Survey of Incidence of and Physicians' Attitudes Toward SEXUAL ASSAULT

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A SURVEY of private physicians was undertaken to gather data for a comprehensive rape-reduction project, funded by a State and county. The project includes a legal component, which is to draft and introduce model rape legislation, an advocacy agency for rape victims, and a program at the emergency room of the Harborview Medical Center (HMC), Seattle, Wash., which is seeking to systematize a medical and psychological protocol for the treatment of victims of sexual assault.

The intent of the physician survey was, first, to obtain data regarding the type and number of victims of sexual assault who had been seen by physicians in private practice during a specified period (1973), and second, to assess the physicians' attitudes toward a range of issues related to the treatment of sexual assault and toward the involvement of police in these cases. The survey of the physicians was a pilot investigation that focused broadly on many issues. Analysis of the physicians' responses suggests certain areas in which greater depth and delineation will be required in future research. The need to assess incidence rates for treatment of rape by private practitioners has been expressed by many workers in this field and was of particular concern to the staff of the rape reduction project in the light of their commitment to community education and involvement in medical education. Dr. Charles R. Hayman, medical director of the Job Corps, Manpower Administration, Department of Labor, has been the author or co-author of a number of articles on rape, including one published in an earlier issue of this journal (*1*). He has expressed the opinion, in correspondence with Stern, that a large portion of sexual assaults on middle-class white women are not reported because the medical services of private physicians are available to this group of victims. We have no data to support or contradict this view.

Many workers believe that the incidence of forcible rape reported to the police, although comprising a significant public health problem in itself, reveals only a small portion of rape occurrences. A survey conducted in the Chicago area, for example, showed that only about one of every four victims of assault was reported to the police (*2*). During the study year 1973, approximately 250 to 300 women from the Seattle area were treated for sexual assault at the HMC emergency room. A previously conducted survey of hospital emergency rooms in the Seattle area showed that in 1972 about 120 rape victims were seen in emergency rooms other than the one at HMC. We believed that a canvass of private physicians would make these figures on rape victims in the Seattle area more comprehensive and therefore undertook the study reported here.

Methodology

The survey instrument for the study was written by the interdisciplinary sexual assault team at the Harborview Medical Center. The questionnaires were mailed in March 1974 to 1,010 physicians, whose names and specialties had been obtained from the 1973 King County medical roster. A followup mailing of approximately 600 questionnaires was also sent to those physicians who failed to return the first ones by April 1.

The information section, or second part of the survey instrument, was administered to 258 college undergraduates in an upper-level course in abnormal psychology, as well as to the private physicians, in order to contrast the knowledge level and attitudes of nonmedical persons with those of physicians. Attitudes were inferred by examining the direction of bias on certain items. For example, the correct completion of the statement that "The emotional trauma associated with sexual assault compares with that of general physical assault in the following manner" would be: "This is unknown." However, the fact that only 20 percent of the responding physicians completed the statement correctly is less significant than the fact that 68 percent felt that the "trauma in sexual assault is

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greater," and that only 7 percent felt that "there was less trauma in sexual assault." This result seems to reflect a willingness by the majority of the responding physicians to acknowledge the emotional and psychological factors associated with sexual assault.

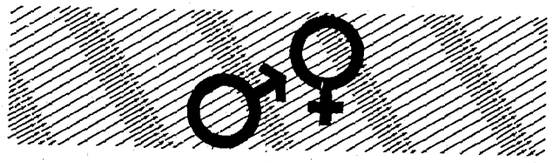
A variety of questions in our survey were designed to elicit physicians' attitudes toward sexual assault and its victims. For example, the private physicians sampled were asked whether they considered rape victims culpable, whether they encouraged them to report assaults to the police, and how they felt about the need for providing psychiatric assistance or referral for victims. We interpreted the information section of the questionnaire from the standpoint of the attitudes the physicians revealed. Such an assessment of attitudes is critical, because the general cultural taboos and strong emotional impact associated with rape cause its victims to be exposed to serious emotional stresses and tensions (*3*).

In most places, "little attention is paid to the emotional trauma, which is often aggravated by the [physician's] examination" (*4*). This emotional trauma is said to occur because "the unhealthly air surrounding such a distasteful situation" is shared by the physician (*5*). The literature reveals no serious study of physicians' attitudes. Yet better knowledge of these should help in the assessment of present problems, the provision of more sensitive care for rape victims, and the intelligent modification of the medical school curriculum.

