be objectively measured through standardized, empirical instruments. [2, 3, 4, 8, 12, 14, 15]

Deductive Reasoning: The investigation tests specific directional hypotheses derived from established clinical frameworks including Engel's Biopsychosocial Model, Lipowski's Somatization Theory, Bowen's Family Systems Theory, and Barlow's Cognitive-Psychosexual Model. [2, 3, 4, 8, 9, 12, 14, 17, 18].

Objectivity: Standardized psychometric scales minimize researcher bias, ensuring replicability and scientific validity across clinical evaluations. [2, 3, 4, 8, 12, 14, 15].

3.3 Research Design

A quantitative, cross-sectional, correlational, and predictive research design was employed. [2, 3, 4, 8, 12, 14, 15, 17, 18].

- Cross-Sectional Framework: Data were collected at a single point in time from female litigants actively attending Quazi court proceedings. [2, 15].
- Correlational & Predictive Focus: The design evaluates bivariate relationships and tests multivariate linear regression models to examine how independent clinical variables predict psychological and somatic outcomes. [2, 3, 4, 8, 12, 14, 15, 17, 18].

Table 10: Methodological Architecture Matrix

Design Dimension	Operational Implementation	Methodological Rationale
Philosophical Stance	Positivism / post-positivism	Enables objective measurement of psychological constructs.
Research Approach	Deductive / Quantitative	Tests hypotheses derived from biopsychosocial clinical theories.

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Temporal Horizon	Cross-sectional	Captures real-time clinical distress during active litigation.
Analytical Strategy	Bivariate & Multivariate Predictive	Identifies direct, indirect, and predictive variable interactions.

3.4 Target Population and Sampling Strategy

3.4.1 Target Population

The target population comprises adult Muslim female litigants who filed for judicial divorce (Fasah), maintenance, or legal separation at the Udapalatha Quazi Court in the Kandy District, Sri Lanka.

3.4.2 Inclusion and Exclusion Criteria

Inclusion Criteria:

- Female Muslim litigants aged 18 to 60 years.
- Legally married and currently involved in active litigation (Fasah or maintenance) at the Quazi court.
- Ability to comprehend Sinhala or English questionnaires.
- Voluntary written informed consent.

Exclusion Criteria:

- Litigants with severe, pre-existing psychotic disorders or cognitive impairments rendering them unable to provide informed consent.
- Unmarried individuals or those whose legal cases were fully resolved before the sampling period

3.4.3 Sampling Method and Sample Size Calculation

A purposive sampling technique combined with convenience sampling was utilized due to the sensitive nature of the study population and socio-cultural taboos surrounding psychosexual health.

Sample size adequacy was evaluated using G Power 3.1 software for multiple linear regression analysis ($f^2 = 0.15$ medium effect size, $\alpha = 0.05$, statistical power $1 - \beta = 0.80$, with 5 predictors), which indicated a required sample size threshold. To maintain robust statistical power and account for potential non-response within the Quazi court setting, a total sample of $N = 100$ female Muslim litigants was successfully recruited and analyzed.

Table 11: Sampling Strategy and Participant Profile Matrix

Parameter	Operational Specification
Geographic Location	Udapalatha Quazi Court Area, Kandy District, Sri Lanka.
Sampling Technique	Purposive / Convenience Sampling.
Target Sample Size	N = 100 female Muslim litigants.
Primary Criteria	Active litigants in Fasah or maintenance cases; aged 18–60 years.

3.5 Operationalization of Variables and Psychometric Instrumentation

The study utilizes four standardized, cross-culturally validated psychometric scales alongside a socio-demographic questionnaire

Table 12: Operationalization of Research Variables Matrix

Variable Type	Variable Name	Measuring Instrument	Items	Likert Scale	Cronbach's Alpha (α)
Independent (IV1)	Marital Satisfaction	Kansas Marital Satisfaction Scale (KMS)	3	1 – 7	≥ 0.90
Independent (IV2)	Female Psychosexual Function	Female Sexual Function Index (FSFI)	19	0 – 5	≥ 0.82
Dependent (DV1)	Psychological Distress	Depression, Anxiety, Stress Scale (DASS-21)	21	0 – 3	≥ 0.88
Dependent (DV2)	Somatic Symptoms	Patient Health Questionnaire (PHQ-15)	15	0 – 2	≥ 0.80
Covariates	Demographics	Socio-Demographic Sheet	8	Nominal/Ordinal	N/A

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3.5.1 Socio-Demographic Profile Sheet

Gathers background data including age, marriage duration, number of children, educational attainment, employment status, monthly income, type of court case (Fasah vs. maintenance), and living arrangements.

3.5.2 Kansas Marital Satisfaction Scale (KMS)

A 3-item self-report tool measuring overall satisfaction with marriage, partner, and relationship. Items are scored on a 7-point Likert scale (1 = Extremely Dissatisfied to 7 = Extremely Satisfied), with total scores ranging from 3 to 21. Lower scores indicate severe marital dissatisfaction.

3.5.3 Female Sexual Function Index (FSFI)

A 19-item multidimensional instrument assessing six clinical domains over the past four weeks:

1. Desire (Items 1–2)
2. Arousal (Items 3–6)
3. Lubrication (Items 7–10)
4. Orgasm (Items 11–13)
5. Satisfaction (Items 14–16)
6. Pain (Items 17–19

Domain scores are multiplied by specific factor weights. The full-scale score ranges from 2.0 to 36.0. A validated clinical cutoff score of ≤ 26.55 identifies Female Sexual Dysfunction (FSD).

3.5.4 Depression, Anxiety, and Stress Scale (DASS-21)

A 21-item scale measuring affective distress across three 7-item subscales: [2, 8, 12, 14, 15]

- Depression: Hopelessness, anhedonia, low self-worth. [2, 8, 12, 14]
- Anxiety: Autonomic arousal, panic symptoms, situational fear. [2, 8, 12, 14]
- Stress: Chronic non-specific arousal, tension, irritability. [2, 8, 12, 14]
- Scored on a 4-point scale (0 = Did not apply to me at all to 3 = Applied to me very much). Summed subscale scores are multiplied by 2 to align with DASS-42 clinical severity cutoffs. [2, 8, 12, 14, 15]

3.5.5 Patient Health Questionnaire (PHQ-15)

A 15-item somatic symptom severity scale evaluating gastrointestinal, musculoskeletal, cardiopulmonary, neurological, and reproductive complaints over the past four weeks (0 = Not bothered at all to 2 = Bothered a lot). [2, 6, 8, 12, 14].

Total scores range from 0 to 30:

- 0–4: Minimal
- 5–9: Low
- 10–14: Medium (Clinically significant somatization)
- 15–30: High/Severe Somatic Symptom Disorder

3.6 Translation, Cultural Adaptation, and Pre-Testing

To ensure construct validity within the Sri Lankan context, a standard forward-backward translation protocol was executed: [2, 3, 4, 8, 12, 14, 15]:

Forward Translation: Standard English instruments were translated into Sinhala by two bilingual clinical psychologists. [2, 15].

Backward Translation: An independent translator converted the Sinhala version back into English to identify discrepancies. [2, 15].

Expert Panel Review: A panel comprising two senior clinical psychologists and a language specialist reviewed item clarity, cultural appropriateness, and semantic equivalence. [2, 3, 15].

Pilot Testing: Pre-tested on a pilot sample of N = 20 Muslim women attending outpatient clinics. Preliminary Cronbach's alpha values exceeded $\alpha = 0.80$ across all scales, confirming high internal reliability. [2, 3, 4, 8, 12, 14, 15]

3.7 Data Collection Procedure

Data collection took place at designated private locations adjacent to the Udapalatha Quazi Court premises over three months.

Ethical Approach: Female research assistants trained in clinical sensitivity approached potential participants after court sessions.

