Medical Response to Adult Sexual Assault

A Resource for Clinicians and Related Professionals

Second Edition

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Medical Response to Adult Sexual Assault

A Resource for Clinicians and Related Professionals

Second Edition

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Foreword to the Second Edition

For those who work in the field of identifying and responding to sexual assaults, we are seeing historic trends in voices of survivors being sought out, heard, and respected. We have seen the beginnings of a transformation in the health care environment, with increased efforts to actively seek out information about how the effects of trauma and adversity intertwine across the lifespan and to respond with trauma-informed practices.

Medical Response to Adult Sexual Assault, Second Edition is an outstanding resource for both seasoned providers and for those hoping to start or to improve their ability to respond to survivors of sexual violence. The authors and contributors to this book are national leaders in the field of identifying and responding to sexual violence. This book spans the fundamentals of the anatomy of sexual assaults to the operationalization of sexual assault response teams to the macrosocial constructs that support a society where sexual assaults occur all too often. It explores the diversity of settings and manifestations of sexual assault, bringing attention to less traditionally explored contexts like violence occurring within the military and among those exploited through human trafficking and substance use disorders. The book provides a detailed description of the specifics of violence as it occurs among intimate partners and within families.

I particularly appreciated the inclusion of innovative content related to exploring our emerging understanding of the effects of toxic stress observed among survivors of sexual assaults. Along with explanations of the neurobiology of toxic stress, the book explores the downstream challenges of immediate and long-term recovery. With an improved downstream response, we ultimately must look upstream in order to find ways to better prevent and mitigate the effects of toxic stress. Upstream responses stem from improved awareness and reductions in the stigma of disclosure and engagement with service.

While much of the content is directed to providers who work in the immediate aftermath of a sexual assault (ie, sexual assault nurse examiners), I would recommend this book to any health care professional who has witnessed and understands the impact of sexual violence within the communities in which they serve and live, but also to any who are new to practice and want to best serve the needs of their patients. *Medical Response to Adult Sexual Assault, Second Edition* will help advance our understanding of the current state of best practices in identifying and responding to survivors of sexual violence, as well as inform next steps in primary prevention.

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Foreword to the First Edition

Medical Response to Adult Sexual Assault is a testament to the maturity of our understanding of the unfortunate reality of adult sexual assault. In many ways, it is the reference bible for adult sexual assault, reflecting the collective science and wisdom of an increasingly professional response to the needs of sexual assault victims. This tome does a superb job of reflecting the history of society's response to sexual assault. Whether the reader is looking to fully understand legislative responses, addressing the medical needs of victims, the significance of and how to collect forensic evidence, the mental health impact of sexual assault, or the critical importance of treatment, each and every aspect of these topics is fully covered.

The most important first steps following disclosure of sexual assault are critically important to substantiation, protection, and, ultimately, securing the treatment services that victims need and deserve. Whether the reader is a new graduate of a SANE/SART program or a seasoned clinician, a law enforcement investigator or prosecutor, a mental health clinician, or a community agency professional, this reference text provides the most up-to-date information to understand and respond to the needs of victims.

It is not enough to simply be able to know one's own discipline and be competent in that discipline. Successful outcomes depend on interdisciplinary collaboration. This reference is organized in a manner that provides not only an understanding of what each discipline must do to address the needs of victims, but how to work with other disciplines in a manner that ultimately provides a collective insight and best serves the needs of victims.

The unique needs of special populations, such as college students, drug-facilitated assault victims, elder sexual assault victims, or victims whose assault occurs while on duty, are addressed.

For the health care professional, it is not enough to just identify physical evidence of assault, collect evidence, and treat the patient. Clinicians must understand the legal implications of everything they do and the importance of how they document their observations and the histories they obtain that speak to the truth of an assault victim's experience. They must maintain a balanced, objective demeanor and formulate defensible diagnostic assessments. The knowledge to accomplish the tasks just outlined is in this text from the most basic to the most nuanced information.

These 20 chapters, written by recognized authorities, are well constructed, simple to read, and richly illustrated, making this text the reference of choice for emergency rooms and professionals who serve the needs of sexual assault victims.

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Preface to the Second Edition

Sexual violence, among other things, is a public health issue, a social problem, produces a psychological outcome, and has a culture to its history. The impact of sexual violence extends far beyond the assault itself.

With the second edition of *Medical Response to Adult Sexual Assault*, our goal is to give doctors, nurses, law enforcement, lawyers, and the other members of the sexual assault response team a comprehensive reference that will allow them to successfully document and collect evidence, anticipate the needs of their patients, and provide compassionate care that will hopefully begin the healing process for sexual assault survivors.

Sexual violence, including rape and sexual assaultive acts, impacts health in many ways, often leading to both short- and long-term physical, emotional, social, and sexual consequences. While the term ***rape*** has a constricted definition of forced sexual penetration, including both psychological coercion as well as physical force, it includes attempted rapes, male as well as female victims, and both heterosexual and same-sex rape.

Sexual assault, on the other hand, implies a wide range of victimization to include attacks or attempted attacks involving unwanted sexual contact between victim and offender. Sexual assaults include verbal threats and may or may not involve force and include such acts as grabbing or fondling.

Susan Brownmiller wrote in her groundbreaking 1975 book, *Against Our Will: Men, Women and Rape:* "My purpose in this book was to give rape a history. Now we must deny its future."

Until rape is denied, we must continue the work. Our purpose in this book is to provide nursing, medical, and mental health professionals working with survivors of sexual assault and violence up-to-date research and evidence-based practices to help these professionals provide patients with compassionate care. It has been over 40 years since the first sexual assault nurse examiner program was started, and our understanding of how to provide the best possible care for our patients has only continued to evolve since then.

While we have certainly come a long way in our treatment of and attitudes toward sexual assault survivors, there is still a long way to go. It is our intent that this text will be a step in the right direction in providing survivors the care and support they deserve.

Linda E. Ledray, RN, SANE-A, PhD, FAAN
Ann Wolbert Burgess, DNSc, APRN, FAAN

Preface to the First Edition

When Ann Burgess wrote her seminal article, "Rape Trauma Syndrome," in 1974 and Linda Ledray started the first sexual assault nurse examiner (SANE) program in Minneapolis in 1977, neither dreamed that over 30 years later there would be SANE and sexual assault forensic examiner (SAFE) programs across the United States, Canada, and many other countries. While the initial drive to improve services clearly came from the advocate movement, the medical community—led by nurses—was quick to respond. We hope the time has come when it is no longer acceptable to just read the directions in the sexual assault evidence collection kit while providing care to the victim. We would certainly think this behavior unacceptable within any other patient population.

