

Attitudes, Experience, and Knowledge of Family Physicians Regarding Child Sexual Abuse

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There is copious literature concerning the physician and child abuse in general. Only a few studies, however, have examined the physician's knowledge, attitudes, or experiences regarding child abuse.¹⁻¹⁶ No study has examined the physician's understanding and perceptions of sexual abuse specifically, despite the physician's key role in the child protection system. Consequently, very little is known about the family physician's perceptions of the problem of child sexual abuse.

This pilot study examined the knowledge, attitudes, and experiences of family physicians regarding child sexual abuse. Its objectives were to (1) estimate the level of family physician suspicion and reporting of child sexual abuse, and (2) identify possible cognitive, attitudinal, and experiential barriers to suspicion and reporting of child sexual abuse.

METHODS

All physician faculty and residents of the Department of Family Medicine at the East Carolina University School of Medicine and all clinical preceptors associated with the program were mailed a questionnaire* that was designed to measure physician knowledge, attitudes, and experiences relating to child sexual abuse. Twenty-four questions assessed the physician's knowledge concerning child sexual abuse, 7 questions explored attitudes toward this problem, and 5 questions dealt with the physician's personal experiences with child sexual abuse. Information

on relevant demographic and practice characteristics was also collected.

Analysis of the data involved determining the association between physician suspicion and reporting of child sexual abuse and the various demographic, practice, knowledge, attitude, and experience variables that were measured. Statistical significance of the relationship between respondent characteristics and attitudes, knowledge, and behavior regarding sexual abuse was determined by the chi-square statistic for categorical variables and Student's *t* test for continuously measured variables. A multivariable logistic regression model was used to identify the unique association of each factor, with the suspicion and reporting of child sexual abuse controlling for other variables.

RESULTS

The overall response rate was 55.8 percent, or 101 out of 181 deliverable questionnaires to currently practicing physicians; only one respondent returned a nonusable questionnaire. The respondents were compared with North Carolina diplomates of the American Academy of Family Physicians. Approximately 75 percent of all North Carolina family physicians are diplomates of this organization. The respondents were similar to North Carolina diplomates of the American Academy of Family Physicians in terms of their sex and residency-training experiences, but had practiced fewer years and, not unexpectedly, were more likely to be in academic medicine.

Fifty-seven percent of the responding physicians suspected one or more cases of child sexual abuse in their practice populations in the past year, but only 39 percent reported one or more cases of child sexual abuse. The relationship between suspicion and reporting of child sexual abuse and demographic, educational, and practice characteristics of respondents is displayed in Table 1. Only the mean number of children seen each month is statistically significant ($P = .03$) for suspecting abuse. Family physicians who indicated they suspected sexual abuse in

* A copy of the questionnaire is available from the authors upon request.

Submitted, revised, April 22, 1987.

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TABLE 1. ASSOCIATION BETWEEN SUSPICION AND REPORTING OF CHILD SEXUAL ABUSE AND SOCIODEMOGRAPHIC AND PRACTICE CHARACTERISTICS OF FAMILY PHYSICIANS

Characteristic	Child Sexual Abuse					
	Suspicion		Chi-square or <i>t</i> value	Reporting		Chi-square or <i>t</i> value
	No Cases	1+ Cases		No Cases	1+ Cases	
Demographic						
Sex						
Male	36	50	0.33	54	32	0.83
Female	7	7		7	7	
Marital status						
Married	34	49	0.83	50	33	0.12
Other	9	8		11	6	
Education						
Family practice residency history						
Graduate	19	28	0.48	27	20	1.50
Current resident	6	9		8	7	
Nongraduate	18	20		26	12	
Board certification						
Yes	31	42	0.00	44	29	0.13
No	11	15		16	10	
Practice						
Arrangement						
Solo	9	15	0.69	15	9	0.14
Group	18	24		25	17	
Other	16	17		21	12	
Years in practice						
(Mean)	13.9 (n = 41)	9.3 (n = 55)	1.75	13.2 (n = 59)	8.3 (n = 37)	2.12*
Patients per month						
(Mean)	346 (n = 43)	407 (n = 57)	-1.05	381 (n = 61)	381 (n = 39)	0.01
Juvenile patients						
(Mean)	63 (n = 42)	99 (n = 56)	-2.17*	74 (n = 60)	99 (n = 38)	-1.33

* $P < .05$

one or more children tend, on average, to see a larger number of children than physicians reporting they suspected no cases of sexual abuse. A second, potentially important predictor of suspicion of child sexual abuse is number of years in practice ($P = .08$). Family physicians with fewer years of practice (younger physicians or more recent graduates) more frequently suspect child sexual abuse. Reporting of possible sexual abuse is associated only with fewer years in practice.

