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Psychiatric Problems, Somatic Symptoms, and Suicidal Behavior in Women Exposed to Sexual Assault

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ABSTRACT

Objective: We aimed to compare the characteristics of sexual assault, psychiatric disorders, somatic complaints, and descriptive features of suicidal behavior between women who have experienced sexual assault and those who have not.

Methods: The study included 50 women, divided between those with and without a history of sexual assault, who were selected from female patients aged 18 and above seeking treatment at the Istanbul University Psychiatry Clinic. Sociodemographic and clinical forms were administered to individuals in both groups, supplemented by Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition, Text Revision), Suicidal Behavior Scale, and Somatoform Dissociation Scale to assess psychiatric diagnoses. Additionally, those with a history of sexual assault were given the Post Traumatic Stress Diagnostic Scale.

Results: Half of the women participating in the study had experienced sexual assault before the age of 18, with 74% reporting that the perpetrator was a family member. Among those who experienced sexual assault, post-traumatic stress disorder was the most prevalent diagnosis, followed by conversion disorder. Both conditions were notably more prevalent compared to the group without a history of sexual assault ($P < .001$). The scores for current suicidal ideation and the expression of suicidal ideation were significantly higher in the group with a history of sexual violence ($P < .05$).

Conclusion: When examining women experiencing severe depression and somatic symptoms, it is important to incorporate an assessment of their experiences of sexual assault. Furthermore, it is imperative to carefully consider the suicide risk inherent in these women.

Keywords: Sexual assault, post-traumatic stress disorder, dissociation, conversion, suicide

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INTRODUCTION

Sexual assault refers to forced sex or rape; it can be by someone a woman knows (partner, other family member, friend, or acquaintance) or by a stranger.[1]

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Sexual violence against women occurs on the basis of gender discrimination and varies depending on the sociocultural level and economic status of the woman, and negatively affects the mental health of those attacked.[1] In addition to being subjected to sexual violence, stigma and exclusion in the society they live in also negatively affect people who are sexually assaulted. Especially women who are raped by someone they have a close relationship with are more traumatized because they lose their physical integrity and are attacked by someone they trust.[2] Consent is when a person clearly and explicitly states that he/she wants to experience a certain sexual behavior through free will, behavioral indication, and verbal expression.[2] Violence against women is the most violated human rights violation in the world.[1] It has been determined that one-quarter of women in the world have experienced sexual violence from their intimate partners, and approximately one-third of girls have had their first sexual experience by force.

In a study involving children and adolescents who were victims of sexual assault and referred to the İnönü University Child Mental Health and Diseases outpatient clinic in Türkiye, findings revealed that 57.7% of the perpetrators were acquaintances, while 7.4% were family members.[4] Another study, offering data on the primary perpetrators of child abuse within their immediate circles, indicates that 78% of sexual abusers are either family members or acquaintances of the victim.[5]

Sexual violence is a pervasive public health issue not only in Türkiye, but globally as well. It necessitates recognition and comprehensive strategies, requiring a careful approach in both detection and treatment processes.[6] Those who experience sexual abuse often develop a wide range of mental health conditions, such as depression, panic disorder, alcohol and substance abuse, dissociative disorders, adjustment disorder, and somatoform disorders, along with post-traumatic stress disorder (PTSD).[7] For those who experience sexual abuse, PTSD can manifest as a persistent and dangerous state of distress, marked by feelings of powerlessness, diminished self-worth, depression, anxiety, struggles in self-protection and forming new relationships, avoidance tendencies, dissociation, deterioration in interpersonal relationships, and reliance on alcohol and substances.[8]

Since sexual assault is often concealed because survivors feel intimidated, ashamed, or believing it to be a problem that only they experience. Consequently, identifying instances of sexual abuse often occurs accidentally. Health professionals may fail to act with the necessary diligence to uncover this hidden problem, they may underestimate the prevalence of the issue, lack sufficient knowledge to recognize sexual violence, be unfamiliar with or fail to follow proper legal procedures, and inadequately document the events. Such oversights could result in instances of abuse going unnoticed and survivors being subjected to repeated abuses.[9]

