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WHY WOMEN DON'T REPORT SEXUAL ASSAULT TO THE POLICE: THE INFLUENCE OF PSYCHOSOCIAL VARIABLES AND TRAUMATIC INJURY

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□ **Abstract—The purpose of this study was to identify the variables that acutely influence reporting practices in female sexual assault victims presenting to an urban clinic or Emergency Department. We conducted a cross-sectional survey of consecutive female victims during an 18-month study period. Patient demographics, assault characteristics, and injury patterns were recorded in all eligible patients using a standardized classification system. At the completion of the forensic examination, victims were asked to complete a psychosocial questionnaire designed to determine specific reasons why women reported or did not report their sexual assault to police. During the study period, 424 women were eligible to participate in the study; 318 (75%) reported the sexual assault to police. One hundred six (25%) did not file a police report, but consented to a medical-legal examination. Women not reporting sexual assault were typically employed, had a history of recent alcohol or drug use, a known assailant, and prolonged time intervals between the assault and forensic evaluation ($p < 0.001$). There were no differences in the extent of nongenital injuries or anogenital injuries between the two groups. Thirty-six percent (152/424) of the eligible population agreed to complete the questionnaire. Only three of the 20 psychosocial variables examined were found to be significantly different in women not reporting sexual assault compared to reporters. The reasons for not reporting were primarily environmental factors (prior relationship with assailant) rather than internal psychological barriers (shame, anxiety, fear).** © 2009 Elsevier Inc.

□ **Keywords—sexual assault; anogenital injuries; reporting; psychosocial; medical-legal**

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INTRODUCTION

Accurate estimates of the incidence of sexual assault are difficult to obtain. One national study reported that female lifetime prevalence rates of sexual assault in the general population were 18% (1). Feldhaus and colleagues recently reported that 51% of women presenting to their Emergency Department (ED) had a history of completed or attempted sexual assault at some point during her life (2). Despite these rates, it is widely recognized that a significant percentage of these assaults are not reported to police or social agencies. The National Crime Victimization Survey estimates that only 38% of sexual assaults occurring in 2005 were reported to police (3).

Sexual assault is treated as a violent crime in all jurisdictions. The legal definition includes a wide range of victimizations that include acts of unwanted sexual contact between the offender and victim, as well as threats and attempts to commit sexual assault (4). How-

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ever, social definitions of sexual assault are diverse, and one's personal conception of rape can inhibit reporting (5,6). Reporting can also be hindered by the perceived outcomes of dealing with the police and criminal justice system, impaired cognitive processing, and the victim/offender relationship (2,7–9).

Much of the literature on sexual assault reporting is outdated or based on retrospective population surveys, telephone questionnaires, or studies of specific populations (e.g., date rape) (1,2,6,10). The present study examined data from a community-based population of women presenting to a sexual assault clinic or ED. Our purpose was to identify the variables that acutely influence reporting practices and to compare the frequency and types of traumatic injuries in women who do and do not report.

METHODS

Study Design

This was a cross-sectional survey of consecutive female patients presenting to an urban sexual assault clinic or local ED during an 18-month study period. The study was designed to explore the primary reasons why women decline to report sexual assault to the police. A secondary objective was to identify any differences in demographics, assault characteristics, or injury patterns in those who do and do not report. The study protocol was approved by the Institutional Review Board at Spectrum Health, Grand Rapids, Michigan.

Study Setting

The Nurse Examiner Program (NEP) is a community-based clinic that provides 24-h comprehensive response to adolescent and adult victims of sexual assault. It is located in downtown Grand Rapids, in the YWCA building. The NEP is associated with a university-affiliated Emergency Medicine residency program and works closely with local law enforcement agencies and the existing domestic/sexual assault programs of the YWCA (11). The vast majority of referrals come from law enforcement dispatch and crisis line contacts. Those sexual assault victims presenting directly to the three downtown EDs are referred to the NEP for evaluation after triage and initial assessment. Transportation is provided if needed or requested. Approximately 3–5 ED patients each year are too severely injured to be evaluated at the YWCA (11). Nurse examiners have completed a credentialing process that allows them to go into the hospital and perform the evaluation and collection of evidence in the ED. Education of the nurse examiner consists of approximately 40 h of training in all aspects of caring for this population, including physical examination, forensic preservation of evidence, documentation, and courtroom testimony.