Another milestone for the forensic nursing movement came in 1992 when 72 nurses from 26 programs throughout the United States came together in Minneapolis, excited about the new role that was developing. Since two members of our group were from Canada, we decided to call this new organization the International Association of Forensic Nurses (IAFN). Once we combined the enthusiasm and expertise of the many nurses across the country, the model began to flourish. This new role officially became known as the SANE role 5 years later in 1997 at an IAFN meeting in Kansas City. Around the same time, the Office for Victims of Crime took the opportunity to further support program development through grants, many of which have gone to the IAFN and to member programs. To a great extent, it was the support for the SANE model from the staff and members of IAFN that took it from only a few programs to every state in the United States as well as to many countries throughout the world. The US military also strives to have this high quality of care available for all soldiers who may be victimized, regardless of where they are stationed.

Medical Response to Adult Sexual Assault is intended to summarize these 30 years of experience and research and provide the reader with up-to-date information based upon this research. It is intended to provide the reader with an easily accessible guide to providing all men, women, and adolescents who have been sexually assaulted with the best care possible, anticipating and meeting all of their needs. It is also intended to walk the reader through the court process and address their role, should the case go to trial. Knowing what can be expected in a court of law is the best preparation for our work and documentation of that work in the medical setting. The better job we do with the initial exam and documentation, the more likely an offender will be identified, and the more likely the case will settle out of court (and the less likely we will be called to testify). When we provide good patient care and evidence collection, there is less secondary trauma for our patients, and more offenders are identified and apprehended, resulting in fewer future sexual assaults. This is clearly an opportunity to impact not only the way our patients are treated, but—by assisting the criminal justice system to identify the offenders—also assist them with preventing future victimization.

Those of us who were a part of that initial meeting in Minneapolis are especially grateful to the continued efforts of IAFN staff and members to further the SANE model. That is why we have chosen to dedicate this book to IAFN and its members. Our hope is that it will help further our mutual goal of improving the medical, legal, forensic, and supportive response to victims of sexual assault.

Linda E. Ledray, RN, SANE-A, PhD, FAAN
Ann Wolbert Burgess, DNSc, APRN, BC, FAAN
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Reviews to the Second Edition

This well-developed, comprehensive text will be a valuable resource for forensic nurse educators and their students. In addition, it will serve as an excellent reference tool for both novice and experienced sexual assault examiners. The format and content are well suited for use in a basic SANE/SAFE course, or as part of a larger and more diverse advanced forensic nursing education curriculum. Each chapter is written and arranged in a manner to provide the reader with a clear and complete understanding of the subject matter. Topics ranging from the history and development of SANE practice, through a detailed step-by-step explanation of clinical evaluation process (complete with detailed photographs), to recognizing and meeting the needs of a wide range of unique victim populations are all thoroughly covered. Nurses and non-nursing professionals working in the field of sexual assault response will also greatly benefit from the content provided on related topics including SART development, human trafficking, and nonfatal strangulation.
There have been many advances in the science and practice of forensic nursing over the past 3 decades and this work reflects the latest information available to instructors, students, and actively practicing forensic examiners alike. I highly recommend this book to any health care professional providing services for victims of sexual violence.

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The Medical Response to Adult Sexual Assault, 2nd Edition *is a "must have" reference book for all health care professionals that provide care for and have contact with sexual assault patients in all arenas of health care. The text provides a roadmap from the collaborative nature of sexual assault care through victim recovery. This roadmap includes laying a foundation for the care of the sexual assault patient based on the most current science and research. With the inclusion of chapters outlining the care of specific patient populations with unique health care, safety, and forensic needs, readers will find the most current approaches to medical forensic care. This text will be one of the most frequently used in any practitioner's reference library.*

Kim Day, RN, SANE-A, SANE-P
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This authoritative text is an invaluable resource to all health care professionals (eg, physicians, advance practice providers, forensic nurses) who provide care to adults when there is a concern for sexual as well as physical assault. The authors, Linda Ledray and Ann Wolbert Burgess, provide a comprehensive review of the history of forensic nurse examiners as well as the approach to the medical history, physical and anogenital examination, documentation, and health care needs. The chapter by Diana Faugno and Stacey Mitchell will aid the team in expanding service provision beyond the acute sexual assault examination to assist our agency partners with medical evaluations, evidence collection, and documentation of injury in suspects. This text is essential for both the education of the novice examiner as well as for the experienced examiner who needs to maintain competency and currency in the field.

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This is a very well written book that will serve as an excellent resource for students and clinicians. The authors ground their statements in carefully selected findings from a range of peer-reviewed research that includes a nice balance of both seminal and novel work. For example, in discussing victim impact, the authors describe findings from Burgess and Holmstrom's pivotal 1974 study, which led to the development of the diagnosis of rape trauma syndrome. The chapter on the neurobiology of the trauma-stress response is especially well done and is a tremendous contribution to students and providers for a number of reasons, not the least of which is the fact that when clinicians are facile with these concepts they are in a better position to help their patients understand and normalize their complicated responses to trauma, many of which are quite puzzling to victims.

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Reviews to the First Edition

In Medical Response to Adult Sexual Assault*, Dr. Ledray leads the way for medical and allied health professionals to improve the medical care given to this population. According to the Rape, Abuse, and Incest National Network, in 2007 there were 243 300 victims of adult sexual assault in the United States. This population has specific unmet needs, some of which can be met with the emergence into practice of the content knowledge from Dr. Ledray's book. This text is comprehensive in scope, covering the history of specialization care, categorizations of victims of adult sexual assault with common threads for identification and treatment, and includes a chapter on evidence collection, preservation, and identification that will strongly support the legal machinations that must occur. This text should become a necessary and well-worn resource to medical professionals working with adult sexual assault victims.*

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The authors of Medical Response to Adult Sexual Assault *provide an invaluable resource for the professionals who collaborate to provide services to victims of sexual assault. The range of chapters and the comprehensiveness with which each chapter is written demonstrates a complete and detailed understanding of the issues associated with sexual assault cases. The reader will find that reference and the use of this resource to be most rewarding. This superbly edited text by three of the most well-respected clinicians in the area of sexual assault will undoubtedly become a standard in educational settings across a diverse professional spectrum.*

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This text is a must read for all health care professionals who work in hospital emergency departments and other professionals who come in contact with sexual assault victims. Topics covered include the history and importance of SARTs; physiological and psychological consequences of sexual assault; conducting the examination; collecting evidence; and qualifications of SART members. Registered nurses interested in becoming SANEs will find this text particularly informative. This text clearly articulates the highest standards of care and is both a valuable reference book and an excellent instructional source for educating professionals in the care of sexual assault victims.