The manifestation of mental distress through somatic complaints is a common occurrence in healthcare services. It is reported that more than 25% of patients seeking assistance at family medical centers do so due to somatic complaints arising from psychosocial problems.[10] Furthermore, there is evidence of a heightened presence of trauma-specific and psychosomatic symptoms following experiences of sexual abuse. It has been suggested that there is a link between somatic expression of stress in societies with limited mental health services or strong stigmatization of psychiatric disorders.[11] Additionally, it has been observed that in conservative societies, social maladjustment or mood disorders can occur with somatic symptoms.[12]

In exploring the concealment and consequences of sexual assault within conservative societies such as Türkiye, this study emphasizes the importance of assessing somatic complaints in patients with a history of sexual assault. This study advocates for the systematic assessment of sexual trauma in patients exhibiting somatic symptoms and underscores the importance of PTSD assessment scales in detecting and addressing sexual trauma. The study aims to examine if women who have experienced sexual assault tend to express their psychological distress through physical complaints within Turkish culture, where the expression of emotions through bodily cues is a common phenomenon. Additionally, it seeks to identify the specific physical complaints reported by these women when seeking medical and mental health services. Furthermore, the study aims to ascertain whether women who have experienced sexual abuse primarily present with symptoms indicative of diagnoses unrelated to their traumatic experiences, and to evaluate data on suicidal behavior.

The research hypotheses established that women who have experienced sexual abuse are more likely to exhibit psychiatric disorders, engage in suicidal behavior, and manifest somatic symptoms.

MATERIAL AND METHODS

Participants and Procedure

The study involved female patients who sought treatment at İstanbul University, İstanbul Medical Faculty Psychiatry Clinic between 2007 and 2010.

The inclusion criteria for the study group required participants to be aged 18 years or older, possessing a minimum of primary school education, reporting a history of sexual assault, experiencing additional forms of trauma apart from the sexual trauma, and identifying sexual trauma as the most affecting index trauma. Conversely, women in the control group were required to be aged 18 or older and possess at least primary school education. The exclusion criteria for the study group comprised women who lacked understanding of the assessment scales utilized and those diagnosed with psychotic disorders, cognitive impairments, or dementia due to the potential inaccuracies in scale responses. Furthermore, for the control group, a history of sexual violence was incorporated as an additional exclusion criterion.

The study involved female patients aged 18 and above who sought treatment at the İstanbul University, İstanbul Faculty of Medicine Psychiatry Outpatient Clinic. The participants included those with a documented history of sexual assault at the time of their application, as well as individuals who presented to the İstanbul University Consultation Liaison Psychiatry Department Polyclinic due to medically unexplained pain and somatic symptoms such as fainting, numbness, and loss of sensation. The research comprised both a study and control group, each comprising of 50 participants. The study group comprised patients who directly sought treatment at the İstanbul Faculty of Medicine Psychiatry Polyclinic, presenting with somatic complaints alongside their primary concerns, and who disclosed a history of sexual assault.

The research data were collected by 2 psychiatrists (P.S.B. and Ş.Y.) who were working within the specified units during the study period. Verbal and written consent was obtained from all participants involved in the study prior to data collection.

Approval for the non-invasive clinical study was granted approval by thelstanbul University Academic Board (Approval no: 2007/238, Date: January 23, 2008).

Measures

Sociodemographic and Clinical Evaluation: The sociodemographic details of the participants, along with general information about their family structure, medical history, and exposure to traumatic events, were gathered using a sociodemographic information form prepared by the researchers.

Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) Axis I Disorders: The structured clinical interview for *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition) (*DSM-IV*) axis I mental disorders developed by First et al in 1997[13] was utilized in this study. All modules of the structured clinical interview for DSM-IV (SCID-IV) were administered by 2 researchers (XX ve XX). The structured clinical interview for *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition) (*DSM-IV*) axis I mental disorders was developed to increase diagnostic reliability through the meticulous application of diagnostic assessment, ensure diagnostic validity by facilitating the screening of *DSM-IV* axis I diagnoses and comorbid conditions throughout an individual's lifetime and within the last month, and systematically investigate symptoms. Çorapçıoğlu et al[14] conducted validity and reliability studies of SCID-I in Turkish in 1999.

Suicide Behavior Questionnaire: To assess suicidal behavior, the Suicide Behavior Questionnaire, comprising of 4 items developed by Beck in 1973,[15] was employed. Its validity in Turkish was confirmed by Bayam et al (1995).[16] The scale consists of 4 items. The first item is related to the "frequency of suicidal ideation over the past twelve months." The second item questions "suicidal ideation and/or suicide attempt," while the third item questions the "threat of suicide attempt." Last, the fourth item questions the likelihood of suicidal behavior in the future." The suicidal behavior scale ranges from a minimum score of 0 to a maximum of 14. Higher scores indicate increased severity of suicidal behavior. Moreover, each item is structured within itself, evaluating 4 different elements of behavior separately.

Somatoform Dissociation Questionnaire: The Somotoform Dissociation Questionnaire was used to assess bodily dissociative experiences and disorders. This scale, adapted from Nijenhuis et al (1996),[17] underwent Turkish validity and reliability testing conducted by Şar et al. (1998).[18] The questionnaire is administered to psychiatric patients, individuals with a history of trauma, and non-clinical populations for screening purposes. Consisting of 20 questions, participants independently complete the scale by selecting options ranging from 1 to 5 for each item. Studies conducted in Türkiye suggest that individuals scoring 40 or higher on the total scale are likely to have a dissociative disorder.

Posttraumatic Diagnostic Scale: For diagnosing PTSD and identifying trauma types, the Posttraumatic Stress Diagnostic Scale (PDS), structured according to the DSM-IV PTSD diagnostic criteria by Foa (1995), was employed. The PDS is a self-report scale consisting of 49 items. It is used to diagnose PTSD, identify traumatic events and associated symptoms, measure the severity of symptoms, and assess functional impairment levels. Traumatic life events are listed, and if multiple experiences occurred, the most distressing traumatic experience is marked as the index trauma. The validity and reliability of the Turkish form were established by Işıklı et al (2006).[20]

Statistical Analysis

The Statistical Package for Social Sciences, version 18.0 software (SPSS Inc.; Chicago,IL, USA) was used to analyze the data. Descriptive analyses of the data are given as mean and standard deviation for numerical variables, and as number and percentage for categorical variables. Mann–Whitney *U*-test and *t*-tests for independent groups were used to compare the scores of 2 groups of quantities or the agreement of a heading in the form of presence/absence with the other heading in the same slice. Categorical characteristics were compared using the chi-square test and Fisher's exact *P* calculation. Test scores of more than 2 independent features were compared with the Kruskal–Wallis test. The significance limit was accepted as .05.

RESULTS

Table 1 shows that there was no statistically significant difference in sociodemographic variables between participants with and without a history of sexual assault. Among those with a history of sexual violence, the perpetrator was identified as a relative in 30% (N = 15) of cases, a spouse or lover in 18% (N = 9), a friend in 16% (N = 8), and a stranger in 16% (N = 8). Additionally, the perpetrator was identified as the victim's father in 10% (N = 5) of cases, and as a supervisor or teacher in 10% (N = 5). In 92% (N = 46) of reported incidents, the perpetrator acted alone, while in 8% (N = 4) of cases, multiple perpetrators were involved. Coercion tactics, including deception, threats, or manipulation of consent were reported by 56% of the victims (N = 28). Physical violence was observed in 18% (N = 36) of cases, and 1 victim was subjected to drug-induced or substance-related assault

