

The Prevalence Rate Of Sexual Trauma In A Primary Care Clinic

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Background: Despite the high prevalence rate of sexual victimization in the general population, little is known about the characteristics of abuse victims in primary care. We studied the prevalence rate of childhood and adult sexual trauma in a primary care clinic, associated psychological distress, and patients' attitudes about physician inquiry into past sexual victimization.

Methods: Self-report questionnaires were given to 162 women in a primary care clinic inquiring about past episodes of childhood sexual abuse, adult sexual assault, and patients' desire that their physicians be aware of their sexually traumatic experiences. The women also completed the Trauma Symptom Checklist-40 (TSC-40), a measure of psychological distress.

Results: The rates of childhood sexual abuse (37 percent) and adult sexual assault (29 percent) in this primary care clinic were comparable with, but somewhat above, the rates reported for the general population. Although most of the women (61 percent) believed it was appropriate for their physician to ask about previous victimization, only 4 percent had been asked. Women who had experienced sexual trauma were more distressed when compared with nonvictimized women, as measured by the TSC-40. Childhood sexual abuse was associated with greater distress than was adult sexual assault, and combinations of childhood and adult trauma were associated with the highest distress levels.

Conclusions: A history of sexual abuse or assault can be a relatively common finding in primary care clinics. Patients might benefit from routine physician inquiry into histories of childhood and adult sexual victimization, and physicians should be mindful of the long-term medical and psychological sequelae that frequently result from this trauma. (*J Am Board Fam Pract* 1993; 6:465-471.)

Approximately one-third of women have experienced sexual contact from an older individual by their middle teenage years,¹ and 1 in 5 adult women has been the victim of a completed rape at some time in her life.² Because the number of victimized women who attend specialty sexual trauma centers is far less than the prevalence of abuse and assault in the general population would suggest, it is likely that many women either go without care or obtain what health care they can from their primary physician.³ Presumably, therefore, primary care physicians come into daily contact with a great number of these sexually victimized survivors.

Despite frequent contact, however, these providers receive little training in how to recognize

or treat sexual abuse or assault sequelae other than in acute management of rape and childhood sexual abuse trauma.⁴ Many physicians are unaware of the histories of victimization in their patients and might be equally uncertain about how to manage the information once it is disclosed. Not surprisingly, less than 10 percent of all sexual abuse reports to state child protective agencies originate from physicians.^{5,6}

Very little is known about the detailed nature of the care provided for these women in primary care clinics. What is the prevalence of previous childhood sexual abuse and adult sexual assault in this setting? Are sexually victimized patients psychologically different from those without such histories? What are patients' attitudes about discussing these experiences with their physicians? Do women with histories of sexual victimization visit their physicians more frequently or have a greater number of physical complaints?

We undertook a pilot study in an attempt to address some of these questions using a self-report questionnaire in a primary care clinic. We

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hypothesized that (1) histories of sexual victimization would be more common in a primary care clinic than in the general population; (2) women who had been sexually victimized would report more psychological distress than women who had not been so victimized; (3) women who experienced childhood abuse would be more distressed than those women who reported adult assault only, and women who reported both childhood abuse and adult assault would be associated with the most current distress; (4) women with past victimization would have a greater mean number of physician visits in the past year and medical complaints in the past month; and (5) women would report that they are not routinely asked about sexual trauma by their physicians.

Methods

During a 2-week period in 1992, we administered an anonymous screening questionnaire to women aged 18 years and older who attended the Family Medicine Clinic of the University of Washington Medical Center. A consecutive sample of 193 adult women was obtained from the total number of women who sought medical care during that time. This sample represented nearly 90 percent of the women who had clinic appointments during those 2 weeks, and although there were brief, periodic lapses in enrollment, these lapses were not thought to influence the sampling. After registering for their appointments, the women were greeted by the study coordinator, a 4th-year medical student, who verbally invited them to participate. Of the 193 women approached, 178 (92 percent) consented to complete the questionnaire, with 162 (91 percent of those consenting, or 84 percent of the approached sample) fully completing the study instrument. Women who were unable to see or read or who did not speak English were excluded from the study, and women who had repeat appointments participated only once.