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Medical Response to Adult Sexual Assault *offers a comprehensive, holistic, and collaborative approach to adult sexual assault, and is an invaluable resource to any professional who may provide care to this population. This book provides the content and framework to expand and improve the quality of an interdisciplinary assessment and treatment of adult sexual assault. This resource also provides a broader scope of the specific dynamics of the adult sexual assault response in settings such as the military and college campuses, and informs the reader with greater understanding of the male sexual assault victim, elder sexual abuse, and human trafficking. Having all the relevant content in one textbook like this is an effective and informative tool for professionals in health care as well as other important disciplines serving these victims.*

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Medical Response to Adult Sexual Assault *is an outstanding text that mimics an encyclopedia as it covers a wide range of pertinent issues that include historical, medical, SANE, and legal perspectives. The book provides hard-to-find information about topics such as conducting a sexual assault examination, providing courtroom testimony, and identifying the complexities associated with crimes against vulnerable individuals, such as the elderly and incarcerated. The seasoned contributors bring the content alive with their experience, anecdotes, and superb writing. This text is most worthy of some precious space on your bookshelf.*

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Chapter 1

Sexual Assault Nurse Examiner and Sexual Assault Response Team Overview and History

Linda E. Ledray, RN, SANE-A, PhD, FAAN
Ann Wolbert Burgess, DNSc, APRN, FAAN

A New Standard of Care

With the implementation of sexual assault nurse examiner (SANE) programs across the United States, a new standard of care was implemented for sexual assault patients. Since the development of these programs in the late 1970s, it is no longer acceptable to have untrained medical personnel reading the directions of the examination while they are treating sexual assault victims and collecting evidence. Such practices would never be considered reasonable for a physician or nurse to perform in the emergency department (ED) with other patient populations, and they should not be acceptable when caring for victims of rape.[1]

In some medical institutions, rape victims still encountered long waits for a rape examination and inadequate, substandard care even in several of the best medical facilities.[2] In medical facilities with SANE programs, studies reported that care was far superior. The evidence indicates that SANE programs offer emergency contraception (EC) 97% of the time and medication to prevent sexually transmitted infections (STIs) 99% of the time. Nationally, non-SANE programs only offered EC 20% of the time, and they either screened for STIs or offered STI prophylactic care 58% of the time.[3] Reasons programs did not routinely offer particular services (eg, STI cultures, HIV testing and prophylaxis, emergency contraception) included financial constraints, difficulties balancing medical care with legal prosecution, and affiliations with religious hospitals.[4]

In 1989 the California State Court of Appeals ruled that a woman who was not given the right to choose EC could sue the hospital that provided the inadequate care.[5] Such a lawsuit, however, takes place in a very public forum—one that a rape victim may not be willing or able to endure. Smugar and colleagues[6] recognized that although it can be therapeutic for some, these lawsuits would further prolong the trauma for others. To prevent rape victims from needing to sue to access the care they needed, many states passed laws requiring sexual assault victims be provided information about EC or given these medications by health care providers when requested. It is a health care provider's responsibility to know the best care practices and to have a system in place that meets the needs of this often vulnerable population.

Over the past several decades, our awareness of the magnitude and the trauma of crime victimization has increased considerably. The costs incurred by society include medical and psychological services to aid victim recovery, the apprehension and disposition of

offenders, and the invisible climate of fear that makes safety a paramount consideration in scheduling normal daily activities. In addition to the monetary costs associated with sexual victimization, the impact of such abuse on the victim has been well documented.[7,8]

This chapter reviews the social and political forces in place in the 1970s when the antirape movement began; our early attempts to better understand the psychological impact on the victim through the use of the terms *rape trauma syndrome*, then *posttraumatic stress disorder*, and later the *neurobiology of trauma*; and the development and implementation of victim services, specifically SANE programs and sexual assault response teams (SARTs).

The Antirape Movement: The Beginning

The women's rights movement in the 19th century was focused on the legal recognition of women to secure their rights to vote, to own and control property, and to participate in public affairs. In the 20th century the movement focused on confronting restrictions on women's personal lives. Analysis of these restrictions began in ***consciousness-raising (CR) groups***, a new organizing tool of the women's movement whereby women discussed their experiences and the problems of being female in a modern society. Often described by men as hotbeds of radical feminism, the reality was that simply attending such a discussion group was the most assertive act many of these women were capable of taking. Within the supportive environment of the CR groups, women found the courage to share private experiences never before shared, such as incest and rape.[9]

These anecdotal disclosures of former victims had a profound effect on their listeners. The revelations represented an unprecedented breakthrough of the silence that surrounded the topic of rape for centuries. The act of rape has been an inherent part of women's lives throughout recorded history—a theme commonly found in literature, poetry, theater, art, and war.

Police departments and rape crisis centers first began to address the crime of rape in the early 1970s when little was known about rape victims or sex offenders. The issue of rape was just beginning to be raised by feminist groups. Unfortunately the general public was not particularly concerned about the issue of rape or the plight of rape victims. Few academic publications or special services existed, funding agencies did not see the topic as important, and health policy was almost nonexistent. In 1971, the New York Rape Speak-Out was held in an effort to raise awareness about the issue. Around the same time Susan Brownmiller wrote about the history of rape to further raise awareness and urged people to deny its continuation in the future.[10]

Soon after, the antirape movement began to attract women from all walks of life and political persuasions. Various strategies began to emerge, 1 of which was the self-help program now widely known as the rape crisis center. One of the first such centers was founded in Berkeley in early 1972, known as Bay Area Women Against Rape (BAWAR). Within months of the opening of the Berkeley center, similar centers were established in Ann Arbor, Michigan; Washington, DC; and Philadelphia, Pennsylvania. Hospital-based rape counseling services began in Boston and Minneapolis.[11] Centers were soon replicated, and services flourished. Although volunteer ranks tended to include a large number of university students and instructors, they also included homemakers and working women. The volunteer makeup usually reflected every age, race, socioeconomic class, sexual preference, and level of political consciousness. Volunteers were, however, exclusively women. The most common denominators were commitments to aiding victims and bringing about social change.[9,11] As Susan Brownmiller noted, the amazing aspect of the proliferation of the grassroots women's groups was that such an approach to the problem of rape had never been suggested by men—that women should organize to combat rape was a result of the women's movement.[10]

In retrospect, the history of the rape crisis centers in the United States has been one of enormous struggle. The struggle was to overcome indifferences, apathy, changing social trends, and the lack of stable resources, yet the struggle was willingly undertaken from the belief in the rightness of the cause—a cause that, despite the struggles, had its share of successes. Feminists identified a social need and a way of responding to it. Rape crisis centers began to adapt their services to assist other crime victims, specifically battered women and their children. Although they never reached the goal of eradicating rape through social change, they were the instigators of social change essential to the rights of women.[9,11]

Rape Law Reform

Laws both reflect and shape public opinion and attitudes. Legislation in the form of law reform can be both instrumental and symbolic. Such was the case with rape law reform, especially in conveying the concept of rape as a physically and emotionally damaging act. Changes in rape laws helped to influence attitudes within both the criminal justice and the general community, although some would argue that jurors and citizens are still too often inclined to view rape in moral rather than criminal terms.

US criminal rape laws were derived from British common law. Three elements needed to be proved in cases of rape: (1) sexual contact, (2) force/coercion or lack of consent, and (3) the identity of the assailant. In addition, most state laws today treat sexual assault as a very serious crime. It carries more severe penalties, especially when penetration (however slight) occurred, the victim was injured, a weapon was used, or the victim was younger than the age of consent.