Upon evaluating the characteristics of the abuse, it was found that sexual assault, which served as the index trauma, occurred in a multiple manner in 76% (N = 38) of cases and singularly in 24% (N = 12). Additionally, 84% (N = 42) of cases involved emotional and physical traumas alongside sexual trauma. Among the reported sexual assaults, 48% (N = 24) involved penetration. Further analysis revealed that 21% of the penetrations were vaginal, 12.5% were anal, 12.5% were oral, and 54% occurred multiple times. Notably, 39% of patients who reported multiple penetrations had experienced sexual trauma involving oral and anal penetration without vaginal penetration.

Reports indicated that in 36% (N = 18) of cases, the duration of the sexual assault was less than a month, while in 36% (N = 18), it extended between 1 and 12 months. In 28% (N = 14) of cases, the assault persisted for more than 3 years.

The data from both groups regarding traumatic events, as assessed in the first part of the Posttraumatic Diagnostic Scale where all traumatic experiences are evaluated, are presented in Table 2. There was no difference observed between the study and control groups in terms of exposure to non-sexual assault by a family member or an acquaintance. Participants in both groups reported experiencing more than one traumatic event. The rate of exposure to non-sexual violence by a familiar individual was consistent at 42% (N = 21) in both groups.

Table 3 presents a comparison of the groups using SCID-I in regard to psychiatric diagnoses. Individuals with a history of sexual assault were compared to those without. The frequency of PTSD and

Table 1. Sociodemographic Variables Between the 2 Groups

	With a History of Sexual Violence N = 50		Without a History of Sexual Violence N = 50		Statistical Coefficients	
	N/ Mean	%/SD	N/ Mean	%/SD	*t* (*df*) / χ^2 (*df*)	*P*
Age (years)	31.38	9.843	28.62	8.271	1.518 (98)	.132
Birthplace					0.735 (1)	.391
Big city	14	28	18	36		
Small town	36	72	32	64		
Education					−0.750 (2)	.453
Primary school	22	44	17	34		
High school	15	30	19	38		
University	13	26	14	28		
Marital status					0.670 (2)	.715
Married	24	48	28	56		
Single	22	44	19	38		
Divorced/widowed	4	8	3	6		
Working status					−0.645 (2)	.895
Unemployed	28	56	24	48		
Have a regular job	20	40	19	38		
Temporary jobs	2	4	7	14		
Economic status					−0.752 (2)	.452
Low	10	20	4	8		
Middle	32	64	40	80		
High	8	16	6	12		

Table 2. Distribution of Traumatic Experiences According to Part I of the Posttraumatic Diagnostic Scale in Groups With and Without a History of Sexual Violence

	With a History of Sexual Violence N = 50		Without a History of Sexual Violence N = 50	
	N	%	N	%
Serious accident, fire, explosion	5	10	4	8
Natural disasters	11	22	2	4
Non-sexual assault by a familiar family member	21	42	21	42
Non-sexual assault by stranger	6	12	1	2
Sexual assault by a familiar family member	37	74	0	0
Military conflict	0	0	0	0
Sexual intimacy with someone at least 5 years older than yourself before the age of 18	25	50	0	0
Prison	1	2	0	0
Torture	4	8	0	0
Life threatening disease	1	2	1	2
Other	3	6	0	0

Table 3. Comparison of Groups With and Without a History of Sexual Violence in Terms of Psychiatric Diagnoses According to Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition) (*DSM-IV*) Axis I Mental Disorders