The questionnaire began with a modified version of the Psychosomatic Symptom Checklist⁷ and included some general questions about health problems that might have occurred in the past month. It then introduced childhood sexual abuse and adult sexual assault as common problems for women and continued by asking (1) how comfortable the woman might be discussing any health issues with her physician, (2) how comfortable she

would feel discussing sexual victimization episodes, (3) whether it would be a good idea for physicians to ask routinely about these experiences, (4) whether a physician ever had asked her at any time about sexual abuse or assault, and (5) how frequently the woman had visited a primary care physician in the past year.

The questionnaire then requested further details about any episodes of sexual trauma. Three questions inquired into episodes occurring before the age of 18 years during which the woman had any of the following sexual experiences with someone at least 5 years older: (1) touching of breasts or genital area, (2) attempts that stopped before penetration, and (3) completed penetration. A second series of questions inquired about adult episodes of sexual assault in which the woman had experienced either completed or attempted penetration using force, threat of force, or incapacitation by drugs or alcohol. Affirmative answers to any of these questions led to a request for further details about concurrent physical assault, relationship to the perpetrator, and whether the woman told anyone, including her physician. The questions were nearly identical to those used in a large crime victimization study of 2291 women from a midwestern primary care health maintenance organization by Koss, et al.³

The questionnaire concluded with the Trauma Symptom Checklist-40 (TSC-40),⁸ a modified version of the Hopkins Symptom Checklist. The TSC-40 has proven reliability and validity and is considered a sensitive instrument in detecting psychological and physical distress in victims of sexual abuse and assault.⁸ It has several scales to measure general psychological distress, depression, anxiety, dissociation, hypothesized sexual abuse trauma, and sexual dysfunction.

We first calculated the prevalence rate of various categories of sexual trauma including both penetration and attempted penetration in both children and adults and genital contact in children. Women who reported rape or attempted rape as children, adults, or both were compared with each other and with women who were not abused with respect to their responses on the TSC-40 using analysis of variance.

Results

The 162 women who completed the questionnaire had a mean age of 37.4 ± 13.7 years (range

18 to 82 years) and an average total household income of approximately \$24,000. On average they completed at least 1 year of college, and 37 percent were married. These demographic characteristics are highly representative of all women attending the Family Medicine Clinic.

When asked about their comfort in discussing various topics with their physicians, 130 (84 percent) said that they would be comfortable discussing anything, and 89 (61 percent) thought that physicians should routinely ask about histories of sexual victimization. Only 6 (4 percent), however, had ever been asked by their physician. There were no significant differences between women who were or were not victims of sexual trauma in the answers to these questions about physician inquiry.

Table 1 shows the percentage of childhood and adult forms of sexual trauma reported by this sample of 162 women. Childhood forms included all forms of physical contact of a sexual nature before the age of 18 years with a person at least 5 years older who was not considered a peer. Adult sexual abuse included all forms of unwanted penetration using force, threat, or incapacitation by drugs or alcohol. Approximately 40 percent of the women had experienced some form of childhood sexual contact, and 1 in 6 had been raped as a child.

Table 2 further details the responses of the 64 women who reported any form of childhood sexual contact (penetration, aborted penetration, and fondling) and the 47 women who reported adult rape or attempted rape using the above definitions. Nearly one-half of the patients had sexual

Table 1. Percentage of Past Sexual Victimization in a Primary Care Sample of 162 Women.

| Reported Trauma | No. (%) |
|--|---------|
| Childhood | |
| Fondling of breasts or genitals | 62 (39) |
| Aborted attempts at penetration | 27 (17) |
| Successful penetration | 26 (16) |
| Either aborted or successful penetration | 37 (23) |
| Any childhood sexual contact | 64 (40) |
| Adult | |
| Aborted attempts at penetration | 33 (20) |
| Successful penetration | 35 (22) |
| Either aborted or successful penetration | 47 (29) |
| Combinations of trauma | |
| Both childhood and adult penetration | 11 (7) |
| Either childhood or adult penetration | 50 (30) |

Table 2. Responses of Women Who Reported Sexual Victimization.

| Response | Childhood Abuse | Adult Assault |
|------------------------------------|---------------------|---------------------|
| | (n = 64) No. (%) | (n = 47) No. (%) |
| Contact by parent or family member | 28 (44) | 29 (60) |
| Contact more than one time | 39 (64) | 24 (49) |
| Also physically abused | 13 (21) | 26 (53) |
| Told anyone about it | 23 (38) | 21 (44) |
| Told a physician | 2 (3) | 4 (8) |
| Did not tell physician | 62 (97) | 43 (92) |
| Physician did not ask | 28 (45) | 22 (51) |
| Physician was not a woman | 5 (8) | 7 (16) |
| No physician was available | 13 (21) | 7 (16) |
| Too embarrassed | 17 (27) | 23 (53) |

contact with a parent or family member when they were children. For more than one-half of the women victimized in childhood, there were repeated episodes. Adult rape or attempted rape was also most frequently perpetrated by a family member.