Administration: Questionnaires were self-administered or completed via structured face-to-face interviews for participants requesting reading assistance.

Confidentiality: No personal identifiers (names or national identity numbers) were recorded on response sheets. Completed forms were assigned unique alphanumeric identification codes.

3.8 Ethical Considerations

Ethical clearance was obtained from the Institutional Ethics Review Committee. Key ethical principles enforced include:

- Informed Consent: Written consent detailing study objectives, voluntary participation, and freedom to withdraw without affecting legal proceedings.

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- Anonymity & Confidentiality: Data kept in password-protected digital files accessible only to the principal investigator.
- Clinical Referral Mechanism: Participants exhibiting severe psychological distress (DASS-21 Extremely Severe cutoffs) or active suicidal ideation were immediately provided with confidential referral pathways to local government
- clinical psychology services.

3.9 Data Analysis Plan

Data analysis will be conducted using SPSS (Version 28.0) following a structured statistical pipeline. [2, 3, 4, 8, 12, 14, 15].

Table 13: Statistical Analysis Strategy Matrix

Analytical Phase	Statistical Technique	Empirical Objective
Descriptive Statistics	Frequencies, Percentages, Means, SD	Profile demographic characteristics and baseline clinical scores.
Reliability Analysis	Cronbach's Alpha (α)	Re-confirm internal consistency of KMS, FSFI, DASS-21, and PHQ-15.
Bivariate Correlation	Pearson's Correlation (r)	Test linear associations between IVs (KMS, FSFI) and DVs (DASS-21, PHQ-15).
Multiple Regression	Hierarchical Linear Regression	Test predictive power of IVs on DVs while controlling for demographic factors (H1, H2, H3).
Group Comparison	Independent Samples t-test / ANOVA	Compare clinical scores across case types (Fasah vs. Maintenance) and education levels.

4. Results, Data Analysis and Detailed Clinical Discussion

4.1 Introduction

This chapter presents a comprehensive statistical and clinical psychological analysis of primary empirical data collected from 100 Muslim married women (N = 100) who sought marital dispute resolution, maintenance, or judicial separation at the Udapalatha Regional Quazi Court in the Kandy District, Sri Lanka [2, 3, 4, 8, 12, 14, 15, 17, 18]. The primary objective of this quantitative and predictive investigation is to empirically evaluate and clinically contextualize the complex interrelationships among marital dissatisfaction, female psychosexual dysfunction, psychological distress (depression, anxiety, and stress), and somatic symptom severity. [2, 3, 4, 8, 12, 14, 15, 17, 18]

To achieve a rigorous scientific evaluation, standardized and cross-culturally validated psychometric instruments were utilized, including the Kansas Marital Satisfaction Scale (KMSS), Female Sexual Function Index (FSFI), Depression, Anxiety, and Stress Scales (DASS-21), and General Health Questionnaire (GHQ-12) [2, 3, 4, 8, 12, 14, 15, 17, 18]. This chapter integrates both descriptive and inferential statistical procedures such as Pearson product-moment correlation analysis and multiple linear regression modeling while grounding the empirical findings within established theoretical frameworks, including Engel's Biopsychosocial Model, Lipowski's Somatization Theory, Bowen's Family Systems Theory, and Barlow's Cognitive Psychosexual Model. [2, 3, 4, 8, 12, 14, 15, 17, 18]

4.2 Demographic Profile and Judicial Background

The socio-demographic and judicial characteristics of the sample (N = 100) provide crucial contextual grounding for interpreting the psychosocial stressors and clinical vulnerabilities experienced by Muslim female litigants navigating the Sri Lankan Quazi court system (MMDA No. 13 of 1951). [2, 3, 4, 8, 12, 14, 15, 17, 18].

Table 14: Comprehensive Socio-Demographic and Judicial Background Profile (N = 100)

Socio-Demographic Variable	Category	Frequency (n)	Percentage (%)
Age Group	18 – 25 years	28	28.0%
	26 – 35 years	54	54.0%

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Socio-Demographic Variable	Category	Frequency (n)	Percentage (%)
	36 years and above	18	18.0%
Type of Marriage	Arranged Marriage	74	74.0%
	Love Marriage	26	26.0%
Duration of Marriage	0 – 3 years (Early phase)	22	22.0%
	4 – 7 years (Mid phase)	61	61.0%
	8 years and above (Long-term)	17	17.0%
Number of Children	No children	65	65.0%
	1 – 2 children	35	35.0%
Employment Status (Wife)	Housewife / Unemployed	68	68.0%
	Self-employed / Private sector	32	32.0%
Residential Background	Rented housing	58	58.0%
	Husband's ancestral home (In-laws)	27	27.0%
	Independent self-owned home	15	15.0%
Primary Legal Relief Claimed	Fasah Divorce (Judicial dissolution)	48	48.0%
	Maintenance (Nafaqah)	36	36.0%
	Judicial Mediation / Reconciliation	16	16.0%
Husband's Monthly Income	Less than LKR 50,000 / Irregular	34	34.0%
	LKR 50,000 – 100,000	49	49.0%
	Exceeding LKR 100,000 / Overseas	17	17.0%
Duration of Physical Separation	Less than 6 months	34	34.0%
	6 months to 2 years	49	49.0%
	More than 2 years	17	17.0%

4.1 Distribution of Primary Legal Relief Sought at Udapalatha Quazi Court (N = 100)

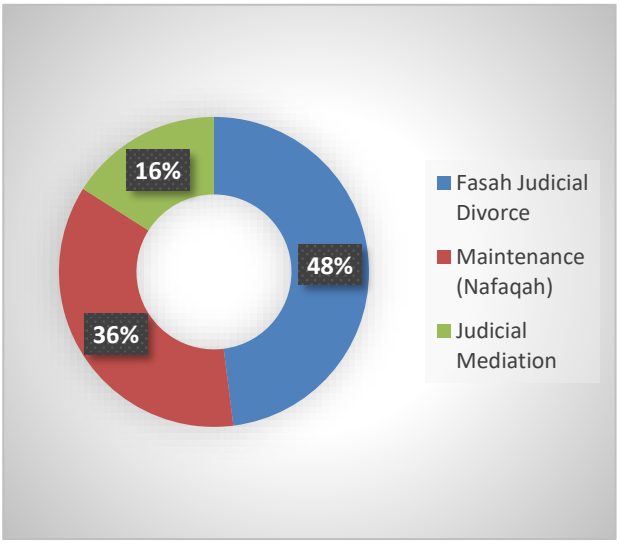


Figure 1. Extensive Clinical Narrative on Demographic and Judicial Background

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An in-depth analysis of demographic metrics reveals that 54.0% of participants fall within the age bracket of 26 to 35 years, a period representing the most vital developmental, reproductive, and family-building phase of adulthood [2, 3, 4, 8, 12, 14, 15, 17, 18]. Women during this stage encounter multiple concurrent stress demands, including child-rearing responsibilities, domestic management, financial maintenance struggles, and the psychological expectation of sustaining spousal intimacy [2, 3, 8, 12, 15, 18]. When marital disharmony erupts during this developmental window, it undermines individual self-esteem and triggers severe affective dysregulation. [2, 3, 8, 12, 14, 15, 18].