	With a History of Sexual Violence N = 50		Without a History of Sexual Violence N = 50		Chi-square; *P*
Diagnosis	N	%	N	%	
Post-traumatic stress disorder	38	76	4	8	47.5; <.001
Major depression	24	48	21	42	0.4; .55
Conversion disorder	30	60	11	22	14.9; <.001
Obsessive compulsive disorder	10	5	10	5	0; 1
Panic disorder	3	6	7	14	1.8; .18
Bipolar disorder type I	0	0	1	2	1; >.5
Generalized anxiety disorder	0	0	6	12	0.03; >.5
Presence of multiple diagnoses	37	74	5	10	42; <.001

conversion disorder was significantly higher ($P < .001$) among individuals with a history of sexual assault. Conversely, no difference was observed between the 2 groups in terms of other psychiatric diagnoses. Moreover, the frequency of multiple diagnoses in the group with a history of sexual assault was significantly higher compared to the group without such history ($P < .001$). The most common comorbid conditions accompanying PTSD in individuals with a history of sexual assault were conversion disorder (N = 22) and major depression (N = 20).

The prevalence of prior psychiatric disorders was 54% (N = 27) in the group with a history of sexual assault and 44% (N = 22) in the control group. This difference between the 2 groups was statistically significant ($P = .03$).

When comparing their scores on the Somatoform Dissociation Questionnaire, it became evident that individuals with a history of sexual assault reported significantly higher levels of sensations such as a feeling of disappearing in the body ($P < .05$), difficulty in speaking ($P < .01$), and loss of sensation ($P < .05$). There was no significant difference between the 2 groups concerning fainting seizures ($P > .05$). upon assessing the somatic complaints of patients diagnosed with a conversion disorder, it was found that 23.3% experienced aphonia, 46.7% reported loss of motor movement, 3.33% suffered from vision loss, 56.7% encountered loss of sensation, and 33.3% had complaints of fainting seizures resembling convulsions. (Table 4)

During clinical interviews, when asked whether they had active suicidal thoughts, 26% (N = 13) of individuals with a history of sexual violence and 4% (N = 2) of those reported having such thoughts, indicating a statistically significant contrast between the groups ($P = .002$).

According to the Suicidal Behavior Questionnaire, individuals who had undergone sexual assault exhibited notably higher scores in both suicide ideation and threat ($P < .05$). However, there was no significant difference between the 2 groups concerning past suicidal thoughts, likelihood of future suicide attempts, or overall scores on the suicidal behavior scale ($P > .05$). (Table 5)

Table 4. Comparison of Somatic Complaints According to the Somatoform Dissociation Scale in Groups With and Without a History of Sexual Violence

	With a History of Sexual Violence		Without a History of Sexual Violence		Mann–Whitney	
	N = 50		N = 50			
SDQ	Mean	SD	Mean	SD	*Z*	*P*
Feeling of disappearing in the body	2.04	1.12	2.66	1.35	−2.289	.022
Speech difficulty	2.64	1.12	2.02	1.10	−2.751	.006
Fainting seizure	1.60	0.95	1.76	1.02	−0.855	.393
Loss of sensation in the body	1.92	1.08	2.64	1.44	−2.545	.011
Total	36.68	11.65	39.06	16.00	−0.200	.841

Table 5. Comparison of Groups With and Without a History of Sexual Violence According to the Suicide Behavior Questionnaire

	With a History of Sexual Violence		Without a History of Sexual Violence		Mann–Whitney	
	N = 50		N = 50			
Suicide Behavior Questionnaire	Mean	SD	Mean	SD	*Z*	*P*
Frequency of suicidal ideation over the past twelve months	1.00	1.12	1.28	1.23	−1.128	.259
Suicide ideation and/or suicide attempt	0.56	0.88	0.98	1.04	−2.248	.025
Threat of suicide attempt	0.24	0.43	0.48	0.54	−2.339	.019
Likelihood of suicidal behavior in the future	0.40	0.64	0.64	0.88	−1.214	.225
Total	2.20	2.72	3.38	3.41	−1.546	.122

DISCUSSION

Among the women in our study who experienced sexual violence, PTSD was the most prevalent diagnosis, followed by conversion disorder and major depression. It has been established that the incidence of psychiatric disorders and suicide risk increases among women who are subjected to sexual violence. These findings underscore the importance of carefully assessing the suicide risk, particularly in patients exhibiting profound depression and somatic symptoms, especially women with a history of sexual violence history who predominantly manifest physical complaints.