Participant Selection

All female sexual assault victims aged 13 years or older who presented to local EDs for treatment or the YWCA Nurse Examiner Program for treatment between November 1, 2001 and April 30, 2003 (18 months) were eligible for the study. Women who could not complete the questionnaire (e.g., non-English speaking), refused forensic examination, or could not remember the sexual assault (e.g., intoxication) were excluded from participation.

Study Protocol

Demographic data, sexual assault history, and clinical findings were prospectively obtained on eligible patients and entered into a Microsoft Excel database (version 2003; Microsoft Inc., Redmond, WA). Abstraction forms were used to guide data collection. It is the policy of the NEP to conduct a complete evidentiary examination for all sexual assault victims who come to the clinic within 72 h of an assault, even if no police report is made. This rationale allows for the collection of evidence without putting pressure on the victim to report the assault if she is not ready to make that decision.

Anogenital trauma is documented at the NEP using colposcopic examination with nuclear staining and digital photography. The following nine anatomic sites are routinely evaluated and photographed for the presence and type of injury: the labia minora, labia majora, posterior fourchette, fossa navicularis, hymen, vagina, cervix, perineum, and perianal area. Anoscopy was performed at the examiner's discretion. For the purposes of this study, the type and location of anogenital injuries were recorded using a standardized classification system (12,13). Definitions of findings used by the nurse examiners were those listed in *Sexual Assault: The Medical Legal Examination* (4).

At the completion of the forensic examination performed at the NEP, victims were asked to voluntarily complete the study questionnaire. The survey instrument consisted of 20 questions designed to determine specific reasons why women reported or did not report their sexual assault to police. The questions were adapted from previous studies on sexual assault, and from anecdotal reports heard by clinicians from their clients (2,6,10). Information was also collected regarding pre-

Table 1. Demographics and Reporting Practices in Female Sexual Assault Victims

	Not Reporting (n = 106)	Reporting (n = 318)
Age of victim (mean years ± SD)	25.2 ± 5.7	23.3 ± 6.5
Age range (years)	13–54	13–76
Ethnicity (% white)	89 (84%)	254 (80%)
Marital status (% single)	92 (87%)	251 (79%)
Employment status (% employed)*	73 (69%)	171 (54%)
Alcohol or drug use < 24 h*	74 (70%)	162 (51%)
No prior history sexual intercourse	8 (8%)	38 (12%)
Last consensual intercourse < 72 h	29 (27%)	95 (30%)
Time interval to examination (mean hours ± SD)	20.2 ± 12.6	11.3 ± 9
History of previous sexual assault	46 (43%)	156 (49%)

* Indicates significance at the $p < 0.01$ level.

vious sexual assaults, prior experience with police, and support systems available to the victim. The questionnaire was pretested on a select group of sexual assault victims presenting to the NEP in September 2001. After revisions were made, the questionnaire was offered to all female sexual assault victims beginning in November 2001. The questionnaire was handed out by the nurse examiner, who explained its purpose and answered any questions. Patients were assured that the questionnaire would remain anonymous and confidential.

Outcomes Measured

The primary outcome of interest was to identify reasons that women decline to report sexual assault to the police. The secondary outcome was to identify any differences in demographics, assault characteristics, or injury patterns in those who do and do not report. We hypothesized that women suffering the most severe assaults would be more likely to report to the police, and that women not reporting might have suffered less severe injury and hence might have less need of medical treatment.