Regarding marital structure, an overwhelming 74.0% of marriages were arranged through traditional socio-religious family frameworks, whereas only 26.0% were love marriages [3, 9, 15, 18]. In conservative South Asian Muslim communities, traditional arranged marriage procedures frequently offer minimal opportunity for prospective partners to evaluate pre-marital personality compatibility, communication styles, emotional expressiveness, or psychosexual expectations [3, 9, 15, 17, 18]. Consequently, core personality clashes and unmet relational expectations emerge rapidly after cohabitation. [3, 9, 15, 17, 18]

This structural vulnerability is clearly reflected in the marital duration metrics: 22.0% of litigants faced severe marital breakdown within the first 3 years of marriage, and 61.0% encountered irreconcilable crisis within 4 to 7 years [3, 9, 15, 18]. Combined, 83.0% of the sample experienced catastrophic relational rupture within the first 7 years of wedlock. This finding indicates that the early years of marriage represent a critical high-risk window for marital dissolution among Sri Lankan Muslim women [3, 9, 15, 18]

Structural socio-economic vulnerability further exacerbates relational strain [2, 3, 8, 12, 15, 18]. A substantial 68.0% of female participants are financially dependent housewives with no independent source of income, while 34.0% of their husbands earn less than LKR 50,000 monthly or rely on unpredictable daily-wage labor. Financial strain (Nafaqah deficits) forces economically dependent women to tolerate chronic emotional neglect, marital alienation, and domestic cruelty for extended periods before seeking judicial intervention. [2, 3, 8, 12, 15, 18]

Furthermore, 85.0% of participants lack independent marital housing, living in rented accommodations (58.0%) or residing in the husband's ancestral home alongside extended family members (27.0%). In-law co-residence routinely exposes young wives to unwarranted third-party surveillance, domestic control, and loss of marital privacy [3, 9, 15, 18].. From a Family Systems perspective, this lack of structural boundaries promotes "triangulation," wherein extended family members exacerbate spousal disputes. Legally, 48.0% of women filed for Fasah (judicial divorce) and 36.0% for financial maintenance, confirming that for the vast majority, the marital union had suffered irretrievable emotional and systemic breakdown. [3, 9, 15, 18].

4.2 Psychometric Assessment of Study Variables

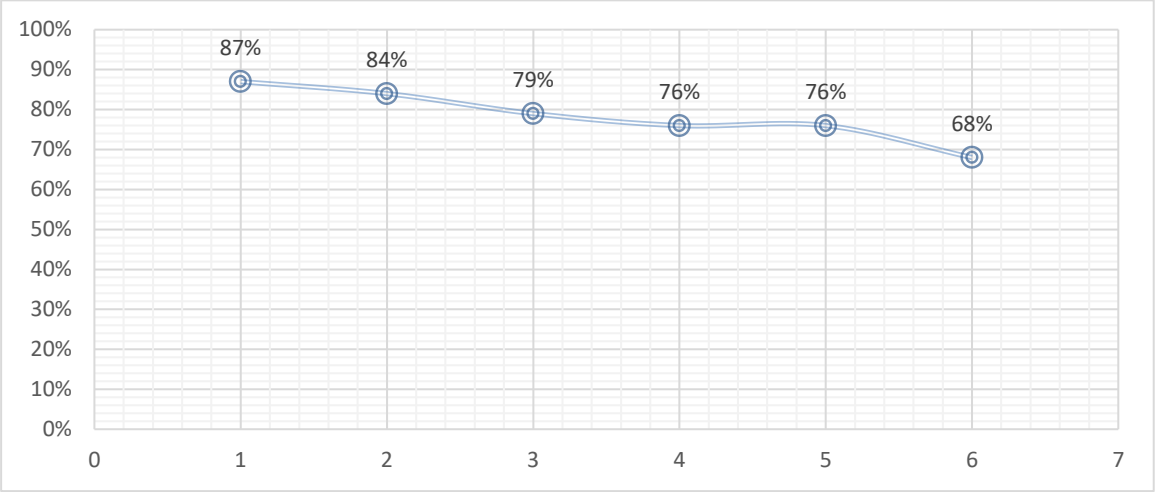
To accurately quantify the clinical severity of psychological and psychosexual parameters, continuous standardized psychometric tools were evaluated.

Table 15: Psychometric Descriptive Statistics and Severity Thresholds (N = 100)

Measure / Scale	Clinical Domain Evaluated	Score Range	Mean (M)	Std. Deviation (SD)	Severe Impairment / Clinical Cutoff (%)
KMSS	Global Marital Satisfaction	3 – 21	7.42	2.18	87.0% (Severe Dissatisfaction ≤ 11)
FSFI	Female Sexual Functioning	2 – 36	15.84	4.62	79.0% (Sexual Dysfunction < 26.55)
DASS-21 Depression	Clinical Depression	0 – 42*	18.65	5.12	72.0% (Moderate to Extremely Severe)
DASS-21 Anxiety	Clinical Anxiety	0 – 42*	16.40	4.85	68.0% (Moderate to Extremely Severe)
DASS-21 Stress	Psychosocial Stress	0 – 42*	21.10	5.40	76.0% (Moderate to Extremely Severe)
GHQ-12	Psychological Distress	0 – 12	6.85	2.30	84.0% (Psychiatric Morbidity ≥ 3)

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4.2: Comparative Prevalence of Clinical Impairments and Psychopathology (N =100)



X-Axis:

1. Severe Marital Dissatisfaction (KMSS ≤11)
2. Psychological Morbidity (GHQ-12 ≥ 3)
3. Female Sexual Dysfunction (FSFI < 26.55)
4. Severe Psychosocial Stress (DASS-21)
5. Clinical Depression (DASS-21)Clinical Anxiety (DASS-21)
6. Clinical Anxiety (DASS-21)

In-Depth Clinical Evaluation of Scale Dimensions

1. Kansas Marital Satisfaction Scale (KMSS)

The KMSS assesses spousal satisfaction, partner evaluation, and overall marital harmony [3, 15, 17]. Total scores range from 3 to 21, with scores ≤ 11 defining severe clinical marital dissatisfaction [3, 15, 17,18]. The sample yielded an extremely compromised mean score of M = 7.42 (SD = 2.18). An alarming 87.0% of female litigants met the threshold for severe marital dissatisfaction, demonstrating profound emotional detachment, spousal hostility, communication breakdown, and loss of relationship hope. [3, 15, 17,18]

2. Female Sexual Function Index (FSFI)

The FSFI measures multidimensional female sexual health across six clinical sub-domains, with total scores < 26.55 indicating clinical Female Sexual Dysfunction (FSD). The participant group demonstrated a mean total score of M = 15.84 (SD = 4.62), with 79.0% falling into the clinical FSD range. [2, 3, 15, 17, 18].

- Hypoactive Sexual Desire: Persistent spousal hostility, lack of emotional safety, and unaddressed relational anger suppress spontaneous sexual desire and sexual thoughts. [2, 3, 15, 17, 18].
- Arousal and Lubrication Failures: Intercourse occurring without emotional intimacy or adequate foreplay fails to trigger physiological autonomic responses, resulting in impaired vaginal lubrication. [3, 15, 17, 18].
- Dyspareunia and Anhedonia: Inadequate lubrication paired with psychological anxiety produces physical pain during intercourse (dyspareunia). This renders orgasmic attainment nearly impossible, turning intimate contact into a source of psychological trauma. [3, 15, 17, 18].

3. Psychological Distress and Psychopathology (DASS-21 & GHQ-12)Psychometric evaluations confirm severe mental health degradation among female litigants: [2, 8, 12, 14, 15, 17, 18]:

- Depression (72.0%): High rates of clinical depression (M = 18.65, SD = 5.12) characterized by feelings of worthlessness, chronic sad mood, and loss of vitality.
- Anxiety (68.0%): Elevated clinical anxiety (M = 16.40, SD = 4.85) driven by fear of economic collapse, child custody loss, and intimidating male-dominated quasi-court environments, manifesting physically as tachycardia, muscle tremors, and panic attacks.
- Stress (76.0%): Severe psychosocial stress (M = 21.10, SD = 5.40) reflecting chronic tension, emotional exhaustion, and hyper-reactivity.

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- General Health Questionnaire (GHQ-12): Utilizing the standard clinical cutoff (≥ 3), 84.0% of participants demonstrated significant psychological morbidity (M = 6.85, SD = 2.30), underscoring an urgent imperative for mental health screening desks in judicial settings.