We compared women who reported a history of any form of childhood sexual contact with women who did not report childhood victimization with respect to TSC-40 distress scores. Women with a history of childhood victimization were significantly more distressed than women without a history of childhood sexual trauma (25.1 ± 15.1 versus 20.5 ± 13.0 ; $t = 2.05$, $df = 160$, $P < 0.05$). Similarly, we compared women who reported adult victimization with those who did not and found that the women who had experienced adult sexual assault were also significantly more distressed than those who had not (26.0 ± 16.5 versus 20.7 ± 12.5 ; $t = 1.96$, $df = 160$, $P < 0.05$). It should be noted that the differences would be even more marked in both comparisons had we excluded women from the comparison groups who had been sexually victimized at a different time (i.e., in comparing childhood versus no childhood abuse, some comparison women did not have childhood abuse but did have adult sexual assault experiences).

We further classified women into combinations of adult and childhood sexual victimization. Table 3 shows the mean and standard deviations of the TSC-40 subscales for four groups of women: those who reported both childhood and adult victimization ($n = 11$), those who reported child-

Table 3. TSC-40 Scores for Women with and without Severe Sexual Trauma: Combinations of Childhood and Adult Trauma.

| | Both Childhood and Adult Trauma (n = 11) Mean ± SD | Childhood Trauma (n = 15) Mean ± SD | Adult Trauma (n = 24) Mean ± SD | No Trauma (n = 112) Mean ± SD | F <i>df</i> = 3158 | P |
|---------------------|--|--|---------------------------------------|-------------------------------------|--------------------|------------------------|
| Composite TSC-40 | 36.7 ± 17.0 | 26.8 ± 15.5 | 23.9 ± 16.4 | 19.9 ± 11.7 | 6.37 | < 0.0001* |
| Dissociation | 4.5 ± 3.3 | 3.1 ± 3.1 | 2.9 ± 3.2 | 2.3 ± 2.3 | 2.65 | < 0.05* |
| Anxiety | 6.5 ± 3.4 | 4.6 ± 4.2 | 4.1 ± 3.5 | 3.8 ± 2.7 | 2.61 | < 0.05* |
| Depression | 8.4 ± 3.5 | 7.1 ± 5.1 | 6.4 ± 4.1 | 5.5 ± 3.4 | 2.64 | < 0.05* |
| PSAT-h [†] | 5.6 ± 3.2 | 3.0 ± 2.2 | 3.1 ± 2.9 | 2.1 ± 2.0 | 9.21 | < 0.0001* [‡] |
| Sleep problems | 5.5 ± 2.1 | 4.1 ± 2.8 | 3.5 ± 2.3 | 3.6 ± 2.5 | 3.15 | < 0.02* |
| Sex problems | 7.5 ± 4.7 | 5.5 ± 3.0 | 5.0 ± 3.0 | 4.0 ± 2.6 | 5.57 | < 0.001* |

*Both-trauma and no-trauma groups significantly different, *P* < 0.05.

[†]Post-sexual abuse trauma-hypothesized.

[‡]Both-trauma group significantly different from all other groups, *P* < 0.05.

hood abuse only (n = 15), those who reported adult assault only (n = 24), and those who reported neither form of trauma (n = 112). We compared the four groups with respect to the overall TSC-40 composite score, and finding this comparison to be significant, we repeated the analysis of variance on each of the subscales as well using a post hoc Tukey test. Although significant differences were found only between the "both child and adult" and "no sexual trauma" groups, on nearly all the scales a trend suggesting a severity gradient was present as one progressed from no abuse through adult, child, and finally child and adult together.