Data Analysis

A power analysis determined that at least 40 patients were needed in each group (reporters vs. non-reporters) to detect a 20% difference in categorical variables with a power of 0.8 and an alpha of 0.05. Analyses were performed using SPSS statistical software (version 14.0, SPSS Inc., Chicago, IL). Descriptive statistics were used to describe the demographic variables, perpetrator factors, and assault characteristics. The mean number of documented anogenital and non-genital injuries for each group was determined, as were the typical locations and type of anogenital injury (abrasion, laceration, erythema, ecchymosis, edema). Discrete variables were analyzed with the use of chi-squared tests; unpaired *t*-tests were used for comparisons of two means. Odds ratios (ORs) with 95% confidence intervals (CIs) were then calculated for the association between survey responses and the women's decision to report sexual assault to police. Due to the number of variables compared, we chose a p-value < 0.01 for statistical significance (14,15).

RESULTS

During the 18-month study period, 337 adult women presented directly to the Nurse Examiner Program; 114 were triaged in one of four local EDs and transferred to

Table 2. Sexual Assault Characteristics

	Not Reporting (n = 106)	Reporting (n = 318)
Multiple assailants	13 (12%)	41 (13%)
Age of assailant, mean (SD)	25.4 ± 7.0	25.9 ± 6.9
Ethnicity of assailant (% white)	50 (47%)	146 (46%)
Relationship to victim*		
Stranger	14 (13%)	102 (32%)
Known assailant	92 (87%)	216 (68%)
Acquaintance/date	76 (71%)	180 (56%)
Previous boyfriend/spouse	8 (8%)	19 (6%)
Current spouse/partner	1 (1%)	8 (3%)
Relative	5 (5%)	5 (2%)
Employer/authority figure	2 (2%)	4 (1%)
Time of assault		
Midnight–5:59 a.m.	52 (49%)	146 (46%)
6:00 a.m.–11:59 a.m.	11 (10%)	48 (15%)
Noon–5:59 p.m.	13 (12%)	35 (11%)
6:00 p.m.–11:59 p.m.	31 (29%)	89 (28%)
Type of sexual assault		
Vaginal	99 (93%)	267 (84%)
Oral	21 (20%)	92 (29%)
Anal	35 (33%)	83 (26%)
Digital	37 (35%)	92 (29%)
Location of assault		
Victim's home	42 (40%)	146 (46%)
Assailant's home	33 (31%)	73 (23%)
Vehicle	16 (15%)	57 (18%)
Outdoor	6 (6%)	41 (13%)
Other	19 (18%)	38 (12%)
Type of coercion		
Verbal threats	52 (49%)	143 (45%)
Physical force	30 (28%)	108 (34%)
Victim sleeping/drugged	26 (25%)	73 (23%)
Use of weapons	13 (12%)	54 (17%)
Non-genital injuries	43 (41%)	143 (45%)
Anogenital injuries	78 (74%)	248 (78%)
Mean no. genital injuries	1.5 ± 1.0	1.7 ± 1.3

* Indicates significance at the $p < 0.01$ level.