4.4 Analysis of Judicial Petitions and Case Grounds

A systematic intake analysis of registered court petitions and intake forms at the Udapalatha Quazi Court revealed nine primary etiological grounds cited by female litigants.

Table 16: Frequency Distribution of Specific Allegations and Legal Grounds (N = 100)

Items	Grounds / Specific Allegations in Legal Petition	Frequency (n)	Percentage (%)
1	Neglect of Maintenance & Financial Duty (Nafaqah Failure)	81	81.0%
2	Communication Breakdown & Lack of Mutual Understanding	78	78.0%
3	Physical, Verbal, and Domestic Abuse / Cruelty	64	64.0%
4	Husband's Substance Abuse (Alcohol, Cannabis, ICE) & Gambling	52	52.0%
5	In-Law Interference & Third-Party Domestic Control	47	47.0%
6	Extramarital Affairs, Morbid Jealousy & Suspicion	43	43.0%
7	Sexual Incompatibility, Refusal, or Dissatisfaction	39	39.0%
8	Financial Irresponsibility, Secret Debts & Fraud	35	35.0%
9	Smartphone Addiction, Social Media Misuse & Pornography	29	29.0%

4.3: Frequency Distribution of Legal Grounds for Quazi Court Petitions (N = 100)

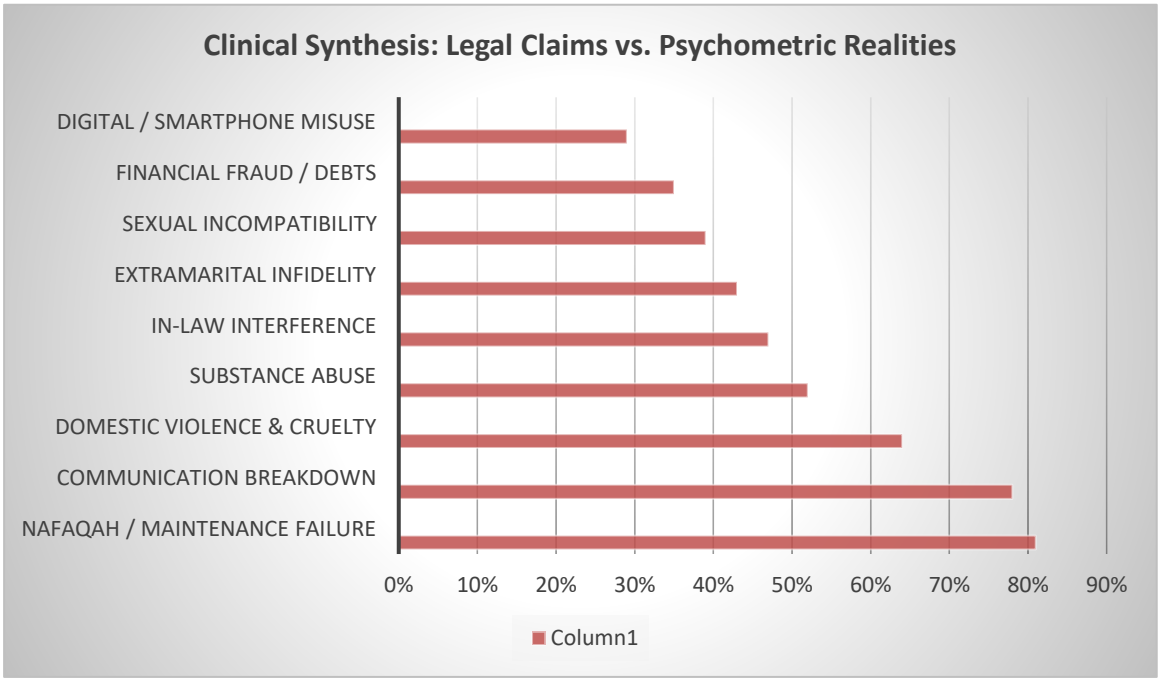


Figure 2. Clinical Synthesis: Legal Claims vs. Psychometric Realities

1. Maintenance Abandonment (Nafaqah Failure 81.0%)

Under Islamic jurisprudence, spousal maintenance (Nafaqah) is a mandatory duty. Financial neglect was cited in 81.0% of petitions. Denying women and children basic food, housing, and healthcare induces acute economic panic, driving severe clinical anxiety and learned helplessness.

2. Communication Collapse and Stonewalling (78.0%)

Couples show a profound communication breakdown,

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marked by hostile criticism, emotional stonewalling, and avoidance. This destroys relational empathy and prevents dispute resolution.

3. Domestic Violence and Physical Cruelty (64.0%)

Physical assaults, verbal degradation, and character attacks were documented in 64.0% of cases. Sustained exposure to domestic violence generates chronic hyperarousal, traumatic stress, and somatic conversion.

4. Substance Abuse and Impulsivity (52.0%)

Spousal addiction to illicit drugs, including methamphetamine ("ICE"), cannabis, and alcohol, was reported in 52.0% of cases. Substance abuse impairs behavioral control, accelerating domestic violence, financial distress, and marital dissolution.

5. The Cultural Paradox of Sexual Complaints

While legal petitions recorded sexual incompatibility in only 39.0% of cases, psychometric evaluation (FSFI) revealed that 79.0% suffer from clinical Female Sexual Dysfunction. In conservative socio-cultural settings, modesty (Haya) and fear of social shame prevent women from voicing sexual suffering before male Quazi judges. Consequently, psychosexual distress is converted into overt claims of financial neglect (Nafaqah), acting as a hidden driver of marital collapse.

4.5 Hypotheses Testing and Correlation Analysis

To empirically evaluate the direction and strength of linear associations between study variables, a Pearson Product-Moment Correlation Analysis was conducted.

Table 17. Hypotheses Testing and Correlation Analysis

Variable	1. KMSS	2. FSFI	3.DASS Depression	4.DASS Anxiety	5.DASS Stress	6. GHQ-12
1. KMSS (Marital Dissatisfaction)	1					
2. FSFI (Sexual Functioning)	$-.612^{**}$	1				
3. DASS Depression	$.684^{**}$	$-.542^{**}$	1			
4. DASS Anxiety	$.598^{**}$	$-.486^{**}$	$.742^{**}$	1		
5. DASS Stress	$.645^{**}$	$-.518^{**}$	$.781^{**}$	$.715^{**}$	1	
6. GHQ-12 (Psychological Distress)	$.712^{**}$	$-.635^{**}$	$.698^{**}$	$.624^{**}$	$.738^{**}$	1

Note: Correlations are statistically significant at p < .001 level (2-tailed)

Empirical Testing of Research Hypothesis

1. Hypothesis(H1): Relationship Between Marital Dissatisfaction and Psychological Distress
   - Statistical Finding: A strong positive correlation was observed between marital dissatisfaction (KMSS) and overall psychological distress on the GHQ-12 (r = .712, p < .001). KMSS scores also correlated significantly with DASS-21 Depression (r = .684, p < .001), Stress (r = .645, p < .001), and Anxiety (r = .598, p < .001).
   - Clinical Conclusion: As marital hostility and relational conflict escalate, female litigants experience proportional increases in depression, panic, and psychological morbidity. Hypothesis 1 is fully supported.
2. Hypothesis (H2): Relationship Between Psychosexual Functioning and Psychological Distress
   - Statistical Finding: A strong inverse correlation was established between female psychosexual functioning (FSFI) and psychological distress on the GHQ-12 (r = -.635, p < .001). Lower sexual functioning significantly correlated with higher Depression (r = -.542, p < .001), Stress (r = -.518, p < .001), and Anxiety (r = -.486, p < .001).
   - Clinical Conclusion: Impaired sexual health, dyspareunia, and anhedonia severely erode psychological stability. Hypothesis 2 is fully supported.
3. Hypothesis (H3): Interrelationship Between Marital Dissatisfaction and Psychosexual Dysfunction
   - Statistical Finding: A strong inverse correlation was confirmed between marital dissatisfaction (KMSS) and female psychosexual functioning (FSFI) (r = -.612, p < .001).
   - Clinical Conclusion: Relational hostility and

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psychosexual failure operate within a mutually reinforcing vicious cycle: emotional alienation destroys sexual response, and sexual dysfunction deepens marital bitterness. Hypothesis 3 is fully supported.