The results of the physician survey were tabulated for all data received by April 15, 1974. The relatively small number of anonymous returns were tabulated separately to avoid any possible contamination of the rest of the data. We reasoned that the responses of physicians not signing the questionnaires might differ in uncontrollable and unpredictable ways from the responses of physicians signing their names and that the two sets of questionnaires did not constitute a homogeneous sample.

Because physicians with certain specialties were most likely to see the victims of sexual assault, those physicians were selected for study. The following table shows the number of questionnaires sent to the physicians and the number and percentage returned, according to the physician's specialty.

Specialty	*Number sent*	*Number returned*	*Percent returned*
General and family practice	390	191	49
Obstetrics and gynecology	120	46	38
Pediatrics	109	52	48
Psychiatry	142	69	49
General surgery	64	21	33
Internal medicine	165	66	40
Other	20	10	50
Unusable returns		46	5
Anonymous returns		22	4
Total	1,010	523	52



The 523 physicians who returned their questionnaires represented slightly more than half of the total population to whom they were sent. We believe that a 50 percent response in this type of survey affords a sufficiently large sample to warrant attention to the results.

Most specialties individually averaged a 50 percent return rate with the exception of obstetrics-gynecology, internal medicine, and general surgery, which when combined averaged 37 percent. The low response rate from specialists in obstetrics-gynecology is of some interest, inasmuch as physicians in this specialty are the primary ones assigned to treat rape victims in hospital emergency rooms. However, interpretation of this result is difficult. It may be due simply to a sampling error. That is, it may be that a replication of the survey would result in entirely different response rates for the various specialties. Also, the failure of the obstetrics-gynecology group to return the questionnaire may have been a defensive reaction. This specialty has been singled out for criticism by the women's health care movement, and the questionnaire was clearly identified as originating with the rape reduction project. Physicians may have chosen not to respond rather than to make themselves further vulnerable to a presumed attack.

Results

Since not all respondents answered every question in the survey, the number of responses per question varies. All percentages in this report were calculated by comparing the responses of a particular group with the total number of responses per question. Percentages have been rounded to the nearest whole number.

Section I of the questionnaire. Nine questions from the first part of the survey are included in this paper, along with a tabulated summary of the specialists' responses to them. The first question and the summary of the answers to it were as follows:

1. How many females alleged to have been raped during 1973 have you seen in your practice?

Response	*Number of respondents*	*Percent of all respondents*	*Number of victims*
No victims seen	309	67	0
Victims seen	149	33	369
Total	458	100	369

Following is the distribution of the 149 victims of sexual assault according to the specialty of the physicians who saw them:

Specialty	*Respondents*		*Victims*	
	Number	*Percent*	*Number*	*Percent*
General and family practice	83	56	191	52
Obstetrics-gynecology	24	16	46	12
Psychiatry	18	12	40	11
Pediatrics	6	4	14	4
Surgery	4	3	14	4
Internal medicine	7	5	16	4
Other	7	5	48	13
Total	149	101	369	100

Specialists in general practice and family medicine saw the greatest percentage of rape victims—52 percent. Since the victims were not evenly distributed among the 149 physicians and relatively few physicians saw the majority of the victims, it would appear that outreach to the private sector would be most effective by concentrating on those physicians seeing most of the rape victims.

The other questions in section I and the summary of the responses to them appear in table 1.

Section II of the questionnaire. The responses of the physicians and of the 110 male and 148 female students to the information section of the questionnaire are summarized in table 2. Again the pattern and the direction of the responses and the relative differences between those of the students and those of the physicians are of interest, rather than the absolute performance of any respondent on a scale of 10. If a difference greater than 5 percent existed between the percentage of the physicians giving the correct response (that is, the one that best reflects current understanding about sexual assault) and the percentage of all students giving the correct response, then a difference was said to exist for that question. If a difference of 5 percent or less existed between the two groups' responses and the