The role of attitudes and experience in the suspicion and reporting of child sexual abuse is shown in Table 2. Family physicians who believe that local social service agencies are ineffective in handling sexual abuse are less likely to suspect abuse. Physicians who believe that they underdiagnose sexual abuse actually suspect sexual abuse more often than physicians who do not feel they underdiagnose sexual abuse. Previous exposure (personal or otherwise) to sexual abuse in childhood does not appear to be an important factor in suspecting abuse. The re-

porting of child sexual abuse is influenced by the same attitudinal and experiential factors identified for suspicion of abuse.

Another attitude that appears to be an important barrier to the reporting of child sexual abuse is the feeling by the physician that reporting abuse will somehow lead to an action (or actions) that will have unfavorable consequences for either the patient, the family, or the physician (Table 3). Most interesting is the perception that physicians are usually required to testify in court after reporting suspicious cases. This perception has no effect on suspicion, but it has a significant inverse association with the reporting of possible sexual abuse; that is, family physicians who perceive that reporting abuse may result in a court appearance are less likely to report suspicious cases.

Multivariate logistic regression analyses that reexamined the data regarding both suspicion and reporting of sexual abuse tend to confirm the previously identified significant relationships, particularly the role of attitudes.

TABLE 2. ASSOCIATION BETWEEN SUSPICION AND REPORTING OF CHILD SEXUAL ABUSE AND EXPERIENCE AND ATTITUDES OF FAMILY PHYSICIANS ON ABUSE

Characteristic	Child Sexual Abuse					Chi-square
	Suspicion		Chi-square	Reporting		
	No Cases	1+ Cases		No Cases	1+ Cases	
Attitudes						
Underdiagnosis						
Yes	24	48	7.67*	40	32	3.44
No	13	6		15	4	
Effective social service						
Yes	13	28	3.92**	17	24	12.02***
No	30	28		44	14	
Experience						
Childhood knowledge of sexual abuse						
Yes	11	21	1.43	16	16	2.39
No	32	36		45	23	

* $P < .01$
 ** $P < .05$
 *** $P < .001$

TABLE 3. ASSOCIATION BETWEEN SUSPICION AND REPORTING OF CHILD SEXUAL ABUSE AND SEXUAL ABUSE OF CHILDREN

Attitude	Suspicion			Reporting		
	No Cases	1+ Cases	Chi-square Value	No Cases	1+ Cases	Chi-square Value
Judicial process harmful to abused child						
Disagree	18	25	0.16	23	20	2.26
Agree	22	29		35	16	
Abused children usually removed from household						
Disagree	30	49	6.62*	48	31	0.58
Agree	14	6		14	6	
Investigative process harmful to abused child						
Disagree	37	38	3.86*	43	32	3.28
Agree	6	17		18	5	
Unproven sexual abuse cases should never have been reported						
Disagree	38	52	1.22	54	36	2.36
Agree	5	3		7	1	
Physician usually required to testify in court on abuse cases						
Disagree	13	22	0.84	16	19	6.04*
Agree	29	33		44	18	

* $P < .01$
 ** $P < .05$

This analysis indicates that the significant factors affecting suspicion and reporting identified in the univariate analyses are not likely to be a consequence of confounding by other variables, including number of children seen in the practice.

Based upon the "knowledge index" previously described, it seems that almost all of the physicians surveyed had the basic cognitive skills to evaluate adequately children who are victims of sexual abuse. The "knowledge index," however, had low internal consistency, (ie, poor reliability) as determined by Cronbach's alpha statistic. Hence, the index could not be used to discriminate physicians with a high level of knowledge from physicians with significantly less knowledge about child sexual abuse.