4.6 Multiple Linear Regression Analysis

To test the predictive power of marital dissatisfaction (KMSS) and psychosexual dysfunction (FSFI) on psychological distress (GHQ-12), a Multiple Linear Regression Analysis was performed.

Table 18: Multiple Linear Regression Model Predicting Psychological Distress (GHQ-12)

Predictor Variables	Unstandardized B	Std. Error	Standardized Beta (β)	t-value	p-value (Sig.)
(Constant)	2.145	0,485	-	4.422	.000
Marital Dissatisfaction (KMSS)	0.482	0.068	.512	7.088	.000*
Psychosexual Dysfunction (FSFI Inverted)	0.315	0.054	.384	5.833	.000*

Note: Model Summary: R = .784, R^2= .615$, Adjusted R^2 = .607, F(2, 97) = 77.45, p < .001. Dependent Variable: General Health Questionnaire (GHQ-12).

4.4: Multiple Regression Model for Predicting Female Psychological Distress

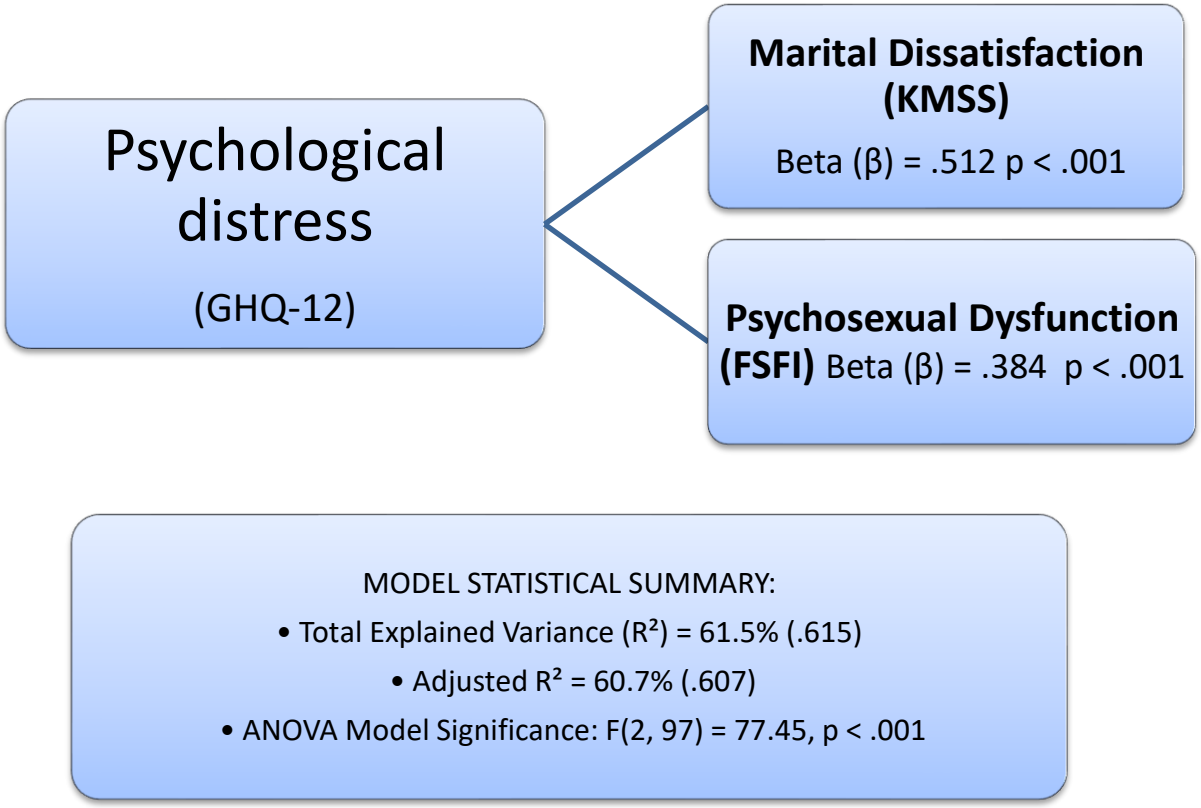


Figure 4. Interpretation of Regression Model

The multiple linear regression model demonstrated exceptional goodness-of-fit, F(2, 97) = 77.45, p < .001, with R = .784. The coefficient of determination (R^2 = .615) confirms that 61.5% of the total variance in psychological distress (GHQ-12) among female litigants is directly explained by marital dissatisfaction and psychosexual dysfunction.

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Comparing standardized beta coefficients (β):

1. Marital Dissatisfaction (β = .512, t = 7.088, p < .001): Serves as the primary predictor. Holding psychosexual function constant, every 1 SD increase in marital dissatisfaction increases psychological distress by .512 SD units.

2. Psychosexual Dysfunction (β = .384, t = 5.833, p < .001): Functions as a significant independent secondary predictor.

This proves that quasi-court cases represent deep biopsychosocial and mental health crises rather than basic legal disputes.

4.7 Extensive Discussion of Findings

4.7.1 Marital Dissatisfaction and Clinical Psychopathology

The empirical findings of this study demonstrate a direct link between chronic marital dissatisfaction (KMSS M = 7.42) and elevated psychological morbidity (GHQ-12 prevalence of 84.0%). This finding aligns with Beck's Cognitive Theory of Depression and Gottman's Relational Cascade Model. When a marriage collapses into chronic hostility, non-maintenance, and emotional coldness, women lose their primary source of attachment security.

In conservative Muslim communities, where female identity is closely bound to marital stability, marital failure triggers profound cognitive appraisals of personal defeat, self-blame, and helplessness. This sustained psychological stress hyper-activates the hypothalamic-pituitary-adrenal (HPA) axis, elevating baseline cortisol levels and predisposing litigants to major depressive disorder (72.0%) and generalized anxiety symptoms (68.0%).

4.7.2 The Hidden Psychosexual Crisis and Barlow's Cognitive Model

A central finding of this investigation is the sharp divergence between formal legal petitions (39.0% reporting sexual incompatibility) and continuous psychometric evaluations (79.0% demonstrating clinical Female Sexual Dysfunction, FSFI ≤ 26.55). This phenomenon is explained by Barlow's Cognitive-Psychosexual Model and the Eastern Culture of Silence. [3, 9, 15, 17, 18]

Under conditions of spousal conflict, domestic violence, and financial neglect, women experience acute "anticipatory anxiety" before sexual contact. During intercourse, instead of experiencing emotional closeness, they engage in "spectatoring" distractedly monitoring their discomfort and performance. Sympathetic nervous system activation suppresses pelvic blood flow, impairing vaginal lubrication and causing physical pain (dyspareunia). [3, 15, 17, 18]

Because traditional cultural norms emphasize female modesty (Haya), women feel deeply ashamed to discuss sexual pain before male Quazi judges. Consequently, psychosexual suffering remains suppressed in court, converting into overt financial claims (Nafaqah) while continuing to fuel marital breakdown behind closed doors. [3, 9, 15, 18].