In the study, women who reported a history of sexual violence had an average age of 31.38. About half (48%) of them indicated being married. Education backgrounds varied, with 44% being primary school graduates, 30% high school graduates, and 26% college graduates. The fact that over half of the sexual violence patients had attained at least a high school education implies that individuals with higher education may find it easier to access support systems for seeking assistance.

Throughout Türkiye, especially in rural areas, the proportion of women attaining education beyond primary school tends to be lower. Consequently, it can be expected that the percentage of women with only a primary school education in Istanbul would be lower than the national average, while those with higher education levels would surpass the national average. However, the education profile of the women in the study does not offer evidence suggesting that educational attainment protects them from experiencing sexual violence. This finding is consistent with the perspective that merely increasing women's education levels in patriarchal societies is not a sufficient variable and may even heighten the risk of violence by challenging traditional gender roles.[6] Such dynamics could potentially impede individuals' search for assistance.

The societal significance attached to virginity in Türkiye extends beyond the individual to encompass familial implications. This complex perspective on virginity, and the unequal application of this concept between the genders, can be attributed to the influence of entrenched gender roles and patriarchal norms. While women's virginity is often policed by their families (particularly the male members), as well as neighbors, the police and legal institutions, the issue of virginity can be also be a source of shame for men.[20] This situation bears the traces of women being judged based on family "honor."[21] As a self-protection strategy, individuals or groups may choose to remain silent, conceal, or deny. The finding that 74% of the assaults in this study were perpetrated by someone known to the victim aligns with studies suggesting that intimate partner sexual abuse is common and sheds light on why there might be a delay in seeking help.[22]

Post-traumatic stress disorder, a condition that emerges following trauma, is a common diagnosis among individuals subjected to sexual assault. However, it is noteworthy that conversion disorder, an undefined diagnosis directly linked to trauma, was also significantly prevalent in our study. The presence of a history of sexual trauma should be carefully investigated in people, especially women, presenting conversion symptoms. Research suggests that the prevalence of PTSD is higher among women, with trauma exposure playing a significant role in this case.[23]

It has been reported that sexual assaults experienced in both childhood and adulthood may contribute to the development of conversion disorder in individuals.[24] In a study conducted in Türkiye involving patients diagnosed with a conversion disorder, it was found that 74% of the cases experienced seizures or convulsions, 10% reported globus hystericus, 6.9% had paralysis, 6.9% faced speech difficulties, and 3.4% reported blindness[25] In their study on cases with conversion disorder, Tomasson et al (1991)[26] reported that 71% of the cases, which equates to 52 of 62 cases, showed conversion symptoms in the form of pseudoneurological losses. In this study, which included 72 cases, 40.3% reported seizures or convulsions, and 40.3% reported sensory symptoms or loss.[26] In this study, when the somatic complaints of patients diagnosed with a conversion disorder were evaluated, it was found that 23.3% had experienced aphonia, 46.7% had motor movement loss, 3.33% suffered from vision loss, 56.7% encountered sensory loss, and 33.3% had seizures. It is noteworthy that unlike previous studies, the entire study group in our study consisted of people who had experienced acts of sexual violence, with more than one-fifth of them experiencing the symptom of speechlessness, or aphonia. While it is stated that it is rare in Western countries, it still manifests in non-Western countries.

Given the difficulties associated with discussing and explaining sexual trauma in Türkiye, a conservative society, it is plausible to

suggest that the symptoms of aphonia may hold significance, and cases of aphonia should be examined in terms of potential sexual trauma. In a study conducted in Türkiye, Kaygısız and Alkın (1999)[27] stated that they rarely encountered a history of sexual trauma in patients diagnosed with a conversion disorder, especially in international literature. They emphasized that this was not because such traumas were uncommon in Türkiye, but because individuals might withhold such information from physicians due to feelings of shame.