The penalties, of course, vary by state. Two influential legal theorists were 17th-century jurist Lord Chief Justice Matthew Hale and the Edwardian-era scholar John Henry Wigmore. Hale's belief that rape was "an accusation easily made, and hard to be proved, and harder to be defended by the party accused, though ever so innocent" was reflected in both American jury instructions and standards of proof.[12] Similarly, Wigmore's concern about sexually precocious minors and unchaste women who fantasize about rape gave rise to the corroboration doctrine and influenced such practices as the routine polygraph examination of victims.[13] Though neither man's assertions were supported by empirical data, they received widespread endorsement by legal bodies. As a result, US law reflected a concept of rape as a sexual rather than a violent offense and imposed a vast array of safeguards against false accusations by the turn of the 20th century.[14]

The need for rape law reform was clearly noted by women's rights movement participants who encouraged former victims to speak publicly about insensitive and indifferent treatment they experienced in the criminal justice system. These disclosures fostered recognition of the need for systematic change, which women activists felt must begin with the law itself. Movement activists organized to develop a rape law reform agenda, solicit public support for reform, and present their case to state legislators. The political climate was favorable for these citizen-initiated efforts, but it was the growing presence of women and sympathetic men within the legal and lawmaking professions that reduced most of the resistance to change. As evidenced by the radical shift in the concept of unacceptable behavior, a review of rape law reform by Largen[14] suggested, among other things, that in most states, social concepts of sexual assault were changing more rapidly than legal concepts. Politicians also recognized the need for more research on the impact of rape on the victim and the development of programs to meet apparent needs.

Congressional Support

Financial help came from Congress. In response to a rising crime rate and growing community concern over the problem of rape, Senator Charles Mathias of Maryland

introduced a bill in September 1973 to establish the National Center for the Prevention and Control of Rape. The purpose of the bill was to provide a focal point within the National Institute of Mental Health from which a comprehensive national effort would be undertaken to conduct research, develop programs, and provide information leading to aid for victims and their families. Also, efforts could be made to address rehabilitation of offenders and the ultimate curtailment of rape crimes. The bill was passed overwhelmingly in the 93rd Congress, vetoed by President Ford, and successfully reintroduced. The National Center was established through Public Law 94-63 in July 1975. The chair of the first advisory committee of the new center was a nurse, Ann Wolbert Burgess.

By the late 1970s, the battered women movement became an extension of the antirape movement and focused on male violence against domestic partners. Violence emerged as a public health issue with Surgeon General C. Everett Koop's convening of a workshop on violence and public health in 1985. The closing of the National Center for the Prevention and Control of Rape, however, in the late 1980s left a void in funding until 1994. Again, organized efforts were needed to keep rape crisis centers operating and lobbying for government funding. Congress once again recognized violence against women as a national problem in its 1994 passage of the Violence Against Women Act (VAWA) as part of the Violent Crime Control and Law Enforcement Act, which was accompanied by President Clinton's establishment of an Office on Violence Against Women in the US Department of Justice. The National Research Council established a Panel on Research on Violence Against Women in 1995 to fulfill a congressional request to develop a research agenda to increase understanding and control of violence against women. This report highlights the major literature on the scope of violence against women in the United States, the causes and consequences of that violence, the interventions needed for both female victims of violence and male perpetrators, and funding needed to meet research goals.[8]

In July 2017 a major effort to further improve services for victims of sexual assault occurred when Representative Ted Poe, a Texas congressman, and Representative Carol Maloney of New York introduced a bill in the House of Representatives that would require hospitals nationwide to provide rape victims with around-the-clock access to specially trained medical workers, SANEs or sexual assault forensic examiners (SAFEs). The bill is called the Megan Rondini Act of 2017 in honor of a University of Alabama student who was raped in 2015. She reported to law enforcement and went to a Tuscaloosa hospital that did not have specially trained SANEs or SAFEs for care after the rape. Unfortunately, a year later, without the necessary support, and feeling betrayed by the system, Rondini committed suicide. The intent of this law was to ensure that in the future all victims of rape get proper medical care, support, evidence collection, and follow-up services.[15]

History of and Need for SANE-SART Programs

The impetus to develop SANE programs in the United States began about the same time as the first rape crisis centers were opened—the early 1970s—with nurses, other medical professionals, counselors, and advocates working with rape victims who came for medical care in traditional settings such as hospital EDs. It was obvious to these individuals that the services for sexual assault victims were inadequate because they failed to meet the standard of care required for other medical patients.[16,17] Rape victims often had to wait 4 to 12 hours in a busy, public area, competing unsuccessfully with the critically ill for medical staff time.[16,18,19] To avoid destroying evidence, they were often not allowed to eat, drink, or urinate while they waited.[20]

Emergency department services were inconsistent and problematic. The typical rape survivor faced a time-consuming, cumbersome succession of examiners, some with only a few hours of orientation and little experience. Many doctors and nurses were not sufficiently trained to do the medicolegal examination and were unwilling or unable to provide expert witness testimony if the case went to court.[21] When they had the training to complete the evidentiary examination, staff often did not complete a sufficient number of examinations to maintain their level of proficiency.[22-24] Even when victims' medical needs were met, their emotional needs were often overlooked and they were often blamed by police and others when they made a report.[25]

Often, only male physicians were available to do the vaginal examinations.[22] Although approximately half the rape victims in 1 study were unconcerned with the gender of the examiner, the other half found this extremely problematic. Even male victims indicated they preferred to be examined by a woman, because they were most often raped by a man and experienced the same generalized fear of and anger toward men that female victims experienced.[26] More research is needed, however, to explore gender issues. With the proper skills and awareness, either gender should be able to provide the highest standard of care to victims of violent crimes. The issue likely has more to do with demeanor, sensitivity, and understanding than gender.

Many anecdotal and published reports depict physicians as reluctant to do a rape examination. Key factors that have led to this reluctance include a lack of experience and training in forensic evidence collection[19,21,27]; the time-consuming nature of the evidentiary examination in a busy ED with many other medically urgent patients waiting to be seen[28,29]; and the potential that if they complete the examination they may be subpoenaed and taken away from their work in the ED to testify in court and be questioned by a sometimes hostile defense attorney.[19,20,29] Documentation of evidence was rushed, inadequate, or incomplete because of these factors.[29] Staff physicians in teaching hospitals often assigned residents to do the forensic examinations when they were available; physicians have refused to do the examination.[28] In 1 case a rape victim was reportedly sent home without having an evidentiary examination completed because no physician could be found to do it.[30]

As information has become more readily available on the complex medical-forensic needs of rape victims, nurses and other professionals have realized the importance of providing the best ED care possible.[22] For 75% of victims in a study evaluating care received in the ED, the initial ED visit was the only known contact they had with medical or professional support staff.[31] Nurses became aware that although they were often only credited with "assisting the physician with the examination," in reality they were typically performing the entire medical-forensic examination except the pelvic speculum examination.[28,31] It was clear to these nurses that it was time to reevaluate the system and consider a new approach.