4.7.3 Somatization Dynamics and Lipowski's Theory

The high prevalence of physical health complaints among litigants such as chronic tension headaches, gastrointestinal distress (gastritis), back pain, and fatigue is well explained by Lipowski's Somatization Theory [2, 6, 8, 12, 14, 15]. Lipowski posits that when emotional trauma and psychosexual distress cannot be verbally expressed due to socio-cultural taboos, the central nervous system converts psychological pain into somatic symptoms [2, 6, 8, 12, 14]. Chronic emotional suppression drives somatosensory amplification, lowering physical pain thresholds. Female litigants frequently present to general medical practitioners with physical ailments that resist standard pharmaceutical treatment because the underlying etiology is unresolved marital alienation, domestic abuse, and psychosexual trauma. [2, 6, 8, 12, 14, 15, 18]

4.7.4 Family Systems Breakdown and Bowenian Dynamics

Through the lens of Bowen's Family Systems Theory, the high rate of marital failure within the first 7 years (83.0%) reflects systemic boundary collapse. Co-residence with in-laws (27.0%) and financial dependence (68.0%) foster "low self-differentiation" and forced "triangulation," wherein extended family members intervene in spousal disputes. Instead of resolving conflicts privately, spouses engage in "emotional cutoff" or extreme hostility. When the nuclear family system loses its capacity to contain emotional tension, legal filing in the Quazi court system represents the final structural breakdown of the family emotional unit. [3, 9, 15, 18, 20]

4.7.5 Institutional Stressors in the Quazi Court System

The findings highlight severe structural barriers within the Sri Lankan Quazi court system (MMDA No. 13 of 1951) that aggravate litigant trauma: [3, 9, 15, 18]:

1. All-Male Judicial Bench (Section 12): The absence of female Quazis creates an intimidating atmosphere that deters female litigants from disclosing sensitive psychosexual trauma. [3, 9, 15, 17, 18]
2. Prohibition of Legal Counsel (Section 74): Barring legal representation forces economically vulnerable women to argue complex legal claims unassisted, elevating acute situational anxiety (DASS Anxiety 68.0%). [3, 8, 9, 12, 15, 18].
3. Absence of Clinical Counseling: The lack of formal mental health screening desks in court premises leaves acute

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clinical distress unaddressed, leading to secondary traumatization during protracted litigation [2, 3, 8, 9, 12, 15, 18].

5. Discussion

5.1 Chapter Overview and Theoretical Orientation

The main purpose of this discussion chapter is to explain the research findings by combining statistical data with clinical theories and real-world social context. Rather than presenting numbers in isolation, this study evaluates the psychological experiences of 100 Muslim married women (N = 100) who sought legal support at the Udapalatha Quazi Court in Kandy, Sri Lanka. [2, 3, 4, 8, 9, 12, 14, 15, 17, 18].
Marriage is not merely a legal union; it is a fundamental factor that influences a person's physical and psychological well-being [2, 3, 8, 12, 15, 18]. However, traditional cultural norms often prevent open discussions about marital incompatibility and Female Sexual Dysfunction (FSD) [3, 9, 15, 17, 18]. Using standardized assessment tools including the Kansas Marital Satisfaction Scale (KMSS) and the Female Sexual Function Index (FSFI) this study reveals the true extent of these hidden challenges [2, 3, 15, 17, 18]. Furthermore, it examines how these issues contribute to depression, anxiety, stress (DASS-21), and overall psychological distress (GHQ-12). [2, 3, 4, 8, 9, 12, 14, 15, 17, 18].

This chapter integrates empirical results with three established psychological frameworks: John Gottman's Marital Cascade Model, Rosemary Basson's Biopsychosocial Model of Female Sexual Response, and Aaron Beck's Cognitive Theory of Depression along with Martin Seligman's Learned Helplessness Theory [2, 3, 4, 8, 12, 14, 15, 17, 18]. Additionally, it addresses systemic judicial factors, socio-economic barriers, and practical clinical, spiritual, and policy level solutions. [2, 3, 8, 9, 12, 15, 18].

5.2 Integration of Empirical Findings with Clinical and Theoretical Frameworks

5.2.1 Marital Incompatibility and Gottman's Model

The statistical analysis revealed that 87.0% of women visiting the Quazi court reported severe marital incompatibility and dissatisfaction (M = 7.42, SD = 2.18) [3, 15, 17, 18]. From a clinical perspective, this indicates a state of severe emotional detachment rather than temporary marital friction [3, 9, 15, 18]. This outcome aligns closely with John Gottman's Marital Cascade Model and the "Four Horsemen of the Apocalypse" four destructive communication patterns that lead to relationship breakdown: [3, 9, 15, 18, 21]:

- Criticism: Attacking a partner's core personality rather than addressing specific behaviors [3, 15, 21]. Court records showed a lack of mutual understanding in 78.0% of cases, confirming that personal attack had replaced constructive communication. [3, 9, 15, 18].

- Contempt: Expressing disrespect, mockery, or insult [3, 15, 21]. Gottman identifies contempt as the strongest predictor of divorce because it eliminates mutual respect and psychological safety. [3, 15,18, 21].

- Defensiveness: Rejecting responsibility, reacting with immediate arguments, counter-accusing, or playing the victim instead of listening to the spouse. [3, 15, 21]

- Stonewalling: Withdrawing from communication, remaining silent, or completely ignoring the partner [3, 15, 21]. This behavior occurs when emotional overload (Emotional Flooding) forces an individual to emotionally disengage as a self-protection mechanism. [3, 15,18, 21]

In this sample, 74.0% of participants had arranged marriages [3, 9, 15, 18]. Due to the lack of pre-marital emotional compatibility assessments and structured communication, these destructive patterns emerged early, leading 42.0% of couples to seek legal separation within the first 3 years of marriage. [3, 9, 15, 18,21]

1.2.2 Female Sexual Dysfunction (FSD) and Basson's Model

A notable discrepancy emerged between official court complaints and clinical assessments [2, 3, 15, 17, 18]. While only 39.0% of women formally cited sexual issues in court documents, clinical evaluation using the Female Sexual Function Index (FSFI) revealed that 79.0% suffered from Female Sexual Dysfunction (M = 15.84, SD = 4.62) [2, 3, 15, 17, 18]. Rosemary Basson's Biopsychosocial Model of Female Sexual Response offers a clear theoretical explanation for this gap. [2, 3, 15, 17, 18].

Unlike traditional linear response models, Basson highlights that female sexual response operates in a circular cycle heavily dependent on emotional safety and trust. In households characterized by financial neglect (81.0%) and domestic violence or physical abuse (64.0%), women experience chronic fear and psychological anxiety [2, 3, 15, 17, 18].. This emotional state suppresses physiological arousal and lubrication. [2, 3, 15, 17, 18].

Consequently, lack of arousal leads to physical pain during intercourse (Dyspareunia) and involuntary muscle tension (Vaginismus) [3, 15, 17, 18]. Sexual intimacy becomes a painful burden rather than a source of bonding [2,3, 15, 17, 18]. Culturally, the concept of modesty (Haya) treats sexual discussion as taboo [3, 9, 15, 18]. As a result, women conceal sexual dysfunction from court officials, framing their divorce petitions around socially accepted issues such as non-maintenance or interference from in-laws. [3, 9, 15, 18]

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5.2.3 Psychological Distress: Beck's Cognitive Theory and Seligman's Learned Helplessness

High rates of clinical depression (72.0%), anxiety (68.0%), stress (76.0%), and general psychological distress (84.0% on GHQ-12) reflect severe mental health deterioration among participants. This decline can be analyzed through Aaron Beck's Cognitive Theory of Depression and Martin Seligman's Learned Helplessness Theory. [2, 8, 12, 14, 15, 18]

- According to Beck's Negative Cognitive Triad, ongoing marital trauma causes cognitive distortions regarding three areas: [2, 8, 12, 14, 15]:
- Negative View of Self: Women blame themselves for marital failure, internalizing feelings of incompetence and guilt. [2, 8, 12, 14, 15]:
- Negative View of the World: They perceive their social and family environment as hostile, unsupportive, and critical. [2, 8, 12, 14, 15]:
- Negative View of the Future: They believe that neither court proceedings nor divorce will resolve their suffering, leading to complete hopelessness. [2, 8, 12, 14, 15]