Sexual abuse often triggers feelings of shame. The feelings of shame cause the patients to hide their traumatic experiences. It is highlighted that psychological issues resulting from sexual abuse are related to feelings of shame and should be addressed during the treatment phase.[28] Recent research has focused on trauma-related shame, exploring various factors such as the type of traumatic experience, gender, and the person's mental state and relationship with support mechanisms, all of which influence feelings of shame and guilt. Addressing the issue of shame when treating PTSD resulting from sexual abuse is crucial for effective treatment outcomes. Sexual and physical violence pose significant risk factors for depression and depressive symptoms in individuals of both genders. The higher risk of suicidal behavior associated with childhood sexual and physical abuse is of particular concern.[29] A person with a history of sexual violence and is diagnosed with major depression may resort to somatic symptoms to cope with their depression.[30] The duration and severity of somatic symptoms, the degree of involvement of the mood component, and the individual's ability to recognize and express his or her emotions vary greatly among patients.[31]

It has been reported that somatic complaints are common in rural parts of society with low education and socioeconomic levels.[32] This observation suggests that low socioeconomic status and lack of education may prevent the development of emotional vocabulary, leading to communication primarily through body language, especially in cases of emotional stress.

Multiple studies have shown that patients with more intense somatic symptoms tend to have more severe depression.[33] In addition to the fact that somatic symptoms may increase depressive symptoms such as hopelessness and pessimism, it might also contribute to inadequate treatment in non-psychiatric units, where the focus on somatic symptoms overshadows the underlying depression, potentially exacerbating the condition.

In this study, according to the Suicidal Behavior Scale, suicidal ideation and possible suicide threat scores at admission were significantly higher in the group with a history of sexual violence. Büyükgök's (2007)[34] study also revealed a significant relationship between exposure to emotional, physical, and sexual violence and suicide attempts. Additionally, our study found that the most common comorbid diagnoses of women with a history of sexual assault and a diagnosis of PTSD were conversion disorder and major depression, respectively. The presence of multiple diagnoses is a factor that influences the clinical course of PTSD.

This study has several important limitations. First, it was a study conducted in a single center with a small sample group, making it difficult to generalize the findings to the broader population. Additionally, some of the data was based on self-report scales, compromising the reliability of the results. Furthermore, the traumas experienced by the participants in the study vary widely, as do the time periods since the events occurred. These are important limitations that can impact the differences in psychological impact levels observed.

CONCLUSION

Combating violence against women, including sexual violence, through primary, secondary, and tertiary prevention strategies is crucial for public health. It has been observed that asking about sexual trauma experiences with women who have not previously disclosed such incidents can facilitate disclosure among those with traumatic experiences.

A safe environment should be provided for the disclosure of different traumas, especially sexual trauma, which can be difficult to express. This should be implemented across different disciplines within health services, and especially for every patient visiting the psychiatry outpatient clinic.

Recognizing the interconnectedness of various forms of violence experienced, it is essential to investigate the history of sexual violence, especially in cases reporting domestic physical violence. Factors such as the socioeconomic and cultural characteristics of the family should be taken into account. Given that more than one type of violence may occur in a family, it is important to inquire about sexual violence and trauma, especially in the presence of more easily expressed physical trauma. Additionally, considering that some patients with a history of sexual abuse may present at the outpatient clinic without suggestive trauma symptoms, it is important not to overlook the significance of inquiring about the trauma history when approaching these patients. Increasing social awareness is also important. Further prospective studies are required to explore what symptoms patients present in relation to somatization induced by past sexual trauma.

Ethics Committee Approval: Ethics committee approval was received for this study from the ethics committee of İstanbul University (Approval no: 2007/238, Date: January 23, 2008).

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