Table 3. Psychosocial Variables Associated with Reporting Sexual Assault

	Not Reporting (n = 41)	Reporting (n = 111)	Odds Ratio (95% CI)
I am reluctant to report rape because . . .			
I do not want the assailant going to jail*	27 (66%)	10 (9%)	19.47 (7.79–48.68)
Police would be insensitive or blame me*	21 (51%)	17 (15%)	5.81 (2.61–12.94)
I know the assailant*	22 (54%)	26 (23%)	3.79 (1.78–8.05)
I was involved in illegal activity during assault	19 (46%)	27 (24%)	2.69 (1.27–5.70)
I am afraid of going to court/trial	25 (61%)	46 (41%)	2.21 (1.06–4.59)
Some people will not believe me	20 (49%)	34 (31%)	2.16 (1.04–4.49)
I have no support from friends/family	2 (5%)	3 (3%)	1.85 (0.30–11.47)
I have had a bad experience with police in past	17 (42%)	32 (29%)	1.75 (0.83–3.68)
My family or friend(s) will be upset	6 (15%)	10 (9%)	1.73 (0.59–5.11)
It would be just his word against mine	26 (63%)	58 (52%)	1.58 (0.76–3.31)
Other people will think I am responsible	30 (73%)	71 (64%)	1.54 (0.70–3.39)
Concerned that others will find out about assault	33 (80%)	81 (73%)	1.52 (0.64–3.68)
The details of the assault are unclear	24 (59%)	54 (49%)	1.49 (0.72–3.08)
I feel partially responsible	27 (66%)	64 (58%)	1.43 (0.67–2.99)
I have a criminal record or am on probation	3 (7%)	6 (5%)	1.38 (0.33–5.80)
I feel ashamed or embarrassed	32 (78%)	80 (72%)	1.38 (0.59–3.22)
I feel anxious	18 (44%)	42 (38%)	1.29 (0.62–2.66)
I am afraid of the assailant	9 (22%)	21 (19%)	1.21 (0.50–2.90)
I have been raped/assaulted before	6 (14%)	19 (17%)	0.83 (0.31–2.25)
Friend/family told me not to report	1 (2%)	3 (3%)	0.90 (0.09–8.91)

* Indicates significance at the $p < 0.01$ level.

the NEP; and 15 patients were evaluated in the hospital by NEP staff due to the severity of their injuries. Of these 466 women, 42 (9%) were excluded from the study for the following reasons: could not recall details of the sexual assault due to intoxication (n = 21), refused forensic examination (n = 9), intercourse was consensual (n = 7), and missing or incomplete documentation (n = 5). Seventy-five percent (318/424) of the women eligible to participate in the study reported the sexual assault to law enforcement.

Women not reporting sexual assault were more often employed, with a history of recent alcohol or drug use, a known assailant, and a prolonged time interval between assault and forensic evaluation ($p < 0.001$). There were no other significant differences in race, marital status, perpetrator factors, or assault characteristics between the two patient groups (Tables 1, 2). A large percentage of women in both groups had a previous history of sexual assault.

Eighty-three percent of known assailants (256/308) were described as acquaintances; 12% (36/308) were current or previous boyfriends or spouses; 3% (10/308) involved other family members (Table 2). Eighty percent of incestuous assaults (8/10) occurred among victims aged 13 to 15 years of age; the majority (64%) of acquaintance rape (164/256) was documented in young adults aged 16 to 25 years of age. Among the older victims (>31 years of age) who knew their assailants, 23% (22/97) were assaulted by current or previous boyfriends or spouses. Women victimized by known assailants were less likely to file a police report (70% vs. 88%, $p < .001$).

There were no differences in the extent of non-genital injuries or anogenital injuries between the two groups (Table 2). Seventy-seven percent (326/424) had documented anogenital injuries. A total of 23% (75/326) had single and 77% (251/326) had multiple sites of trauma. The pattern of anogenital injuries was similar in both groups of adult patients with the majority of injuries (80%) occurring at one of three anatomical sites: labia minora, fossa navicularis, and posterior fourchette. Superficial lacerations and erythema were the most common types of injuries documented in women reporting sexual assault as well as those not reporting assault (Figure 1).

Of the 424 women eligible to participate in the study, 152 (36%) agreed to complete the psychosocial questionnaire. There were no significant differences in demographics, perpetrator factors, or assault characteristics between those who completed the survey and those who refused. Seventy-three percent (111/152) of the women who completed the survey reported the sexual assault to police.

Table 3 details the responses of women to the psychosocial questionnaire. A majority of women in both groups felt partially responsible for the assault, were concerned about public exposure, and were ashamed or embarrassed by the assault. However, these internal psychological barriers (i.e., shame, anxiety, fear) were not significantly associated with reporting sexual assault to police.