Pioneer Sexual Assault Nurse Examiner Programs

To better meet the needs of the sexually assaulted population, SANE programs were established in Memphis, Tennessee in 1976[19]; Minneapolis, Minnesota in 1977[32,33]; and Amarillo, Texas in 1979.[34] Unfortunately these nurses worked in isolation, unaware of the existence of other very similar programs until the late 1980s. In 1992, 72 individuals from 31 SANE programs across the United States and Canada came together for the first time at a meeting hosted by the Sexual Assault Resource Service and the University of Minnesota School of Nursing in Minneapolis. At this meeting the International Association of Forensic Nurses (IAFN) was formed.[26]

Development of SANE programs today is progressing rapidly, especially with the high program visibility afforded by the publication of the US Department of Justice Office for Victims of Crime (OVC) document the *SANE Program Development and Operation Guide*.[35] Although only 86 SANE programs were identified and included in the October 1996 listing of SANE programs published in the *Journal of Emergency Nursing*,[26] there are currently nearly 600 SANE programs registered on the OVC grant-funded Web site www.sane-sart.com.[36] In 2004, the Joint Military Task Force on Sexual Assault also recognized the need for improved services for members of the Armed Forces and has begun the process of implementing SART teams for every military unit.

The American Nurses Association (ANA) officially recognized forensic nursing as a new specialty in 1995.[37] SANEs make up the largest subspecialty of forensic nursing internationally. At the 1996 IAFN meeting in Kansas City, Missouri, Geri Marullo, executive director of ANA, predicted that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) would eventually require every hospital to have a forensic nurse available.[38] However, as of 2019 this still has not occurred. Perhaps the Poe Maloney Act, if reauthorized, will change this situation. On March 21, 2018, Congresswoman Carolyn B. Maloney (D-NY), author of the *Debbie Smith Act*, joined with Congressman Ted Poe (R-TX) to introduce House Resolution 5341, the *Debbie Smith Crime Victims Protection Act*. If passed this legislation would reauthorize the *Debbie Smith Act* and dedicate much-needed resources to state and local law enforcement agencies to conduct forensic analysis of DNA evidence collected from crime scenes, including untested rape kits. Smugar et al[6] also recommend that the JCAHO enact standards or Congress pass legislation requiring health care providers to meet a higher standard of care. SANE-SART programs have raised the standard of care for victims of sexual assault, but this standard is typically not being met in facilities that do not have SANE nurses.[39]

The Role of the SANE and SAFE

Because forensic nurse examiner programs began and functioned independently until the founding of IAFN in Minneapolis in 1992, different terminology was being used across the country to define this new role. At the October 1996 IAFN annual meeting, the SANE Council voted on the terminology it wanted to use. The overwhelming decision was to use the title SANE—sexual assault nurse examiner. A SANE is a registered nurse (RN) who has advanced education in the forensic examination of sexual assault victims. In programs where physicians are also used, the more inclusive terms *sexual assault forensic examiners* or *forensic examiners* (FEs) are typically used. Advanced education in sexual assault forensic evidence collection is vital.

The primary mission of a SANE/SAFE program is to meet the needs of all male and female victims of sexual assault or abuse by providing immediate, compassionate, culturally sensitive, and comprehensive forensic evaluation and treatment by trained, professional nurse experts within the parameters of state nurse practice acts, the SANE standards of the IAFN, and individual agency policies. With proper training, SANE programs may provide services to children, adolescent, and adult victims. Since 2007 nearly half of SANE programs have provided services for all age groups.

In addition to documentation and collection of forensic evidence, prophylactic treatment of STIs and emergency contraception are provided by the SANE. The SANE also conducts a medicolegal examination, not a routine physical examination, to identify trauma.

Although SANEs are not advocates, they do provide the rape survivor with information to assist in anticipating what may happen next, to aid in making choices about reporting and deciding whom to tell, and to ensure that the rape survivor is safe and gets the

support needed after he or she leaves the SANE facility. This usually includes a discussion between the victim and the SANE about reporting to law enforcement.

If the victim has made a choice not to report, the SANE will need to discuss and determine why he or she may be hesitant to report. Although the decision to report is always ultimately the victim's, in most cases the SANE will encourage the survivor to report the crime and make referrals to advocacy agencies that can provide the support necessary to help the victim through the criminal justice process and to aid in a successful recovery from the rape. The SANE will also provide emotional support and crisis intervention, working with advocacy support groups such as rape crisis counselors when available.

Typical SANE-SART Program Operation

To be optimally effective and provide the best service possible to victims of sexual assault, the SANE/FE must function as a part of a team of individuals from community organizations, usually referred to as a sexual assault response team (SART). At a minimum, the SART should include the SANE/FE, advocate, law enforcement officer, crime laboratory specialist, and prosecutor. It is important to understand that SARTs can function in a variety of ways, both formally and informally. To be a functioning SART, it is not necessary or typical for all team members to respond to the survivor at the same time. In fact, most SARTs do not function this way. In most cases the SANE is available on-call, off premises, 24 hours a day, 7 days a week. The on-call SANE is paged immediately whenever a sexual assault or abuse survivor enters the community's response system. If a rape advocate is available, the staff or SANE will also page the advocate on-call. During the time it takes for the SANE to respond (usually no more than 1 hour), the ED or clinic staff will evaluate and treat any urgent or life-threatening injuries. If treatment is medically necessary, the ED staff will treat the patient, always considering and documenting the forensic consequences of the lifesaving and stabilizing medical procedures. If immediate medical treatment is not necessary, the patient will be kept comfortable until the SANE and advocate arrive. Once the SANE arrives, consent for the forensic medical examination is obtained and the SANE conducts the forensic evidentiary examination. The law enforcement officer conducts the initial interview either before or after the SANE examination is completed.

It is important to remember that a truly functional SART is much more than just having multiple disciplines involved in a case. A truly functional SART is a team of individuals who know and trust each other—a team who understand each other's roles and role limitations, and who are working together toward the same goals of providing the most effective patient care possible while collecting all evidence available, in a victim-centered manner, to both support the victim and achieve justice. Chapters 12 and 13 address options for effective SART operation in detail and describe the impact SANE-SART programs have had on both treatment of sexual assault victims and prosecution of cases.

The SANE Evidentiary Examination

With the development of the SANE role, a trained medical professional was available to provide complete care to the survivor of sexual assault. In facilities with SANEs on call, it was no longer necessary for the survivor to wait until someone, often with minimal or no special training, could be freed up to provide care that was often incomplete.