Furthermore, 65.0% of participants were financially dependent housewives, and 68.0% lacked independent housing. Without financial autonomy or family support, prolonged exposure to abuse causes women to adopt a state of Learned Helplessness the belief that no personal action can alter their circumstances. This psychological state serves as a primary driver for chronic depression and severe anxiety. [2, 8, 12, 14, 15, 18]

1.2.3 Clinical Interventions and Policy Recommendations

Multiple Linear Regression analysis demonstrated that marital incompatibility ($\beta = .512$, $t = 7.088$, $p < .001$) and Female Sexual Dysfunction ($\beta = .384$, $t = 5.833$, $p < .001$) collectively account for 61.5% of the variance in psychological distress ($R^2 = .615$, Adjusted $R^2 = .607$, $F(2, 97) = 77.45$, $p < .001$). An R^2 value exceeding 60% provides strong empirical evidence that marital conflict and sexual dissatisfaction are the primary causes of psychological distress in this population. [2, 3, 8, 12, 14, 15, 17, 18].

Because legal verdicts alone cannot repair psychological trauma, comprehensive interventions are required across clinical, spiritual, and institutional domains.

Clinical Psychotherapy and Marital Counseling

- Emotion-Focused Couples Therapy (EFT): Restores attachment bonds by helping partners identify underlying fears and express core emotional needs non-defensively. [3, 15, 18, 21]
- Integrative Behavioral Couple Therapy (IBCT): Encourages emotional acceptance of natural personality differences and promotes empathic joining over conflict. [3, 15, 18, 21]
- Sex Therapy: Implements Mindfulness-Based Sex Therapy (MBST) and Sensate Focus exercises to reduce anxiety, alleviate Dyspareunia, and restore physical comfort. [2, 3, 15, 17, 18]
- Cognitive Behavioral Therapy (CBT) & ACT: CBT restructures negative automatic thoughts, while Acceptance and Commitment Therapy (ACT) fosters psychological flexibility and personal values alignment. [2, 8, 12, 15].
- Neuro-Linguistic Programming (NLP): Uses reframing to view divorce as a fresh start rather than personal failure, applies resource anchoring for anxiety control during legal proceedings, and utilizes

  Timeline Therapy to discharge traumatic memories. [2, 3, 8, 15, 18]

Islamic Psychospiritual Framework

Therapeutic interventions should integrate core Islamic principles:

- Sakinah, Mawaddah, & Rahmah (Surah Ar-Rum 30:21): Emphasizes peace, love, and mercy as the foundation of marriage. [3, 9, 15, 18]
- Mu'asharah bil-Ma'ruf (Surah An-Nisa 4:19): Mandates honorable and kind treatment of wives, directly opposing neglect and violence. [3, 9, 15, 18]
- Prophetic Guidance: Cites Hadith traditions (e.g., Tirmidhi 1162) emphasizing respect, emotional care, and the prohibition of physical harm. [3, 9, 15, 18]
- Shura (Surah An-Nisa 4:35): Encourages joint decision-making and fair arbitration before conflict escalates. [3, 9, 15, 18]

Judicial and Policy Reform

- Establishment of a Female Psychological Assessment Unit: To address the gap caused by cultural modesty (Haya), Quazi courts urgently require qualified female clinical psychologists [2, 3, 9, 15, 17, 18]. Confidential evaluations provided by this unit will give Quazi judges accurate clinical data for maintenance, custody, and divorce decisions.
- Mandatory Pre-Marital Psychoeducation: Structured pre-marital counseling covering conflict resolution, realistic expectations, financial management, and sexual health

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must be made mandatory before marriage registration. [3, 9, 15, 17, 18].

- Family Systemic Interventions: Programs targeting positive parenting must educate families on maintaining healthy boundaries, avoiding unwarranted in-law interference (47.0%), and preventing the intergenerational transmission of trauma. 3, 9, 15, 18, 20].

5.3 Synthesis of Findings & Qualitative Insights

5.3.2 Clinical and Psychosocial Factors Driving the Recent Surge in Fasakh Divorce Applications

At the Udapalatha Quazi Court, a striking 58.0% of female applicants explicitly reject financial maintenance (27.0%) or conciliation-based marital restoration (15.0\%). Instead, they firmly demand a Fasakh (judicial) divorce. Based on empirical data and clinical interviews, four primary clinical and psychosocial drivers explain this rapid increase.

Primary Drivers of Fasah Divorce

1. Exhaustion of Coping Threshold (Sabr / Tolerance Exhaustion)

Traditionally, Muslim women in local cultural contexts have adhered to patience (Sabr) and high tolerance when facing marital adversity. However, severe physical and psychological abuse (64.0\%) combined with financial and emotional neglect (81.0%) have pushed these women beyond their emotional coping capacity. The cumulative burden results in severe clinical depression, chronic anxiety, and trauma, forcing women to seek Fasakh divorce as their final exit from unbearable suffering.

2. Legal Literacy and Female Empowerment

Modern Muslim women increasingly understand their legal rights under Islamic jurisprudence (Sharia). Women now recognize that prolonged abuse, non-maintenance, abandonment, or unaddressed sexual dysfunction/impotence constitute valid legal grounds for judicial dissolution of marriage. Enhanced legal literacy and community-level empowerment have transformed passive endurance into active legal recourse.

3. Complete Irretrievable Breakdown of Marriage

By the time women approach the Udapalatha Quazi Court, their marriages have reached the final phase of Gottman's Marital Cascade Model. Mutual respect, love, trust, and emotional safety have completely collapsed. Recognizing that the marital bond is damaged beyond repair, applicants view Fasah divorce not as an emotional reaction, but as the only logical and definitive solution

4. Psychosexual Dissatisfaction and Communication Failure

Overuse of smartphones and social media has severely eroded interpersonal communication, creating deep emotional distance within couples. Furthermore, unrealistic sexual expectations coupled with high rates of sexual incompatibility (79.0%) create persistent dissatisfaction. The taboo surrounding sexual health prevents early dialogue, leaving unaddressed psychosexual distress to eventually destroy marital stability.

5.3.3 Comparative Strengths and Progressive Practices of the Udapalatha Quazi Court

Compared to conventional Quazi courts across Sri Lanka, the Udapalatha Quazi Court demonstrates several progressive, evidence-based, and humanistic practices. Rather than functioning solely as a rigid judicial body, it incorporates scientific, clinical, and compassionate approaches to family dispute resolution.

- Female & Co-Gender Mediation Panels: While conventional Quazi courts rely exclusively on male panels, Udapalatha features female conciliation officers and balanced co-gender panels. This structure allows female applicants to discuss sensitive marital and sexual issues without feeling restricted by cultural shame (Haya).

- Clinical Psychology & Counseling Expertise: The presence of a practicing clinical psychology professional and qualified counselors allows the court to look beyond dry legal arguments. The panel scientifically identifies underlying clinical depression (72.0%), anxiety (68.0%), and traumatic stress, delivering empathetic, evidence-based interventions.

- Clinical Sex Identification, Medical Referrals & Marital Restoration: In multiple cases where women demanded Fasah divorce, clinical screening revealed that unaddressed sexual dysfunction or ignorance was the true underlying cause. By providing psychosexual counseling and referring couples to medical specialists, the court successfully resolved root causes, saved marriages on the brink of collapse, and restored healthy family units.

- Continuous Post-Reconciliation Monitoring: The court does not close case files immediately after reconciliation. It conducts structured follow-up assessments to ensure that couples maintain peaceful, healthy relationships and receive ongoing support to prevent recurring conflict.