The three most common reasons for not reporting sexual assault included: not wanting the assailant to go to

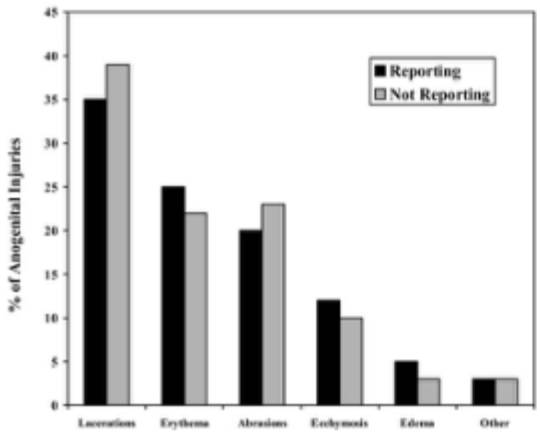

Figure 1. Types of genital trauma in sexual assault victims with anogenital findings (n = 326).

jail (OR 19.47, 95% CI 7.79–48.68), a prior relationship with the assailant (OR 3.79, 95% CI 1.78–8.05), and feeling that the police would blame the victim or be insensitive (OR 5.81, 95% CI 2.61–12.94). Seven percent of women not reporting sexual assault (3/41) had a criminal record or were on probation; however, 42% (17/41) reported a "bad experience" with police in the past or were involved in illegal activity during the assault (19/41). This illegal activity generally involved underage drinking or recent drug use.

DISCUSSION

These results show that in a community-based urban population, one-quarter of women presenting to a sexual assault clinic or ED chose not to report the rape to police. This rate is consistent with a previous study in Minneapolis that reported that 24% of sexual assault victims treated in an ED by nurse examiners refused to file a police report (16). During the past three decades, women have become more likely to report rapes and attempted rapes—particularly those involving known assailants—to police (3). But the fact remains that less than half of such crimes are reported (1,3). In fact, law enforcement officials consider sexual assault to be the most underreported violent crime in America (17).

It is apparent that the majority of rape survivors who seek post-assault health care in community clinics or EDs have already made the decision to involve the police (7,16,18). The simple act of seeking medical help may in turn lead a woman to define a situation as rape and report it. For those victims who have not decided whether or not to report the assault, trained examiners, when available, can discuss the survivor's fears and concerns about reporting and provide the information necessary to make an informed decision (16). A recent study by Crandall and Helitzer examined the legal outcomes for sexual assault cases seen at the University of New Mexico's Health Sciences Center. After inception of a Sexual Assault Nurse Examiner (SANE) program, approximately 28% of rape victims declined to report the assault to the police, compared with 50% before the SANE program was launched in their community (19).

It has been hypothesized that women suffering the most severe assaults are more likely to report to the police, and hence might access medical care through the police (18,20,21). It follows that women not reporting might have suffered less severe assaults and hence might have less need of medical treatment.

Although the majority of our study population had documented physical injuries, we found no differences in the frequency or severity of injuries between reporters and non-reporters. In addition, we found that the use of force and the pattern of anogenital injuries were similar in both groups. Therefore, although the severity of physical injuries may cause the rape survivor to seek appropriate medical care, it does not significantly influence their decision to report. These findings are consistent with a recent Danish study of women presenting to a sexual assault center in Copenhagen. They also concluded that the severity of the assault or the documentation of injuries did not influence police reporting (20).

Since 1970, social scientists have investigated a number of possible reasons why women don't report rape, ranging from fears, beliefs, and characteristics of the women themselves, to the nature of the relationship between the victim and the assailant, and the characteristics of the particular rape. The usefulness of these studies in determining the relative importance of these factors is limited by the research methodologies used and the populations studied. The only way clinicians can really determine why sexual assault victims do not report to police is to ask the victims themselves. The current study was designed to accomplish this goal within a community-based sample of women presenting for medical care after an assault. The results of this study identified six distinct factors associated with not reporting sexual assault to law enforcement.

