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Rape: Primary Care Providers Help Pick Up the Pieces

For ten years, Mary P. Koss, PhD, of the Family and Community Medicine Department and the Arizona Prevention Center, and Paul G. Koss, MD, of the Thomas-Davis Medical Centers in Tucson, Arizona, have conducted extensive research on the long-term mental and physical health repercussions of rape. In recent years some of their colleagues have collaborated in these efforts. The following article, published by the Arizona Department of Health Services, in its epidemiology newsletter, Prevention Bulletin, *provides a summary of their research results, as well as practical guidelines for health providers whose clients have been victims of sexual violence.*

Rape is one of life's most devastating traumas. It is as likely to lead to serious post-traumatic stress disorder as is exposure to combat. Medical texts have historically emphasized rape's emergency handling and forensic documentation. Substantial clinical literature now exists on the longitudinal health care repercussions of rape. This article reviews the links of rape to chronic illness and discusses clinical management. Primary care providers are uniquely situated to assist survivors of sexual victimization, and these interventions need not be time consuming. In fact, such efforts can save time in the long run because they usually result in a more precise diagnosis of underlying etiology, reduced overall health care utilization, and prevention of further negative health consequences.

Incidence and Prevalence

Rape is vaginal, oral ,or anal penetration against consent , eg, when obtained through force or threat of bodily harm; or without force but with an incapacitated person unable to consent, eg, someone sleeping, unconscious or intoxicated. Sexual assault is a broader term that includes rape as well as various nonpenetration sexual offenses. Estimates based on federal incidence data indicate that almost 5 per 1,000 women over age 12 years were raped or sexually assaulted in 1992, but these data understate the importance of rape in primary care. Because rape may continue to affect the survivor for years, its impact is cumulative. To capture this effect, prevalence is calculated using the lifetime as the reference period. Nationally, approximately 13% of women have endured forcible rape at least once in their lifetimes. Within primary care practices, approximately 20% of women reveal a history of rape, and more than half of the victims were raped before they were 17 years old.[1]

Impact

Stereotypes suggest that the typical rapist is a violent stranger. In reality, 8 of 10 rape victims know the men who attack them, and one-half to two-thirds sustain no physical injuries. The vast majority of rapes occur within marriages or other close relationships. Self-report and interview-administered symptom checklists reveal that victims of rape report more symptoms of illness across virtually all body systems except the skin and eyes and perceive their health less favorably than do nonvictimized women. Severe victimization is also associated with lowered likelihood of practicing healthful lifestyles: rape victims are more likely to smoke and use alcohol and less reliable in their use of seat belts. Research data are lacking regarding the association between sexual vicitmization and other forms of self care: obtaining preventive health care, early prenatal care, safe sex, substance abuse, and pregnancy planning/prevention/education programs (especially among teens).

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Increased Medical Expenditures. Women patients at one large HMO who had a history of rape and physical assault were studied. Severely victimized women made nearly twice as many physician visits a year as nonvictimized women (6.5 versus 3.5).[2] Utilization data across five years ruled out the possibility that the victims had been high health service users prior to their attacks. These findings were replicated in studies of Medicaid patients, whose medical utilization increased 22% on average as a result of rape.

Associations with Chronic Illnesses. Apart from lifetime elevated risks of psychiatric illness, the following long-lasting symptoms and illnesses have been associated with rape: chronic pelvic pain; premenstrual syndrome; gastrointestinal disorders; and several chronic pain disorders, including headache, back pain, and facial pain.[3,4] Rape victimization is also more prevalent among persons with serious drug problems and those who report unsafe sex practices. These findings might suggest that victims are somaticizing their psychic distress. However, the number of rape victims who qualify for the psychiatric diagnosis of somatization disorder is small. In one large epidemiologic community survey, with a sample size of more than 3,000, too few cases of somatization disorder were identified to analyze statistically.

Furthermore, a great deal of effort also has been devoted to discovering whether victims' chronic complaints have a medical basis. Several studies have found that rape victims compared with nonvictimized women were more likely to report *both* medically explained (30% versus 16%) and medically unexplained symptoms (11% versus 5%).

Difficult Management. Leserman, et al, observe that patients with histories of rape and other forms of sexual abuse may raise difficult management issues.[4] Among them are difficulties undergoing certain procedures including dental, rectal, pelvic, or endoscopic examinations. Difficulties in the therapeutic relationship may include magical expectations for cure and delegation of decision making to the physician, coupled with poor compliance. Feelings of shame may influence the patient's willingness to submit to unneeded or painful procedures.