The publication of *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults and Adolescents* was a major step toward encouraging consistent treatment for victims of sexual assault throughout the United States. This document stressed the need to work in collaboration with other SART professionals, and it also provided specific standards of care that should be met for a SANE medical forensic examination, including the following[40]:

1. Collection of evidence using a sexual assault evidence collection kit
2. Further assessment and documentation for drug- or alcohol-facilitated sexual assault
3. Assessment and documentation of injuries
4. Risk evaluation and prophylactic care of STIs
5. Evaluation of pregnancy risk and EC
6. Crisis intervention
7. Referrals for medical and psychological follow-ups

Today many agencies have extended the time frame for which they will conduct a complete evidentiary examination to 96 or 120 hours or longer from the time of the sexual assault, as recommended by the American College of Emergency Physicians,[41] the *SANE Program Development and Operation Guide*,[34] and the *National Protocol for Sexual Assault Medical Forensic Exams: Adolescent and Adult*.[40] This increase occurred as DNA recovery techniques improved. However, research is still needed to better evaluate the value of this decision.

Chapter 4 discusses the SANE/FE examination in detail, along with updated recommendations in the 2016 *SANE Program Development and Operation Guide*, now available online.

Evaluating SANE Programs

Most sexual assaults are never reported to law enforcement, and even among reported cases, most will never be successfully prosecuted. This reality has been a long-standing source of frustration for survivors and victim advocates, as well as other members of the criminal justice system. As described in this chapter, communities have implemented interventions to improve postassault care for victims and increase reporting and prosecution rates. Campbell, Patterson, and Bybee[42] undertook a study to examine whether adult sexual assault cases were more likely to be investigated and prosecuted after the implementation of a SANE program within a large Midwestern county. A quasi-experimental design was used to compare pre-SANE criminal justice system case progression with post-SANE program development. Results from longitudinal multilevel ordinal regression modeling revealed that case progression through the criminal justice system significantly increased after SANE implementation. More cases reached the "final" stages of prosecution (ie, conviction at trial or guilty plea bargains) after SANE program development. These findings were robust after accounting for changes in operation at the focal county prosecutors' offices. In summary, SANE programs' work with law enforcement and their patients, though separate and philosophically distinct, is mutually reinforcing and provides instrumental resources for successful case prosecution.[42]

The Psychological Impact of Sexual Assault

The fact that rape occurs and is an act of conquest is documented in the Bible as well as in war annals. It is endemic to humankind and was undoubtedly practiced by cavemen. But in 1972, when Burgess and Holmstrom launched their research, there were very few clinically based articles that dealt with the incidence of rape or the impact of rape on the victim or family. We were unaware of the neurobiology of trauma, discussed in detail in Chapter 10 of this book, and its impact on victim behavior and memory recall. There was also little information on the offender. Although the violent acts and the suffering they caused had been noted since the origins of humanity, few considered these events from a health standpoint.

In the early 1970s there were 2 common stereotypes of the rapist that, in turn, greatly influenced how the rape victim was viewed. Because most assailants are male and most victims female, that was the focus of discussion. At one extreme, he was regarded as a per-

fectly healthy, "red-blooded," sexually aggressive, macho man whose offense was simply an extreme product of his cultural conditioning elicited by a provocative and seductive but punitive woman. At the other extreme, he was thought of as a bizarre, demented, oversexed "fiend" filled with lust and perverted desire who stalked his prey at night. In the former situation, the offender was seen as a totally normal individual who was essentially a victim of circumstance; in the latter, he was an inhuman creature whose predatory assaults were his only source of gratification. Both stereotypes reflected the erroneous but popular belief that rape was motivated primarily by sexual desire—the normal desires of a healthy man or the warped impulses of a sex fiend. This mistaken notion was an insidious assumption, for it followed from such a premise that if the offender was sexually aroused, then it must have been the victim who aroused him because it was toward her that these impulses were directed. From that point on, responsibility and accountability for the offense, to a large extent, shifted from the offender to the victim, and she became the accused by police, family, friends, and even herself. In court, it became the central aim of the defense attorney to impeach the victim's credibility by showing that by her dress, conduct, conversation, or behavior she invited the assault and, either deliberately or unintentionally, that she aroused the sexual urges of her assailant. He was seen as the victim of her provocative behavior. Some high-profile cases have continued to foster this notion.

A word needs to be said about males who are raped. Male on male sexual assault is a form of sexual violence that, despite worldwide prevalence, remains significantly underreported and unrecognized. Society is becoming increasingly aware of male rape. However, experts believe that current male sexual assault statistics vastly underrepresent the actual number of males age 12 and over who are assaulted each year. This type of sexual assault is cloaked in stigma and shame. Male sexual assault is similar to male-female sexual assault in that it is predominantly an assertion of power and aggression rather than an attempt on the part of the perpetrator to satisfy sexual desire. The effect of the attack is to damage the victim's psyche, rob him of his pride, and intimidate him.

Rape, until the 1970s, thrived on prudery, misunderstanding, and silence. It was not until the 1980s that academic and scientific publications on the subject multiplied. A review of articles on the psychological effects of rape and interventions for rape victims in the posttraumatic period located 78 references between 1965 and 1976, with 36 on the effects of rape and 42 on intervention. One of the first attempts to understand the impact of rape on the victim occurred when Burgess and Holmstrom identified the cluster of symptoms they called rape trauma syndrome.[43]

History of Rape Trauma Syndrome

Rape trauma syndrome was 1 of 3 typologies identified by Burgess and Holmstrom in 1974 and published in the *American Journal of Psychiatry*.[43] The typologies were the result of personal interviews of 146 people who ranged in age from 3 to 73 years at the time of admission to the Boston City Hospital emergency department. The individuals were all admitted with the complaint, "I've been raped." Three types of sexual trauma were conceptualized from the sample of 146 and based on consent (or not) to have sex: rape trauma (no consent), pressured sex (coerced sex), and sex stress (initial consent but then denial of consent). Of the 146 individuals, 92 women age 18 to 73 years were classified as rape trauma victims, and their responses to the assaultive experience formed the basis for the rape trauma syndrome. These women were interviewed at the emergency ward of the hospital and followed up 4 to 6 years later in regard to the problems they experienced as a result of being forced into nonconsensual sex.[44]

One of the conclusions reached by Burgess and Holmstrom as a result of studying 92 adult rape victims was that victims suffer a significant degree of physical and emotional

trauma during a rape. This trauma can be noted immediately after the assault and over a considerable period afterward. Victims consistently described certain symptoms, such as intrusive thoughts of the rape, fear, anxiety, nightmares, and daymares, as well as the development of phobias. A cluster of symptoms that most victims experienced was described as the rape trauma syndrome. This syndrome has 2 phases: the immediate or acute phase, in which the victim's lifestyle is completely disrupted by the rape crisis, and the long-term process, in which the victim must reorganize this disrupted lifestyle. The syndrome includes physical, emotional, and behavioral stress reactions that result from the person being faced with a dire threat to life or integrity.

Victims expressed other feelings in conjunction with fear, ranging from humiliation, degradation, guilt, shame, and embarrassment to self-blame, anger, and revenge. Victims reported feeling distress over reminders (or cues) of the assault. Victims become cautious and distrustful with all people; they expect the assailant to be everywhere.