Age, marital status, and ethnicity were not associated with police involvement; however, employment status differed significantly between non-reporters and those reporting sexual assault (69% vs. 54%, respectively). Some rape victims likely chose to avoid the notoriety and stigma attached to rape prosecution, or they feared rejection by friends and co-workers (17,20). More than half of the women we surveyed felt partially responsible for the assault (60%), were concerned about public exposure (75%), and were ashamed or embarrassed by the

assault (74%). Practical issues may also be involved—a victim may not have the time to participate in a criminal prosecution, especially if she is employed (22).

Seventy-three percent of sexual assaults in our study were committed by known assailants. This is consistent with other studies such as the National Crime Victimization Survey, which reported that approximately two-thirds of rape victims knew their assailant (3). Our results also demonstrate that women assaulted by a known assailant are significantly less likely to report the crime compared to those assaulted by a stranger. Not surprisingly, the response on the psychosocial survey that had the greatest association with non-reporting was: "I do not want the assailant going to jail" (OR 19.47, $p < 0.001$). The complex nature of the victim-assailant relationship is known to influence perceptions of the seriousness and sequelae of the sexual assault (23). It also is clearly the most important factor influencing a victim's decision to report (18,20–22).

Sexual assault victims having experienced acquaintance rape are typically young adults, 16 to 25 years old. Sex-role socialization encourages this type of assault victim to see herself as a possible contributor to her own victimization (22). In a survey of high school students, teenage girls who had experienced forced sex believed that consensual sex play provoked the non-consensual intercourse and therefore felt they were at fault, not the perpetrator who ignored pleas to stop (23). Moreover, intoxication in the context of a dating relationship can lead to the misinterpretation of friendly cues as sexual invitations, diminished coping responses, and the woman's inability to ward off a potential attack (24).

At least one-half of all violent crimes involve alcohol or drug use by the perpetrator, the victim, or both (3,24). Sexual assault certainly fits this pattern. Alcohol, marijuana, cocaine, and other illicit drugs were used by 56% of all the women in our population. Although not statistically significant, almost half of our respondents did not report rape because they were involved in illegal activity at the time of the assault. This illegal activity generally involved underage drinking or recent drug use and probably contributed to victim's feelings of fear, guilt, embarrassment, and blame. In addition, intoxication was likely the key reason that 51% of our respondents stated that "the details of the assault are unclear."

Another significant reason for not reporting assault was the belief that police would be insensitive or blame the victim (OR 5.81, $p < 0.001$). Only 7% of non-reporters had a criminal record or were on probation; however, a considerable number of these women reported a "bad experience with police in the past" (42%) or were "involved in illegal activity during assault" (46%). Previous research has shown that victims may also lack confidence in the ability of the criminal justice system to apprehend or punish the assailant (22,24).

According to Williams, most people think of rape as a sudden, violent attack by a stranger in a deserted, public place, after which the victim is expected to provide evidence of the attack and of her active resistance (22). These characteristics, then, constitute what is referred to as the classic rape situation. When an individual is confronted with a situation that does not conform to the stereotypical concept rape, she may be reluctant to report the incident or seek medical care (7). This reluctance is aptly demonstrated by the prolonged time interval between assault and forensic evaluation among non-reporters (20 h vs. 11 h, $p < 0.001$). Any delay in presentation is troublesome in light of previous studies that suggest that the timing of the examination is the most significant predictor of abnormal anogenital findings in both children and adult victims of sexual assault (25,26). For example, the frequency of anogenital lacerations and abrasions may decrease from 50% at < 24 h to 13% at > 96 h after the assault (26).

LIMITATIONS

There were several limitations in our study. We could not control for the clinical evaluations by different examiners. It may be that documentation was not uniform, although the nine nurse examiners had a similar level of training and experience. The findings of the examiners were recorded on state-mandated reporting forms and were taken as the most accurate representation of the actual physical findings. Over half of all patients had been exposed to alcohol or illicit drugs during the time of the assault. It is unknown what impact this might have had on the accuracy of the history or the degree of anogenital injuries. However, the documented history of the sexual assault by forensic nurses is quite detailed and considered accurate by legal authorities. In addition, women were excluded from participating in the survey if the nurse examiner felt they were still clinically intoxicated.