Table 1. Summary of responses to questions in section I of survey

Survey questions and responses [1]	*Number of respondents*	*Percent of respondents*
2. In how many of the sexual assault cases did your patient—		
Report to the police	211	57
Not report to the police	101	27
No information	57	15
Total	369	[2]99
3. Would you support mandatory reporting by physicians of suspected cases of rape?		
Yes, for all patients	199	46
Yes, for patients under 18	33	8
Yes, other	38	9
No	159	37
Total	429	100
4. Do you feel that there is a need for a routine social service agency (public assistance, public health, etc.) for intervention to help provide adequate treatment for post-traumatic problems (such as pregnancy, VD, emotional disturbance)?		
Yes	291	75
No	119	29
Total	410	100
5. Which of the following do you feel characterize police contacts you have observed in cases of alleged rape? (You may indicate more than one.)		
Favorable response	259	75
Unfavorable response	87	25
Total	[2]346	100
6. Are you reluctant to examine alleged rape victims because of the possibility of being required to testify in legal proceedings?		
Virtually always	43	12
Most of the time	25	7
About half of the time	12	3
Few times	37	10
Virtually never	243	68
Total	360	100

Table 1. Summary of responses to questions in section I of survey—Continued

Survey questions and responses [1]	Number of respondents	Percent of respondents
7. Have you ever testified in a legal proceeding for rape?		
Never	371	85
Only once	42	10
1 to 5 times	18	4
More than 5 times	3	1
Total	434	100
8. Do you generally—		
Encourage or strongly encourage patients to report rape to police?	248	70
Not encourage or discourage patients from reporting rape to police?	27	8
Discourage or strongly discourage patients from reporting rape to police?	1	...
Vary your advice considerably from case to case?	78	22
Total	[3]354	100
9. In your opinion, what percentage of rape victims increased their likelihood of being attacked by behavior such as wearing revealing clothes or behaving in a suggestive manner?		
0–2	59	41
20–40	16	11
40–60	46	32
60–80	17	12
80–100	6	4
Total	[4]144	100

[1] Responses to question 1 are summarized on page 104.
[2] Components do not add to 100 because of rounding.
[3] Because only 149 of the physicians answering this question had seen sexual assault victims, the answers reflect in part what the physicians believed they would do rather than their actual experience.
[4] Only 144 of the 523 physicians returning questionnaires chose to respond to this "projective" rather than "objective" type of item. Therefore response attrition biases this sample, making interpretation of the responses difficult.

Table 2. Summary of responses to questions in section II of survey

Survey questions and responses	Physicians		Male Students		Female students		All students	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
1. Forcible rape rates during the past decade—[1]								
Increased somewhat	70	21	30	28	31	21	61	24
More than doubled (6 percent difference)	151	44	53	50	73	50	126	50
Tripled	83	24	29	18	30	21	49	20
Did not change	35	10	4	4	11	8	15	6
Total	339	[2]99	106	100	145	100	251	100
2. In the 1970s, rape increased greater than any other crime.[1]								
True (9 percent difference)	208	66	54	51	85	61	139	57
False	105	34	52	49	54	39	106	43
Total	313	100	106	100	139	100	245	100
3. The proportion of rapes that occur in the victim's home is quite small.[3]								
True	53	15	13	13	38	26	51	20
False (5 percent difference)	291	85	91	88	108	74	199	80
Total	344	100	104	[2]101	146	100	250	100