We compared the four groups with respect to their reported number of clinic visits for the last year. There were no significant differences in the mean number of reported visits (both child and adult abuse = 4.4 ± 3.1, child abuse only = 2.5 ± 1.7, adult abuse only = 3.7 ± 2.9, no abuse = 3.7 ± 4.0, *df* = 3158, *F* = 0.53, NS) or mean number of medical complaints on the Psychosomatic Symptom Checklist (both child and adult abuse = 4.7 ± 2.2, child abuse only = 3.9 ± 3.3, adult abuse only = 3.5 ± 3.0, no abuse = 3.6 ± 2.4, *df* = 3158, *F* = 0.36, NS).

Discussion

The results of this study showed that the prevalence rates of childhood and adult sexual trauma in our primary care clinic were comparable with, but slightly above, those rates found in the general population. Although 61 percent of the women stated that physicians should routinely ask

about these experiences, only 4 percent had been asked by their physicians. Women who had been sexually victimized were significantly more distressed when compared with nontraumatized women, as measured by the TSC-40, with childhood abuse associated with greater distress than adult assault, and combinations of childhood and adult trauma associated with the greatest amount of current distress. Victimization status was not related to self-reported medical care utilization or number of physical symptoms or diseases.

This investigation was a pilot test of a questionnaire to be used in a larger primary care population study of sexual trauma sequelae, and several factors suggest that the results should be interpreted with caution. The data are based on a relatively small sample and are taken from a multicultural, urban, primary care clinic in a university hospital, a setting that might produce higher rates of psychopathology. Questionnaire-based sexual trauma rates might not be comparable with those obtained during face-to-face interviews, and self-reports of medical utilization and symptom complaints might be less valid than medical record data. Nevertheless, even with these limitations, the high prevalence rates of childhood and adult sexual trauma found in this clinic and the great degree of psychological distress among survivors of abuse suggest that further study of this population is warranted.

Three other studies have examined the prevalence rate of sexual abuse victimization in primary care samples.^{3,9,10} Koss, et al.³ administered a

mailed, self-report instrument to 2291 adult women in a midwestern primary care health maintenance organization as part of a study of crime victimization and found the prevalence of forced adult sexual contact to be 21 percent. The prevalence rate of adult rape in the present study (29 percent) is similar to that reported by Koss, et al. and to the general population rates reported by Kilpatrick, et al.¹¹ (23 percent), Russell¹² (24 percent), and Wyatt¹³ (20 percent for white women, 25 percent for African-American women).

Friedman, et al.⁹ used self-report questionnaires in two urban primary care hospital clinics and found the prevalence rate of sexual trauma to be 17 percent. That the principal goal of the study was not to establish prevalence rates, but to examine physician and patient preferences for inquiring into past physical and sexual abuse, could account for the lower rate. Their study had a lower participation rate (approximately 63 percent) than our study and used a less-specific, global lifetime definition of sexual victimization, which blurred the distinction between child and adult forms of trauma and did not allow later analysis of perceived severity.

Greenwood, et al.¹⁰ interviewed 100 patients in a general medical population (59 women and 41 men) and found the rate of sexual victimization to be 17 percent of the women and 0 percent of the men. Eighty percent of the sexual victimization episodes happened before the age of 10 years. This study benefited from a clinician interview and more specific abuse questions, but their study sample represented a more homogeneous, middle-class Midwest population, which could account for the relatively lower prevalence rate of reported trauma.

While all three investigations found rates of sexual victimization somewhat comparable with those of the present study, their findings are difficult to compare because of important differences in methods. The study of sexual victimization prevalence rate in primary care populations is relatively new and is beset by the same methodological problems inherent in all sexual trauma investigations. Differences in victimization definitions, retrospective recall of sometimes distant events, and the absence of standardized data collection instruments have led to discrepancies in case determination and findings of unknown validity. Results can also be highly influenced by the

demographic composition of the samples, with studies of urban, multicultural populations from lower socioeconomic strata often yielding higher rates of psychopathology and trauma.

Nevertheless, nearly all victimized women eventually visit primary care physicians. In the study by Koss and colleagues,³ 93 percent of the women visited their primary care physician within 1 year after the assault, and all had visited during the 2nd year. Despite this apparent frequency of contact and the finding of the present study that 61 percent of our sample thought that physicians should routinely ask about sexual trauma, only 4 percent of the women in this study had ever been asked by any primary care physician. Friedman, et al.⁹ also found that 68 percent of primary care patients favored routine inquiry about sexual victimization, whereas only 6 percent had ever been asked.