This study, like all studies of rape victims, is vulnerable to sample or selection bias. Previous research suggests that many victims of rape are not likely to seek medical care or even to identify themselves as rape victims (2). In fact, the desire to avoid using the term "rape" is frequently very high. It should also be noted that this study considered women who reported to the police, the NEP, or a local ED. If all women experiencing sexual assault who neither reported to the police nor came to the NEP/ED were included, the results might have been different.

Of the 424 women eligible to participate in the study, 152 agreed to complete the psychosocial questionnaire,

for a response rate of 36%. This limited response rate was understandable because, in many cases, subject recruitment took place within hours of the sexual assault and women were not compelled to participate. There were no significant differences in demographics, perpetrator factors, or assault characteristics between those who completed the survey and those who refused. However, the small sample size and the more stringent level of significance ($p < 0.01$) made for a less robust study.

Over the past two decades, there have been a number of initiatives aimed at improving the legal treatment of sexually assaulted women (27). Rape crisis centers and victim assistance programs offer crisis intervention, emotional support, counseling, and advocacy to women who have been sexually assaulted. Hospital-based sexual assault care and treatment programs have been established, providing victims with around-the-clock support and crisis counseling, medical care, referrals to local service providers, and forensic evidence collection for potential court use. Although one of the goals of these initiatives was to increase the proportion of women reporting sexual assault, results from retrospective studies evaluating their effectiveness have been mixed and have not captured the complexity of factors that may influence women's post-assault decisions. Qualitative, in-depth interviews with women who have been sexually assaulted hold unique promise for evaluating treatment programs and enhancing women's interaction with the criminal justice system (27). Moreover, given that women do not constitute a unified and homogeneous group, future research may want to employ more sophisticated measures of age, ethnicity, culture, education, and assault characteristics to examine their collective impact on reporting practices.

CONCLUSIONS

In a community-based urban population, one-quarter of women presenting to a sexual assault clinic or ED chose not to report the sexual assault to police. These results suggest that women who are employed, raped by a known assailant, have a history of recent alcohol or drug use, and prolonged time intervals between the assault and forensic evaluation are more reluctant to involve the police. No differences were found in the extent of nongenital injuries or anogenital injuries between reporters and non-reporters. When surveyed, the reasons given by assault victims for not reporting to police were primarily environmental factors (e.g., relationship with the assailant) rather than internal psychological barriers (e.g., shame, anxiety, fear). Further study is needed to identify the policies or practices that encourage reporting and to apply those practices elsewhere. Such a strategy might, in turn, increase the chance of arrest and prosecution and, ultimately, the deterrent effect of the criminal justice system.