Table 2. Summary of responses to questions in section II of survey—Continued

Survey questions and responses	Physicians		Male students		Female students		All students	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
4. The proportion of women raped to the number of women reporting rape is believed to be—[3]								
2:1	27	8	14	13	4	3	18	7
4:1 (5 percent difference)	125	38	44	41	41	28	85	33
8:1	80	24	27	25	48	33	75	30
10:1	95	29	22	20	54	37	76	30
Total	327	[2]99	107	[2]99	147	[2]101	254	100
5. Victims of rape are usually—[1]								
White	100	30	32	30	38	27	70	28
Black	34	10	7	6	5	3	12	5
Oriental								
Indian	2	1						
No racial predilection (8 percent difference)	196	59	69	64	100	70	[1]69	67
Total	322	100	108	100	143	100	251	100
6. Assailants in rape cases are usually—[1]								
White	65	21	21	20	24	17	45	18
Black	55	19	9	8	14	10	23	9
Oriental								
Indian								
No racial predilection (11 percent difference)	192	62	77	72	104	73	181	73
Total	312	[2]101	107	100	142	100	249	100
7. What percentage of rape victims suffer physical trauma?[1]								
0–25 (34 percent difference)	95	43	9	9	11	9	20	9
26–50	82	37	36	38	33	27	69	32
51–75	14	6	15	16	34	27	49	22
76–100	32	14	35	37	46	37	81	37
Total	223	100	95	100	124	100	219	100
8. The emotional trauma associated with sexual assault compares with that of general physical assault in the following manner—[1]								
Trauma in sexual assault is greater	224	68	87	81	132	90	219	87
No difference in trauma	14	4	3	3	3	2	6	2
Less trauma in sexual assault	24	7	1	1	0	0	1	0
This is unknown (9 percent difference)	67	20	16	15	11	8	27	11
Total	329	[2]99	107	100	146	100	253	100
9. The period of time in which emotional trauma associated with sexual assault is most likely to become evident is the first 2 months following the assault.[3]								
True (0 percent difference)	213	70	74	77	97	66	171	70
False	93	30	22	23	50	34	72	30
Total	306	100	96	100	147	100	243	100
10. Of the over 2,500 women reported raped in New York City in 1972, the number of men convicted and sentenced for rape was—[3]								
Approximately 500	5	2	6	6	10	7	16	6
Approximately 100	69	25	29	27	40	28	69	27
Approximately 50	126	44	44	40	52	36	96	38
Approximately 10 (1 percent difference)	81	29	30	28	41	29	71	28
Total	281	100	109	[2]101	143	100	252	[2]99

[1] Percentage of physicians giving correct response differed from percentage of all students giving correct response by more than 5.
[2] Components do not add to 100 because of rounding.
[3] Percentage of physicians giving correct response differed from percentage of all students giving correct response by 5 or less.
NOTE: Boldface type denotes answer that best reflects current understanding about sexual assault.

correct answer, then no difference was said to exist for that question. Each question was classified on this basis.

Discussion

Contrary to the notion that women seen by private physicians constitute a vast hidden iceberg of unreported rapes, we found that 57 percent of the women treated had reported their sexual assault to the police (table 1). In 15 percent of the rape cases, it was not known to the physician whether or not the women had given reports to the police, and presumably a certain proportion of this 15 percent also chose to report their rapes to the police. Furthermore, the number of rape victims (369) seen by private practitioners was fewer than the number seen at all Seattle emergency rooms during the same period (470). If the Ennis ratio of four women who do not report rape to every one who does (2) is accurate, these data suggest that many women simply receive no treatment for their sexual assault. Workers in the field have speculated that women might seek care from private physicians rather than present themselves at emergency rooms, not because they had undergone insufficient trauma of an emergency nature, but rather because of the relative anonymity insured by a private consultation. Reporting of sexual assault to the police is not mandatory for the private physician, as it is at most emergency rooms. Further, when a rape victim goes to a private physician, there may be less danger of publicity, being recognized, or having family members (parents, husbands) notified regarding billing.

If the epidemiologic figures for the incidence of rape are to be accepted, then several factors may be proposed to account for the discrepancy between the number of women assaulted and the number requesting either emergency room or private care related to their assaults. One possible factor is that women may be seeking help under other pretexts, for example, presenting themselves to a venereal disease clinic for examination for possible venereal disease without mentioning that sexual assault has occurred. Another possible factor is that professionals may be underestimating the extent to which sexual assault is a problem for poor women who are unable to afford the care of private physicians, but yet are too embarrassed or intimidated to go to a hospital emergency room in the absence of physical trauma. Finally, also, many women find it difficult to be candid with their physicians concerning sexual matters, and the same fears that prevent these women from going to an emergency room may function to a greater extent than workers have anticipated when these women see a private physician. Indeed, the private physician may not seem a safe haven to the raped woman at all because, for example, of the possible conflict in loyalties the physician may face in deciding whether to inform the patient's parents or spouse. Epidemiologic studies of different populations of women, to determine their attitdues and preferences, would seem to be the next research strategy.

A general willingness to cooperate with law enforcement agencies characterized the physicians' responses to many items on our questionnaire. Nevertheless, 37 percent (table 1) would not support mandatory reporting of rape. Seventy-five percent indicated that their impressions of police contacts in cases of sexual assault were favorable. Seventy percent stated either that they "strongly encouraged" or "encouraged" patients to report rape to the police. Sixty-eight percent denied being reluctant to testify in cases of rape. Physicians' fears of being called to testify appear to be exaggerated, as only 5 percent of those in our study reported testifying more than once in a case of rape.