Screening

The American Medical Association recommends screening for exposure to violence at every entrance to the health care system.[5] However, the data suggest that such screening is rare, even among psychiatric physicians. Male physicians in particular may fear that their interest in this subject will be misunderstood or considered too personal even for the doctor-patient relationship. On the contrary, women say they consider such questions to be welcome and germane to routine medical care.

To question about rape, physicians may wish to keep several suggestions in mind:

First, set the stage for inquiry: "Physicians are learning that unwanted sexual experiences involving strangers, friends, and even family members are far more common than previously thought and have health-related consequences."

Second, give enough detail to initiate the inquiry: "Have you ever felt forced to have sex with anyone at all when you didn't want to?"

Third, be nonjudgmental and validating: "I'm sorry that happened to you." Remember that medical providers routinely depend on the patient's perspective and their self report in diagnosis.

DO NOT treat rape as an exception and try to second guess what *really happened.* DO NOT use the word "rape." This is a legal term that many women avoid using it in reference to themselves: they are unaware of its exact meaning and also wish to avoid the stigma of rape.

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Intervention with Identified Survivors

The hesitancy to screen may stem from the fear of opening Pandora's Box. Will the patient break down or use too much time? What does the physician do with a positive identification? Physicians practicing today were trained to handle chest pain, not sexual victimization. However, most physicians' fears about lacking skill and knowledge are unfounded.

By screening and responding nonjudgmentally, the physician can at least offer the option of revisiting the subject later. Patients often reveal only to their physicians experiences that happened years before. As time passes, the patient often express a desire to discuss possible links between sexual victimization and health, or they may even ask for assistance in coping. At this point, referral may be appropriate, and specialized agencies exist to provide services for adult survivors of rape and sexual abuse in childhood at little or no cost. It may NOT be a good idea to suggest counseling immediately upon disclosure, especially if the patient has coped for years without using it. People go through states of readiness in the process of change, and a referral may be more likely to be acted upon when its suggestion coincides with a willingness to consider counseling.

Research on secrets has shown immediate and long-lasting positive effects on indices of immune functioning following simple disclosure. Offering the opportunity to unburden and describing community resources are not very sophisticated interventions when viewed from the biomedical perspective of modern imaging techniques and powerful pharmaceuticals, but in the case of rape, it may be all the patient needs to initiate healing.

References

1. Walker EA, et al. The prevalence of sexual abuse in a primary care clinic. J Am Board Fam Prac 1993: 6:465-471.

2. Koss MP, Koss PG, and Woodruff WJ. The deleterious effects of criminal victimization on women's health and medical utilization. Arch Intern Med 1991;151:342-347.

3. Koss MP and Heslet L. The somatic consequences of violence against women. Arch Fam Med 1992; 1:53-59.

4. Leserman J, et al. Sexual and physical abuse history in gastroenterology practice: How types of abuse impact health status. Psychosomatic Med 1995; 58:4-15.

5. Council on Scientific Affairs, American Medical Association. Violence against women: Relevance for medical practitioners. JAMA 1992;267:3184-3189.

Adapted from Koss MP and Koss PG. Rape: Primary Care Providers Help Pick Up the Pieces. The Prevention Intervention. In: Prevention Bulletin. Arizona Department of Health Services 1996; 10(6)

Parke-Davis Influenza Vaccine Recall

On February 12, 1997 the Parke-Davis division of Warner-Lambert Campany voluntarily recalled all remaining lots of its influenza vaccine containing A/Nanchang/933/95 (H3N2). Because this component has been shown to lose its potency over time, the vaccine potentially will not provide protection through the stated expiration date. The affected lots numbers are 00296P, 00376P, 00476P, 00596P, 00696P, 01186P, 01286P, 01386P. These lots were of standard potency during their period of distribution and throughout the typical period for influenza vaccination; the recall is strickly precautionary. Based on current information, CDC and FDA are not recommending revaccination of persons who received vaccine from these recalled lots of Parke-Davis Vaccine.

For further information contact Pablo Bastida of the Immunization Division at (512) 458-7294.

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The Infectious Disease Epidemiology and Surveillance Division (IDEAS) is cleaning up and closing out the 1996 database of disease reports. Please notify IDEAS of any unreported cases with onset dates in 1996 as soon as possible. The absolute last day reports can be accepted is March 31. Records received after the cut-off date will not be included in Texas morbidity statistics for 1996. Report to your local health department by calling (800) 705-8868. *For further information contact IDEAS by phone: (512) 458-7218, FAX: (512) 458-7616, or internet email: eheinzke@discon.tdh.state.tx.us.*