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REFERENCES

1. Tjaden P, Thoennes N. Prevalence, incidence, and consequences of violence against women: findings from the National Violence against Women Survey (NCJ 183781). Washington, DC: National Institute of Justice; November 2000. Available at: http://www.ncjrs.org/pdffiles1/nij/183781.pdf. Accessed September 5, 2007.
2. Feldhaus KM, Houry D, Kaminsky R. Lifetime sexual assault prevalence rates and reporting practices in an emergency department population. Ann Emerg Med 2000;36:23–7.
3. Sedgwick JL. Criminal victimization in the United States, 2005: statistical tables (NCJ 215244). BJS Bulletin; December 2006. Available at: http://www.ojp.usdoj.gov/bjs/pub/pdf/cvus05.pdf. Accessed September 5, 2007.
4. Crowley SR. Sexual assault: the medical legal examination. New York: McGraw-Hill; 1999.
5. Renner KE, Wackett C, Ganderton S. The "social" nature of sexual assault. Can Psychol 1988;29:163–73.
6. Peretti PO, Cozzens N. Psycho-social variables of female rapees not reporting and reporting the first incidence of rape. Acta Psychiatr Belg 1979;79:332–42.
7. Burgess AW, Fehder WP, Hartman CR. Delayed reporting of the rape victim. J Psychosoc Nurs Ment Health Serv 1995;33:21–9.
8. Dupre AR, Hampton HL, Morrison H, Meeks GR. Sexual assault. Obstet Gynecol Surv 1993;48:640–8.
9. Novacek J, Rashkin R, Bahlinger D. Rape: Tulsa women speak out. Tulsa, OK: Tulsa Institute of Behavioral Sciences; 1992.
10. Rickert VI, Wiemann CM. Date rape among adolescents and young adults. J Pediatr Adolesc Gynecol 1998;11:167–75.
11. Rossman L, Dunnuck C. A community sexual assault program based in an urban YWCA: the Grand Rapids experience. J Emerg Nurs 1999;25:424–7.
12. American College of Emergency Physicians. Evaluation and management of the sexually assaulted or sexually abused patient. Irving, TX: American College of Emergency Physicians; 1999.
13. Slaughter L, Brown C. Colposcopy to establish physical findings in rape victims. Am J Obstet Gynecol 1992;166:83–7.
14. Pocock SJ, Geller XPL, Tsiatis AA. The analysis of multiple endpoints in clinical trials. Biometrics 1987;43:487–98.
15. Aluman D. Practical statistics for medical research. London, UK: Chapman and Hall; 1995.
16. Ledray LE, Kraft J. Evidentiary examination without a police report: should it be done? Are delayed reporters and nonreporters unique? J Emerg Nurs 2001;27:396–400.
17. Kilpatrick DG, Edmunds CN, Seymour A. Rape in America: a report to the nation. Arlington, VA: National Victim Center; 1992.
18. McGregor MJ, Wiebe E, Marion SA, Livingstone C. Why don't more women report sexual assault to the police? CMAJ 2000;162:659–60.
19. Crandall CS, Helitzer D. Impact evaluation of a Sexual Assault Nurse Examiner (SANE) program (NCJ 203276). Washington, DC: National Institute of Justice; December 2003. Available at: http://www.ncjrs.gov/pdffiles1/nij/grants/203276.pdf. Accessed September 5, 2007.
20. Schei B, Sidenius K, Lundvall L, Ottesen G. Adult victims of sexual assault: acute medical response and police reporting among women consulting a center for victims of sexual assault. Acta Obstet Gynecol Scand 2003;82:750–5.

21. Rennison CM. Rape and sexual assault: reporting to police and medical attention, 1992–2000 (NCJ 194530). Washington, DC: National Institute of Justice; August 2002. Available at: www.ojp.usdoj.gov/bjs/pub/pdf/rsarp00.pdf. Accessed September 5, 2007.
22. Williams LS. The classic rape: when do victims report? Soc Probl 1984;31:459–67.
23. Davis TC, Peck GQ, Storment JM. Acquaintance rape and the high school student. J Adolesc Health 1993;14:220–4.
24. Rickert VI, Wiemann CM. Date rape among adolescents and young adults. J Pediatr Adolesc Gynecol 1998;11:167–75.
25. Sachs CJ, Chu LD. Predictors of genitorectal injury in female victims of suspected sexual assault. Acad Emerg Med 2002;9:146–51.
26. Bush C, Jones JS, Rossman L, Wynn B, Alexander C. Patterns of anogenital injury in female sexual assault victims following delayed forensic examination (abstract). Ann Emerg Med 2003;42:S90.
27. Baumer E. Temporal variation in the likelihood of police notification by victims of rapes, 1973–2000 (NCJ 207497). Washington, DC: National Institute of Justice; April 2004. Available at: www.ncjrs.gov/pdffiles1/nij/grants/207497.pdf. Accessed September 5, 2007.