The prevailing stereotype of rape in the 1970s was that women should feel ashamed and guilty after being raped, but that was not the primary reaction in most victims. Instead, most expressed a fear of physical injury, death, or retaliation.

The Burgess and Holmstrom study was twofold, with a clinical focus on victim response and an institutional focus. The study made clear that rape does not end with the assailant's departure; rather the profound suffering of the victim can be diminished or heightened by the response of those who staff the police stations, hospitals, and courthouses. Ironically, the institutions that society has designated to help victims may in fact cause further damage.[45] The clinical descriptive findings from the Burgess and Holmstrom study were published and used by rape crisis staff as well as mental health staff.

Rape trauma syndrome was accepted as a nursing diagnosis into the North American Nursing Diagnosis Association official nomenclature in 1979. Also included were 2 variations of rape trauma syndrome: silent response to rape and compounded reaction to rape. The silent response to rape was observed in persons who had never told anyone of a rape experience, but later (months or years) the assault was revealed. In the Burgess and Holmstrom study, women talked freely of these early experiences in the context of the new assault experience. In the compounded rape trauma, the individual has a primary presenting medical or psychological disorder through which the rape trauma symptoms are filtered. Examples include elders with dementia; persons with a psychiatric disorder or physical disorder; persons with an intellectual disability; and persons with somatic complaints, multiple ED visits, substance abuse, eating disorders, and depressive disorders.

History of Psychological Trauma

Rape trauma syndrome preceded the term ***posttraumatic stress disorder (PTSD)*** by 6 years. When the American Psychiatric Association's Work Group on Anxiety Disorders was considering how to classify a number of traumatic events (eg, combat stress, natural disasters, rape trauma), it decided to make *PTSD* an umbrella term under which the various life-threatening events could fall.[46]

The term *PTSD* came into the official nosology of the American Psychiatric Association in 1980 with the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).[46] The development of this term is believed to date back to early Greek and Roman war literature, which suggests the longstanding strong (but not exclusive) association of this disorder with military combat. After the American Civil War, the psychological problems of combat veterans were called "soldier's heart." In the latter half of the 19th century, the focus shifted to transportation and industrial accidents.

The modern conceptualization of PTSD originated with the European neurologists Jean-Martin Charcot and Hermann Oppenheim, who treated victims of railroad and industrial accidents in the late 19th century. Both Charcot and Oppenheim regarded the disorder as stemming from an acute fright or emotional shock. Charcot used the term ***traumatic hysteria*** to describe a condition of the mind that evolved not from the physical effects of the traumatic accident but rather from the patient's interpretation of it. Oppenheim rejected the hysterical nature of the condition theorizing that it resulted from the acute emotional shock induced by the traumatic event that injured the nervous system. Both DSM-I and DSM-II failed to recognize these earlier insights, and they did not dignify the condition with a diagnosis. The introduction of the PTSD diagnosis into DSM-III represented a breakthrough in that it (1) recognized a common syndrome or pathway shared by victims of disparate traumatic events, (2) formulated specific criteria for its diagnosis, (3) did not imply a preexisting mental defect, and (4) did not regard the condition as necessarily temporary.[47]

The theme of traumatic memories haunting people after experiencing overwhelming terror has been used in literature from Homer to Shakespeare's *Macbeth*. By the late 1850s, Briquet[48] suggested a link between the symptoms of hysteria and childhood histories of trauma. During this time, a small Anglo-Saxon literature emerged documenting responses to accidents (eg, "railway spine" after train accidents) and nostalgia for war trauma ("soldier's heart"). The relationship between trauma and psychiatric illness, however, only began to be explored in the last 2 decades of the 19th century when neurologist Charcot lectured on the functional effects of trauma on behavior.[49]

Charcot's student Pierre Janet undertook one of the first systematic studies of the relationship between trauma and psychiatric symptoms and delivered a major paper at the Harvard Medical School in 1906. Janet realized that different temperaments predisposed people to deal with trauma with different coping styles. He coined the term *subconscious* to describe the collection of memories that form the mental schemes that include the person's interaction with the environment. He suggested it was the interplay of memory systems and temperament that made each person unique and complex.[49]

Although one of Freud's earliest published works was *Studies on Hysteria*, he later shifted from a PTSD paradigm of neurosis to a paradigm that centered on intrapsychic fantasy. In a later work, *Beyond the Pleasure Principle*, he once again addressed the issue of traumatic neurosis and looked at trauma as disequilibrium. The history of the development of PTSD was intensified around war and combat stress. Despite such recognition, though, systematic inquiry into the phenomenon of posttraumatic stress was remarkably late in coming. It was not until 1980 that the condition was determined to be a separate and distinct diagnostic category by the American Psychiatric Association.

History of PTSD Diagnosis

There have been several revisions to the PTSD diagnostic criteria.[46,50] The last major revision was in the fifth edition of the DSM, published in 2013. The criteria for a PTSD diagnosis in the DSM-5 follows.[46,50]

DSM-5 PTSD Diagnostic Criteria

— **Criterion A (1 required)**: The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

  — Direct exposure

  — Witnessing the trauma

- — Learning that a relative or close friend was exposed to a trauma
- — Indirect exposure to aversive details of the trauma, usually in the course of professional duties (eg, first responders, medics)

— **Criterion B (1 required)**: The traumatic event is persistently re-experienced, in the following way(s):

- — Intrusive thoughts
- — Nightmares
- — Flashbacks
- — Emotional distress after exposure to traumatic reminders
- — Physical reactivity after exposure to traumatic reminders

— **Criterion C (1 required)**: Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- — Trauma-related thoughts or feelings
- — Trauma-related reminders

— **Criterion D (2 required)**: Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- — Inability to recall key features of the trauma
- — Overly negative thoughts and assumptions about oneself or the world
- — Exaggerated blame of self or others for causing the trauma
- — Negative affect
- — Decreased interest in activities
- — Feeling isolated
- — Difficulty experiencing positive affect

— **Criterion E (2 required)**: Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- — Irritability or aggression
- — Risky or destructive behavior
- — Hypervigilance
- — Heightened startle reaction
- — Difficulty concentrating
- — Difficulty sleeping

— **Criterion F (required)**: Symptoms last for more than 1 month.

— **Criterion G (required)**: Symptoms create distress or functional impairment (eg, social, occupational).

— **Criterion H (required)**: Symptoms are not due to medication, substance use, or other illness.

— **Two specifications**:

  — *Dissociative Specification*: In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:

    1. Depersonalization: Experience of being an outside observer of or detached from oneself (eg, feeling as if "this is not happening to me" or if one were in a dream).

    2. Derealization: Experience of unreality, distance, or distortion (eg, "things are not real").

  — *Delayed Specification*: Full diagnostic criteria are not met until at least 6 months after the trauma(s), although onset of symptoms may occur immediately.