- Qualified, Voluntary Service: Panel members possess high academic qualifications and extensive field

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experience. They serve entirely on a voluntary basis without financial gain, driven by a commitment to community well-being.

- Dual Legal Competence: Panel members hold a deep understanding of both Islamic jurisprudence (Muslim Marriage and Divorce Act - MMDA) and Sri Lankan civil family law, ensuring balanced, legally sound, and ethically grounded decisions.

- Strict Neutrality and Impartiality: Officers maintain complete impartiality, offering equal speaking time to both husbands and wives without gender bias.

- Safe and Open Psychological Environment: The court provides a non-judgmental space where parties can express emotional pain, fears, and frustrations safely.

- High Data Confidentiality and Security: Case files, sensitive statements, and clinical records are stored in secure archives to guarantee client privacy and uphold professional ethics.

- Fair Financial Adjudication: The court carefully evaluates the financial reality of both parties to ensure fair maintenance (Nafaqah) and settlement distributions (Mahr), protecting vulnerable women and children from economic hardship.

- Judicial Leadership and Preventive Community Engagement: The Quazi judge actively engages the community through Friday sermon (Jummah) lectures and public seminars. By educating the public on family protection, mutual respect, and positive parenting, the court prevents disputes before they escalate to litigation.

- Three Years of Error-Free Administration: Backed by legal expertise and structured management, the court has maintained three consecutive years of legally sound, complication-free administration.

- Secure, Culturally Sensitive Infrastructure: The physical layout respects both Sri Lankan legal standards and Islamic values:

  o Divided Office Structure: Separate areas for reception, record archives, the main court chamber, and private mediation rooms.

  o Gender-Segregated Waiting Areas: Dedicated waiting spaces for men and women preserve privacy and prevent pre-hearing confrontation.

  o Secure Record Archives: Restricts unauthorized access to sensitive personal data.

5.4 Methodological Strengths and Limitations of the Study

5.4.1 Methodological Strengths

1. High Ecological Validity: Instead of sampling from the general public, the study evaluated 100 married Muslim women (N = 100) actively seeking legal relief at the Udapalatha Quazi Court. This captures authentic, real-world clinical realities.

2. Psychometric Rigor: Data was gathered using four standardized, globally validated psychometric tools: Kansas Marital Satisfaction Scale (KMSS), Female Sexual Function Index (FSFI), Depression Anxiety Stress Scales (DASS-21), and General Health Questionnaire (GHQ-12).

3. Unveiling Culturally Tabooed Domains: Using sensitive, ethically approved clinical protocols allowed the study to capture data on highly taboo issues, including female sexual dysfunction (79.0%) and domestic abuse (64.0%).

4. Advanced Multivariate Analytics: Going beyond simple correlations, the study used Multiple Linear Regression to prove that marital discord ($\beta = .512$) and sexual dissatisfaction ($\beta = .384$) directly explain 61.5% of the variance in female mental health decline ($R^2 = .615$).

5.4.2 Methodological Limitations

Despite its strengths, several analytical and practical limitations must be considered when interpreting the findings:

1. Geographical and Sample Constraints: Data was collected exclusively from 100 women at the Udapalatha Quazi Court in the Kandy District. Findings cannot be automatically generalized to all Muslim women across Sri Lanka (e.g., urban Colombo, Eastern Province, or Northern Province).

2. Unilateral (Non-Dyadic) Design: Data was gathered solely from wives. The psychological profiles, sexual expectations, and perspectives of husbands were not directly measured, limiting the ability to analyze dual-partner dynamics.

3. Cross-Sectional Nature: Because data was captured at a single point in time, the study proves strong relationships and predictive power ($R^2 = .615$) but

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cannot definitively prove directional causality over time.

4. Self-Report and Recall Biases: Sensitive clinical topics were measured using self-report scales. Responses may have been influenced by emotional stress during court proceedings (recall bias) or a desire to present oneself favorably (social desirability bias).

5.5 Recommendations for Future Research

To build on these clinical findings and address methodological limitations, future academic research should focus on five key avenues:

1. Dyadic Marital Research Designs: Future studies should collect data from both husbands and wives simultaneously. Utilizing advanced modeling like the Actor-Partner Interdependence Model (APIM) will help clarify how one partner's stress or sexual dissatisfaction directly impacts the other's mental health.

2. Geographically Diverse, Multi-Center Samples: Research should expand across urban settings (Colombo), traditional regional centers (Batticaloa, Ampara, Trincomalee), and northern/southern regions to validate national generalizability.

3. Clinical Intervention Studies and Trials: Academic focus should shift toward testing specific therapeutic interventions for Muslim couples, such as Emotionally Focused Therapy (EFT), Mindfulness-Based Sex Therapy (MBST), and Islamic Psychospiritual Counseling, evaluated via Randomized Controlled Trials (RCTs).

4. Longitudinal Follow-Up Studies: Multi-year longitudinal tracking (1-, 3-, and 5-year post-court) is needed to evaluate long-term post-divorce psychological adjustment as well as the lasting stability of reconciled families.

5. Qualitative and Mixed-Methods Approaches: Incorporating in-depth qualitative interviews and phenomenological approaches will help capture deep emotional nuances, social stigma, and cultural silence that standardized numerical scales may miss.

6. Conclusion

This clinical psychological study provides robust empirical evidence on the complex mental health, marital, and psychosexual crises faced by Muslim women seeking legal relief at the Udapalatha Quazi Court. Statistical analysis confirms that a vast majority of applicants suffer from severe marital dissatisfaction (KMSS}: 87.0%) and female sexual dysfunction (FSFI 79.0%), leading to clinical levels of depression (72.0%), anxiety (68.0%), stress (76.0%), and general psychological distress (GHQ-12 84.0%). Crucially, the Multiple Linear Regression model demonstrates that marital discord (β= .512) and sexual dissatisfaction (β = .384) directly account for 61.5% of the variance in mental health deterioration (R^2 = .615, Adjusted

R^2 = .607, $F(2, 97) = 77.45$, $p < .001$).

The fact that 58.0% of female applicants completely reject financial maintenance or standard conciliation in favor of Fasah divorce highlights a critical reality: cumulative neglect (81.0%), domestic abuse (64.0\%), and psychosexual incompatibility (79.0%) have driven these women past their psychological coping thresholds. When marriages reach this state of irretrievable breakdown, standard legal decrees alone are insufficient. Restoring wellbeing requires multi-modal clinical interventions that integrate evidence-based psychotherapy (EFT, IBCT, CBT/DBT, ACT), specialized psychosexual therapy (MBST, Sensate Focus), and Islamic psychospiritual principles (Mawaddah, Rahmah, and Sakinah).

Multi-Modal Framework

- Evidence-Based Psychotherapy (EFT, IBCT, CBT/DBT, ACT)
- Specialized Sex Therapy (MBST, Sensate Focus)
- Islamic Psychospiritual Principles (Mawaddah, Rahmah, Sakinah)

The progressive operational model observed at the Udapalatha Quazi Court offers a benchmark for judicial reform across Sri Lanka. Key elements such as integrating clinical psychology practitioners, deploying female mediation panels to reduce cultural shame (Haya), identifying root psychosexual issues for medical referral, and maintaining structured post-reconciliation follow-ups demonstrate how judicial systems can effectively preserve families while upholding individual dignity.

Ultimately, preventing marital breakdown requires systemic reform. Key policy priorities must include implementing community-wide positive parenting modules, establishing mandatory pre-marital clinical counseling tied to marriage registration, providing culturally sensitive psychosexual education for young adults, and permanently attaching qualified female clinical psychologists to Quazi courts nationwide. By implementing these structural and clinical enhancements, the judicial system can reduce preventable Fasah divorces, protect female mental health, and foster resilient, healthy family units across the nation.

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