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CLINICAL ARTICLE

Psychiatric evaluation of women who were assisted at a university referral center in Campinas, Brazil, following an experience of sexual violence

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ABSTRACT

Objective: To present the sociodemographic characteristics and psychiatric symptoms of women who have been raped. *Methods:* Between 2006 and 2010, a retrospective study was conducted of 468 women who underwent psychiatric evaluation at a university referral center in Brazil after an experience of sexual violence. *Results:* The women had a mean age of 24.1 years; were predominantly white, unmarried, childless, and employed; had 9–11 years of education; and had a religion. Rape was the first sexual intercourse for 124 (26.8%) of 462 for whom data were available; 53 (13.6%) of 389 had a personal history of sexual violence and 29 (8.0%) of 361 had a family history. No psychiatric symptoms were reported in 146 (32.9%) of 444 women, mild/short-term symptoms were reported in 107 (24.1%), and a psychiatric diagnosis was made for 191 (43.0%). Psychiatric comorbidity was seen in 59 (12.6%) women, and 174 (38.0%) received pharmacologic treatment. All follow-up consultations were attended by 215 (45.9%) of 468 women; 166 (35.5%) attended some, and 87 (18.6%) attended only one during the 6-month follow-up period. *Conclusion:* The frequency and severity of psychiatric symptoms and mental disorders among women who have been raped highlights the importance of mental health monitoring.

1. Introduction

Violence has been recognized since 1993 as a leading worldwide public health problem, and 20 years later, it is still an ongoing issue [1,2]. Sexual violence is defined by WHO as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances…against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work"[1]. Globally, the prevalence of sexual violence by an intimate partner is 30%, whereas the prevalence of sexual violence by a nonpartner is 7.2%, but the latter may reach more than 15% in some regions [2,3].

A US survey [4] found that nine of 10 people who experience sexual violence are women, and a Brazilian study [5] confirmed that it is mainly women who experience domestic and sexual violence, from childhood to old age. The Brazilian Penal Code [6] defines rape as follows: "to constrain someone by violence or serious threat, to have sexual intercourse or to practice or allow the practice of other lewd acts with him/her." In Brazil, a total of 43 227 rapes were reported from 2001 to 2003 [7].

The consequences of rape do not only compromise interpersonal relationships but also professional aspects of the life of the person who has been assaulted. Physical and mental health is affected in the short- and long-term [1,2,8,9]. Unwanted pregnancy, abortion, sexually transmitted infections (STIs), sexual dysfunction, infertility, and urinary and genital lesions are some of the physical short-term outcomes [2,9,10]. People who have been raped are at increased risk of suicide, abuse of alcohol and other substances, and other mental disorders [1–3].

The most profound long-term consequence of rape might be the impact on a person's mental health [2,8,9,11]. The psychological sequelae of rape include not only recognized psychiatric diagnoses but also a range of mental health symptoms [8]. Burgess and Holmstrom [12] described a range of psychological, cognitive, emotional, and behavioral responses to rape (the "rape trauma syndrome"), suggesting that there is an acute phase marked by disorganization of the person's lifestyle with the presence of physical and mental symptoms, followed by a long-term reorganization process. Whether the adaptation responses are better or worse depends on the age and lifestyle of the affected person, the circumstances of the rape, personality characteristics, and the person's support network [10].

Rape survivors have a greater risk of being diagnosed with a psychiatric illness and of experiencing trauma-induced symptoms such as nightmares, inability to concentrate, sleep and appetite disturbances, and feelings of anger, humiliation, and self-blame [11,12]. One-third of

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people who have been raped develop post-traumatic stress disorder (PTSD); in fact, rape survivors constitute the largest single group of people with PTSD and they are more likely to have persistent symptoms than are people who have experienced another type of trauma [11–13]. Another third experience at least one depressive episode in the first year after the assault, and these people have a 13-fold increased risk of attempting suicide [14]. People who have experienced child abuse are at greater risk for depression, drug misuse, PTSD, and suicide in adulthood [15]. Rape survivors with a personal history of physical, psychological, or social problems tend to develop additional symptoms of depression, display psychotic and suicidal behaviors, use psychoactive substances, and experience sexual changes [9,12].

The aim of the present study was to evaluate the psychiatric health of women who have experienced sexual violence and to assess the relationship between psychiatric symptoms after the trauma and sociodemographic characteristics.

2. Materials and methods

The present study was a retrospective, descriptive, and quantitative study that involved evaluation of the medical records of women who had experienced sexual violence and who were subsequently assessed at the referral center for sexual violence at Dr. José Aristodemo Pinotti Women's Hospital, State University of Campinas, Campinas, Brazil. The study protocol was reviewed and approved by the local institutional ethics committee. Informed consent was not needed because the data were extracted from medical records.

At the study hospital, emergency and outpatient health care related to sexual violence has been provided by a multidisciplinary team of gynecologists, nurses, psychologists, and social workers since 1994. The aims are: to promote women's physical, psychological, and social recovery; to prevent pregnancy and STIs; and, if needed, to provide assistance for rape-related pregnancy in accordance with the guidance provided by the Ministry of Health [16].