DISCUSSION

This study suggests at least three barriers to the suspicion and reporting of sexual abuse by family physicians. The first barrier is lack of confidence by the physician in the local social service agency's ability to deal effectively with sexual abuse. Whether this perception is a result of prior experience with the agency cannot be determined from the data. Second, there is the failure by the physician to harbor adequate suspicion or to believe that sexual abuse occurs in the frequency indicated by the literature. The third possible barrier is the attitude that reporting suspected sexual abuse will result in unfavorable consequences.

Previous research on physical (but not sexual) abuse of children has identified similar reasons for physician reluctance to refer possible abuse cases. These reasons include inadequate experience, emotional responses to the situation, fear of retaliation, and reluctance to spend the necessary time involved in reporting cases.^{17,18}

In evaluating these findings, it should be kept in mind that the respondents were physicians with affiliations with academic medicine, although most were in private practice. Nevertheless, these physicians' views are believed to be consistent with those of others in family practice because of the variety of practice settings and stages of practice represented. While these findings are preliminary, they are likely to reflect the dynamics between family physicians and the issue of sexual abuse.

Future research should be directed toward confirming and expanding these findings. These efforts should involve

a much larger sample of primary care physicians. Other professionals (ie, teachers) who deal frequently with children may also merit inclusion in this research. It would be particularly helpful to interview physicians regarding the exact role of the identified attitudes and perceptions in inhibiting the reporting of sexually abused children. Future efforts should also be directed at devising an adequate scale for assessing physicians' knowledge of child sexual abuse. It is hoped that, as more is learned about the attitudes of participants in the child protection system, this system can be modified and made more effective.

References

1. Cantwell HB: Vaginal inspection as it relates to child sexual abuse in girls under thirteen. *Child Abuse Negl* 1983; 7:171-176
2. DeJong AR, Emmett GA, Hervada AA: Epidemiologic factors in sexual abuse of boys. *Am J Dis Child* 1982; 136:990-993
3. DeJong AR, Emmett GA, Hervada AA: Sexual abuse of children. *Am J Dis Child* 1982; 136:129-134
4. DeJong AR, Hervada AA, Emmett GA: Epidemiologic variations in childhood sexual abuse. *Child Abuse Negl* 1983; 7:155-162
5. Greenberg NH: The epidemiology of childhood sexual abuse. *Pediatr Ann* 1979; 8:289-299
6. James J, Womack WM, Stauss F: Physician reporting of sexual abuse of children. *JAMA* 1978; 240:1145-1146
7. Jason J, Williams S, Burton A, Rochat R: Epidemiologic differences between sexual and physical child abuse. *JAMA* 1982; 247:3344-3348
8. Jones JG: Sexual abuse of children. *Am J Dis Child* 1982; 136:142-146
9. Kempe CH: Sexual abuse, another hidden pediatric problem: The 1977 C. Anderson Aldrich lecture. *Pediatrics* 1978; 62:382-389
10. McKittrick CA: Child abuse: Recognition and reporting by health professionals. *Nurs Clin North Am* 1981; 16:103-115
11. Mindlin R: Child abuse and neglect: The role of the pediatrician and the academy. *Pediatrics* 1974; 54:393-395
12. Rimsza ME, Niggemann EH: Medical evaluation of sexually abused children: A review of 311 cases. *Pediatrics* 1982; 69:8-14
13. Russell DEH: The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. *Child Abuse Negl* 1983; 7:133-146
14. Sanders R: Resistance to dealing with parents of battered children. *Pediatrics* 1972; 50:853-857
15. Chang A, Oglesby AC, Wallace HM, et al: Child abuse and neglect: Physicians' knowledge, attitudes, and experiences. *Am J Public Health* 1976; 66:1199-1201
16. Scherzer LN, Lala P: Sexual offenses committed against children—An analysis of 73 cases of child sexual abuse. *Clin Pediatr* 1980; 19:679-685
17. Tilelli JA, Turek D, Jaffe AC: Sexual abuse of children—Clinical findings and implications for management. *N Engl J Med* 1975; 302:319-323
18. Woodling BA, Kossoris PD: Sexual misuse: Rape, molestation, and incest. *Pediatr Clin North Am* 1981; 28:481-499