Although the studies by Koss, et al. and Friedman, et al. focussed on different aspects of victimization, the strength of the current investigation is that it bridges the two studies while validating their findings. We were also able to obtain more specific information on the perceived severity and age of onset of the sexual trauma, as well as obtain an index of current psychological distress.

The TSC-40 findings are in agreement with a substantial literature, which suggests that women who report sexual abuse are more distressed than women who do not report abuse.¹ Clinicians generally regard childhood abuse as a more powerful determinant of adult psychological disability than adult-onset victimization, and we expected to find important differences along a gradient consisting of no trauma, adult only, child only, adult plus child. Because of the relatively small cell sizes in our study, we are not able to show statistical differences between groups except between the adult-plus-child and no-victimization groups; however, a trend appears to be present in the TSC-40 composite scores, as well as its subscales, which suggests that this severity gradient might exist.

Primary care physicians (including family physicians, gynecologists, internists, and pediatricians) are in a unique position to intervene in the recognition and treatment of medical and psychological sequelae of sexual abuse and assault, as most reproductive-aged women seek relatively frequent, recurrent care for gynecological health and birth control. In addition to administering

physical health care, primary care physicians provide 60 percent of the total mental health care in the United States, whereas the specialty mental health settings account for only 15 percent.¹⁴ Thus, it is important that these primary care providers be aware of the high prevalence rate of earlier sexual victimization in this population, as well as the treatment of the medical and psychological sequelae of this trauma.

The women in both the Friedman, et al. study and our investigation indicated a willingness to be asked about sexual trauma, and approximately 90 percent of those in the Friedman, et al. study reported that they would respond truthfully if directly asked. Although primary care physicians might not believe they can provide for the many complex psychological needs of sexual trauma survivors, they could benefit from training that enhances their awareness of sexual victimization prevalence, as well as their ability to inquire more deeply into histories of trauma. The Council on Scientific Affairs of the American Medical Association has recently issued a special report declaring the need for increased awareness on the part of physicians for all forms of violence against women and has suggested guidelines for physician training in the assessment of past victimization as part of the routine care of women.⁴

We did not observe increased medical utilization or symptom reporting by the abused women compared with nonabused women. This finding, which was unexpected given the magnitude of the psychological distress scores, could be due to a number of factors. The nonoverlapping victimization classifications used in this study resulted in relatively small sample sizes in some of the cells, thus decreasing power. We also did not screen for emotional and physical abuse or neglect, and many of the comparison subjects could have had earlier experiences of this abuse, which would tend to decrease differences in utilization between the groups. There are important limitations in using self-reported recall of utilization or past medical symptoms, as retrospective recall is frequently flawed. Nevertheless, although there were no significant differences between the groups, there was a trend for adults who experienced both childhood and adult trauma to report a greater number of clinic visits.

As the burden of routine psychological care gradually shifts to the primary care physician, the

data from this study suggest the importance of further research into the longitudinal course of sexual victimization in primary care settings. A better understanding of the relation between sexual trauma and subsequent primary care utilization could lead to more thorough primary prevention of sexual abuse and assault and better primary care treatment of long-term trauma survivors. Decreased health care costs would result from earlier recognition of both acute and chronic symptoms of sexual abuse, as well as the long-term health risk behaviors, such as early pregnancy and sexually transmitted diseases that might be associated with earlier victimization.

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EXPIRATION OF PRACTICE CATEGORY FOR ABFP CAQ IN GERIATRICS

The practice eligibility category for qualifying for the American Board of Family Practice Certificate of Added Qualifications in Geriatric Medicine will expire with the April 12, 1994, examination. After 1994, eligibility will be limited to those ABFP Diplomates who have successfully completed a two-year accredited Geriatric Fellowship.

Requirements for the exam include current certification with the American Board of Family Practice, current and unrestricted licensure in the United States or Canada, and eligibility through one of the following routes:

- A. Two years of accredited Geriatric Fellowship training;
- B. One year of accredited Geriatric Fellowship training plus two years of substantial (20%) geriatric practice; or,
- C. Four years of substantial (20%) geriatric practice.

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