Approximately 60 percent of the physicians correctly answered each item in the information section. No striking differences were noted between the physicians' responses and the responses of the students taken together or between the responses of male students and physicians. Of the 10 questions presented, differences greater than 5 percent were found for 6 and differences of less than 5 percent for 4 (table 2). Of the 6 questions in which there were differences, the differences were not great—6, 9, 8, 11, 34, and 9 percent. The question in section II for which the differences were most marked was No. 7 (34 percent difference); this differences may have stemmed in part from a wording that failed to distinguish between physical trauma (cuts, bruises) and forceful penetration. The difference probably also can be attributed to a popular conception of rape as a far more violent crime than it frequently is; 37 percent of the students believed that physical trauma occurred in 76 to 100 percent of the cases.

The responses of the female students departed from those of the male students and the physicians in the direction of overestimating the frequency of rape. Thirty-seven percent of the female students believed that the proportion of women raped to the number reporting rape was 10 to 1, whereas only 20 percent of the male students and 29 percent of the physicians made that estimate. Furthermore, women tended to agree more frequently than the male students or physicians that "trauma in sexual assault is greater than trauma associated with general physical assault" (female students 90 percent agreement, male students 81 percent, physicians 68 percent). The female students believed more frequently than did the other two groups that emotional trauma following sexual assault was more likely to emerge after 2 months. The general tendency in female responses was to emphasize the duration and severity of the emotional trauma that they believed was associated with sexual assault and to overestimate the incidence. This result seems to reflect the women's greater sense of vulnerability and identification with the victims of sexual assault. It may be argued that because of regional variations and lack of hard data on the subject, female students are more accurate in their perceptions and that male students and physicians underestimate these issues. The pattern of responses, in particular to the more "projective" questions such as the comparison between trauma associated with sexual and nonsexual assault, suggests that our interpretation is accurate. However, until this survey is replicated with different samples, this statement cannot be made with certainty.

There was a general tendency for all groups to overestimate rather than to underestimate the incidence of rape (question No. 4). A tendency was also seen to stereotype rape victims as white (question No. 5), and for physicians to overemphasize the role of the black male as assailant (18 percent for physicians versus 9 percent for all students). However, the differences only showed trends and were not marked. In summary, response patterns among the three groups for this section of the questionnaire showed remarkable similarities. The general tendency was to overestimate the incidence of psychological and physicial trauma associated with sexual assault rather than to deny them.

There are implications from these data for the treatment of rape victims, for the training of those who provide it, and for further research. The results suggest that the emergency room is still the principal treatment site for rape victims and that efforts at increasing services and care for these women should be directed there. Since the general practitioner, rather than the specialist, is most frequently consulted by the victims of sexual assault, it would seem appropriate to provide medical students with information regarding the physical and emotional treatment for sexual assault and not reserve such instruction until the student specializes.

Because of the broad nature of this investigation, certain significant questions could not be answered. They include (*a*) the type of victim seen by the various kinds of specialists in terms of victim's age, race, type of assault, relationship to offender, presenting complaint, and the kind of relationship of the physician to the rape victim (that is, family physician, walk-in consultation, and so forth) and (*b*) the demographic and ethnic characteristics of the physicians who saw victims of rape, the physician's age, sex, location of office, community involvement, and whether he inquired when he suspected sexual assault.

The reliability of the information or attitudes section of the questionnaire could be increased by doubling the number of questions asked from 10 to 20. Elimination of the questions for which the correct response was most equivocal would facilitate interpretation of results. By determining the correlation coefficients among the items in the questionnaire, the consistency of the physicians' responses could be ascertained and thus the validity of the survey instrument assessed. The questionnaire also could be further validated by cross-validating items from the information section to relevant questions in the first section, for example, attitudes regarding the reporting of rape by the physician and the encouragement of reporting by the physician.

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SYNOPSIS

McGUIRE, L. S. (University of Washington School of Medicine), and STERN, MICHAEL: *Sexual assault: Survey of incidence of and physicians' attitudes toward. Public Health Reports, Vol. 91, March-April 1976, pp. 103–109.*

In a recent pilot project, the number of women treated by private physicians for sexual assault was surveyed, and information was obtained regarding the physician's knowledge of, and attitudes toward, issues related to sexual assault. The high incidence rates for treatment of rape by private physicians that have been speculated in the literature were not confirmed by the survey results. Sixty-seven percent of the 458 physicians responding to the survey reported seeing no rape victims during the study year. Since, however, the proportion of physicians seeing rape victims may show regional variations, this result should not be applied too generally.