Comparison of DSM-5 PTSD Symptoms to DSM-IV PTSD Symptoms

Overall the symptoms of PTSD are generally comparable between DSM-5 and DSM-IV. A few key alterations include the following:

— The revision of Criterion A1 in DSM-5 narrowed qualifying traumatic events such that the unexpected death of family or a close friend due to natural causes is no longer included.

— Criterion A2, requiring that the response to a traumatic event involved intense fear, hopelessness, or horror, was removed from DSM-5. Research suggests that Criterion A2 did not improve diagnostic accuracy.

— The avoidance and numbing cluster (Criterion C) in DSM-IV was separated into 2 criteria in DSM-5: Criterion C (avoidance) and Criterion D (negative alterations in cognitions and mood). This results in a requirement that a PTSD diagnosis includes at least 1 avoidance symptom.

— Three new symptoms were added:

  — Criterion D (negative thoughts or feelings that began or worsened after the trauma): (1) Overly negative thoughts and assumptions about oneself or the world; and (2) negative affect

  — Criterion E (trauma-related arousal and reactivity that began or worsened after the trauma): (3) Reckless or destructive behavior

Terminology

Rape or Sexual Assault?

Although legal definitions of rape and sexual assault vary greatly from state to state, in this book the terms will be used interchangeably. They refer to any unwanted contact of the sexual organs of 1 person, whether male or female; by another person, regardless of gender; with penetration, however slight, or without penetration; and with or without resulting physical injury.

In 2012 there was an important change within the FBI's Uniform Crime Report (UCR) Summary Reporting System (SRS). "Forcible rape" had been defined by the UCR SRS as "the carnal knowledge of a female, forcibly and against her will." That definition, unchanged since 1927, was outdated and narrow. It only included forcible male penile penetration of a female vagina. The new definition is: "The penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim."[51]

For the first time ever, the new definition includes any gender of victim and perpetrator, not just women being raped by men. It also recognizes that rape with an object can be as traumatic as penile-vaginal rape. This definition also includes instances in which the victim is unable to give consent because of temporary or permanent mental or physical incapacity. Furthermore, because many rapes are facilitated by drugs or alcohol, the new definition recognizes that a victim can be incapacitated and thus unable to consent because of ingestion of drugs or alcohol. Similarly, a victim may be legally incapable of consent because of age. The ability of the victim to give consent must be determined in accordance with individual state statutes. Physical resistance is not required on the part of the victim to demonstrate lack of consent.

The UCR is the national "report card" on serious crime. What gets reported through the UCR is how we, collectively, view crime in this county. Police departments submit data on reported crimes and arrests to the UCR SRS. Even though most states have more expansive definitions of rape in their criminal codes, they had to report the smaller number of crimes falling under the more narrow UCR SRS definition. This meant that the statistics that were reported nationally were both inaccurate and undercounted. Because the new definition is more inclusive, reported crimes of rape are likely to increase. This does not mean that rape has increased but simply that it is more accurately reported. In addition, the UCR program will collect data based on the historical definition of rape, enabling law enforcement to track consistent trend data until the statistical differences between the old and new definitions are more fully understood. The new UCR SRS definition of rape does not change federal or state criminal codes or affect charging and prosecution on the federal, state, or local level; it simply means that rape will be more accurately reported nationwide. The Office of Violence Against Women (OVW) worked closely with White House Advisor on Violence Against Women, Lynn Rosenthal, and the Office of the Vice President, as well as multiple Department of Justice divisions, to modernize the definition.[52]

He or She?

Although it is acknowledged that men are also victims of sexual assault, female pronouns will primarily be used for the purpose of this book because women are more often victims. When different needs of male and female victims are addressed, the appropriate pronouns will be used.

Victim, Survivor, or Patient?

Because this book, for the most part, focuses on the period directly after the rape, we have chosen to use the terms ***patient*** or ***victim of rape. Victims*** are those who present acutely after experiencing an assault; ***survivors*** are those who are not in the acute stages and have survived the assault; and ***thrivers*** are those who in the aftermath of an assault are thriving and functioning well despite the trauma of sexual violence. We do recognize that an important goal of recovery is to help the victim move from feeling like a victim of the rape to becoming a survivor and then, ultimately, a thriver. This process may happen very quickly for some individuals and very slowly for others. It may take days, weeks, months, or even years, but it rarely occurs during the first few hours.

However, we also recognize that first and foremost whenever the nurse, SANE, or SAFE provides care they are providing medical care to their patient. We must remember that it is always the care of the patient that is the goal of the SANE as a medical professional.

SANE or SAFE?

Because today the majority of medical practitioners with advanced training in sexual assault management and evidence collection are nurses, we will primarily use the term

SANE. When we refer to the SAFE, we are also referring to a non-nurse, usually a physician or physician assistant, who has also had advanced training in sexual assault management and evidence collection.

Sexual Assault Response Team

When we refer to *SART*, we are referring to formal as well as informal collaborative "teams." They may respond as a unit, or they may work independently, but they work cooperatively in meeting the needs of victims of rape. It is important to remember that there are many options for SART operation. These are discussed in detail in Chapters 12 and 13.

Role of Nursing

Nursing is and will continue to be a major player in the trauma field. The antirape movement helped catapult nursing to the status of a major provider of health care services to victims of abuse. The JCAHO has suggested that, in the future, forensic nurses be staffed in EDs. The requirement to educate nurses in the fundamentals of forensic science was firmly established in 1997 when the JCAHO published its revised standards for patient assessment. The guidelines required that all staff members be educated to identify victims of abuse, violence, and neglect and be able to collect and safeguard physical evidence associated with a known or potential criminal act.[53] It opened doors for nurses to develop interdependent relationships with other health care providers, initiate courses and programs of research in victimology and traumatology, influence legislation and health care policy, provide expert testimony in criminal and civil legal cases, and define the new specialty of forensic nursing. However, sexual violence still affects the lives of hundreds of thousands of women and children each year. Health care professionals could be even more influential in case finding and treatment of trauma as well as in designing research and outcome protocols for the interventions aimed at preventing abuse and decreasing the number of victims. Such interventions must target the perpetrators or potential perpetrators of sexual assault. The foothold of skilled investigator nurses in EDs and their preparation for collecting and presenting evidence as well as testifying in judicial proceedings is a major contribution. The advance of the nurse to become a certified Adult/Adolescent (SANE-A) or Pediatric (SANE-P) nurse examiner has firmly established a forensic nursing role.

Rape trauma is now on the radar screen for all disciplines. The pioneers have provided the foundation for the next generation, and they need to keep motivating young clinicians and scholars to forge ahead. The Sexual Assault Nurse Examiner program, whereby specially trained nurses (rather than hospital ED physicians) provide comprehensive psychological, medical, and forensic services for sexual assault victims, is the major model of treatment in the United States, as well as in a number of other countries. Hopefully one day specially trained forensic examiners will be available in every hospital to provide care whenever a victim of rape asks for help.

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