Emergency care procedures for women who have experienced sexual violence follow an organized routine and the women are then referred within 7–10 days to outpatient care for 6 months [17]. Mental health support (psychological and psychiatric assessment and treatment) is available to every rape survivor during the outpatient follow-up, which is composed of a monthly psychiatric appointment and weekly psychological appointments. After that period, if mental health treatment is still needed, patients may be referred to a primary care unit in their home town.

It is unique to Brazil that the multidisciplinary team responsible for the assessment of female rape survivors includes a psychiatrist. Psychiatric evaluation was established in June 2006 and has since been performed by psychiatrists and by psychiatry residents under supervision using a semi-structured interview. The interviews are used to capture reports on sexual violence, actively investigate physical and psychiatric symptoms, and establish whether the woman has a personal and family history of mental health problems. If psychiatric symptoms are identified, these are matched to the criteria for psychiatric disorders from the International Classification of Diseases, 10th revision [18]. If a woman meets the criteria for a psychiatric diagnosis, medication may be prescribed. All women are offered psychotherapy.

The present study included all women aged 12 years or older who sought care for sexual violence between June 1, 2006, and December 31, 2010, and underwent psychiatric evaluation at least once at the outpatient clinic. Patients younger than 12 years were referred to a child and adolescent outpatient service at the same university and were excluded from the present study, as were women whose assault was not of a sexual nature (according to the emergency evaluation) and those who did not attend the outpatient clinic.

Data for the study were collected from the evaluation records of the multidisciplinary team responsible for emergency and outpatient care and from the patient charts. A data collection form was used that had been specifically designed for the present study; a previous version of this form had been tested on the medical records of 50 women to verify its applicability. The assessed variables included sociodemographic characteristics, initiation of sexual intercourse prior to the assault, and personal and family history of sexual violence. In addition, information was obtained on the personal and family history of psychiatric illness, current psychiatric diagnoses among the study participants or their family members, current psychiatric or psychological treatments, and drug classes in current use.

Based on the psychiatric evaluation, the mental and somatic symptoms were grouped into four clusters: suicidal behavior (suicidal ideation or planning and suicide attempt); social response to trauma (shame and self-blame); avoidance behaviors (social withdrawal, social restriction, and routine changes); and apprehension response to trauma (fear of contracting an STI, fear of rape-related pregnancy, and fear of a repeat experience). Women were deemed to have no psychiatric symptoms related to trauma, mild/short-lasting symptoms, or symptoms meeting the criteria for a psychiatric diagnosis. Comorbid diagnoses were categorized as affective/mood disorders, disorders related to the use of psychoactive substances, intellectual disability, psychotic disorders, anxiety disorders, appetite disorders, personality disorders, and others.

Prescribed psychiatric medications were classified by drug class (antidepressants, anxiolytics, mood stabilizers/anticonvulsants, antipsychotics, and other drugs). Adherence to the outpatient appointments during the 6-month follow-up period was classified as full attendance of consultations, partial attendance of consultations, and attendance of a single consultation only.

The data were analyzed with SPSS version 11.5 (SPSS Inc, Chicago, IL, USA) and SAS version 9.2 (SAS Institute, Cary, NC, USA). Descriptive data were presented as frequencies (categorical variables) and measures of dispersion and position (numerical variables). Assessment of associations and comparisons of proportions were performed using the χ^2 or Fisher exact test, as appropriate. The Mann-Whitney *U* test was used for the comparison of numerical data. $P < 0.05$ was considered statistically significant.

3. Results

During the assigned period, 745 women sought emergency care because of sexual violence and 468 patients underwent psychiatric evaluation (Fig. 1). The women had a mean age of 24.1 years; were predominantly white, unmarried, childless, and employed; had 9–11 years of education; and had a religion (Table 1). Half the women were Catholic, and three-quarters practiced their religion (Table 1).

Of 462 women for whom data were available, 338 (73.2%) women had initiated sexual intercourse prior to the assault (Table 1). Fifty-three (13.6%) of 389 women had a personal history of sexual violence and 29 (8.0%) of 361 reported a family history of sexual violence; the mothers and sisters of these 29 women were predominantly affected (Table 1). Data concerning the mental health history of the women are presented in Table 2.

The mean elapsed time between the assault and the psychiatric evaluation was 37.2 days (median, 17 days; mode, 13 days; range, 0–1825 days). Problems related to the episode were identified in the majority of the women and mainly comprised sleep disturbances, depressive symptoms, and anxiety symptoms (Table 3). Many women developed social responses to the assault and avoidance behavior, nearly one-fifth displayed suicidal ideation, and apprehension responses affected up to one-quarter (Table 3).

Approximately one-third of the women did not develop any trauma-related symptoms, and approximately one-quarter had mild/short-lasting symptoms (Table 3). Psychiatric diagnoses were made in 191 (43.1%) of 444 women (Table 3). Psychiatric comorbidities