Ten factual questions about rape were sent to more than 1,000 physicians and given to 258 undergraduate psychology students of both sexes. Both the responding physicians and the students answered approximately 60 percent of the questions correctly (that is, selected the answers that best reflect current understanding about sexual assault). The respondents' attitudes toward sexual assault were inferred from the direction of their responses. Physicians were seen to share attitudes similar to those of the male students, but not of the female students. The female students tended to overestimate the incidence of rape, the physical trauma associated with it, and the timing of its psychological after effects.

Life Crisis as a Precursor to Child Abuse

BLAIR JUSTICE, PhD, and DAVID F. DUNCAN; BA

CHILD ABUSE can be regarded as a major public health problem (*1,2*). Kempe reports that roughly 25 percent of all fractures seen in the first 2 years of life and 10 to 15 percent of all trauma seen in the first 3 years are due to abuse by parents or parent surrogates (*3,4*). The true prevalence of child abuse is difficult to estimate. According to Gil (*5*), 6,617 cases were reported in 1968. Estimates of the total number of actual cases per year range from Zalba's estimate of 200,000 to 250,000, with 30,000 seriously hurt (*6*), to Light's of a half-million (*7*), to Gil and Noble's of an upper limit of between 2.5 and 4.1 million (*8*).

What distinguishes the abusing family from the nonabusing one? We have found that people who abuse are neither cruel maniacs nor even parents who do not love their children. For the most part they are not insane—they defy psychiatric classification as a group (*9*). Therefore, how do they differ from parents who do not abuse?

One answer is provided by the environmental-stress theorists, as represented by Gil. In his nationwide case-register study, Gil (*5,10*) found that reports of child abuse were concentrated among the poor. Child abuse may, therefore, be regarded largely as being one more aspect of the lifestyle associated with the poverty syndrome. In Gil's words (*10*), "Life in poverty generates many additional stressful experiences which . . . are likely to become precipitating factors of child abuse. The poor are subject to the same psychological conditions which may cause violent behavior toward children as are the non-poor; but in addition to this, they are subject to the special environmental distresses and strains associated with socioeconomic deprivation." Gil's approach should not be misinterpreted as a single-cause theory. Rather, it is one which emphasizes social and cultural influences and particularly the stresses associated with an inegalitarian society (*11*).

A similar viewpoint is present in Gelles' social-psychological theory of child abuse (*12*). Essentially, Gelles sees child abuse as a particular form of adaptation to stress. Considering also such factors as societal values and norms, socialization experience, and "psychopathic states," Gelles emphasizes such stress areas as socioeconomic position of parents, marital stresses, excess children, unemployment, social isolation, unwanted or "problem" children, and immediate precipitating situations such as an argument or child misbehavior.

The foremost theory in the field of child abuse is the psychodynamic one developed by Kempe (*3,4*), Helfer (*13*), and Steele and Pollock (*9*). This approach presents a three-factor theory of the causation of child abuse. The three factors as described by Helfer (*13*) are: First, the parent must have the potential to abuse, primarily as a result of receiving an inadequate "mothering imprint" in his or her own childhood. Second, the child must be seen by the parent as being "special" whether he really is or not. Third, a crisis must occur which precipitates the incident of abuse.

In the psychodynamic theory, stress also plays a part, but only as a precipitating event. This crisis may be as major as a husband being drafted or as not having enough money to buy food, or it may be as small as a washing machine breaking down (*3,4,13*).

Each of the preceding briefly summarized theories gives stress an important part in the causation of child abuse, whether as a basic cause, a precipitating event, or both. Stress in each case is viewed as an aversive state or incident. It is something unpleasant that happens to a person.

An alternate conception of stress, based on change, has been developed within the field of psychosomatic medicine. This approach grew out of Meyer's (*14*) "life chart" that arranged for each patient a record of ". . . changes of habitat, of school entrance, graduations or changes or failures; the various jobs, the dates of possibly important births and deaths in the family, and other fundamentally important environmental influences" which could be charted against changes in physical or mental health. In this approach stress is

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