

2. Victim-Centered Care

Recommendations at a glance for health care providers and other responders to facilitate victim-centered care during the exam process:

- Give sexual assault patients priority as emergency cases.
- Provide the necessary means to ensure patient privacy.
- Adapt the exam process as needed to address the unique needs and circumstances of each patient.
- Be aware of issues commonly faced by victims from specific populations.
- Understand the importance of victim services within the exam process. Involve victim service providers/advocates in the exam process (including the actual exam) to offer support, crisis intervention, and advocacy to victims, their families, and friends.
- Respect patients' requests to have a relative, friend, or other personal support person present during the exam, unless considered harmful by responders.
- Accommodate victims' requests for responders of a specific gender as much as possible.
- Prior to starting the exam and conducting each procedure, describe what is entailed and its purpose to patients. After providing this information, seek patients' permission to proceed and respect their right to decline any part of the exam. However, follow exam facility and jurisdictional policy regarding minors and adults who are incompetent to give consent.
- Assess and respect patients' priorities.
- Integrate exam procedures where possible.
- Address patients' safety concerns during the exam. Sexual assault patients have legitimate reasons to fear further assaults from their attackers. Local law enforcement may be able to assist facilities in addressing patients' safety needs.
- Provide information that is easy for patients to understand and that can be reviewed at their convenience.
- After the exam is finished, provide patients with the opportunity to wash, brush their teeth, change clothes, get food or drink, and make needed phone calls. Assist them in arranging transportation home or to another location if needed.

It is critical to respond to individuals disclosing sexual assault in a timely, appropriate, sensitive, and respectful way.³⁶ Every action taken by responders during the exam process should be useful in facilitating patients' care and healing and/or the investigation (if the case was reported).

Give patients priority as emergency cases. Recognize that every minute patients spend waiting to be examined may cause loss of evidence and undue trauma. Individuals disclosing a recent sexual assault should be quickly transported to the exam site, promptly evaluated, treated for serious injuries, and undergo a medical forensic exam. (For more discussion on this topic, see *C.2. Triage and Intake*.)

Provide the necessary means to ensure patients' privacy. Exercise discretion to avoid the embarrassment for individuals of being identified in a public setting as a sexual assault victim. Some health care facilities use code plans to avoid inappropriate references by staff to sexual assault cases. Also, do not leave sexual assault patients in the main waiting area at the exam site. Instead, give them as much privacy as possible (e.g., a private treatment room and waiting area) and be cognizant of their sense of safety (e.g., do not examine suspects in same location at the same time). Make sure that the first responding health care providers attend to patients' initial medical needs and arrange for an on-call advocate to offer onsite support, crisis intervention, and advocacy. It may be useful to give patients the option of speaking with an advocate via a 24-hour crisis hotline (if one exists) until an on-call advocate arrives. Health care providers should provide patients with access to a phone to contact family members and friends as desired, and should

Sexual Assault Victims, 2000.

³⁶ The chapter was partially built on information from the *North Carolina Protocol for Assisting*

promptly contact law enforcement, if not already involved, if patients want to report the assault (or according to jurisdictional policy).

Health care providers should explain to patients the scope of confidentiality during the exam process and during communication with advocates. (For information on this topic, see *A.4. Confidentiality*.)

Recognize that the medical forensic exam is an interactive process that must be adapted to the needs and circumstances of each patient. Patients' experiences during the crime and the exam process, as well as their postassault needs, may be affected by multiple factors, such as:

- Age;
- Gender and/or gender identity;
- Physical health history and current status;
- Mental health history and current status;
- Disability;
- Language needs and communication modalities;
- Ethnic and cultural beliefs and practices;
- Religious and spiritual beliefs and practices;
- Economic status, including homelessness;
- Immigration and refugee status;
- Sexual orientation;
- Military status;
- History of previous victimization;
- Past experience with the criminal justice system;
- Whether the assault involved drugs and/or alcohol;
- Prior relationship with the suspect, if any;
- Whether they were assaulted by an assailant who was in an authority position over them;
- Whether the assault was part of a broader continuum of violence and/or oppression (e.g., intimate partner and family violence, gang violence, hate crimes, war crimes, and trafficking);
- Where the assault occurred;
- Whether they sustained physical injuries from the assault and the severity of the injuries;
- Whether they were engaged in illegal activities at the time of the assault (e.g., voluntary use of illegal drugs or underage drinking) or have outstanding criminal charges;
- Whether they were involved in activities prior to the assault that traditionally generate victim blaming or self-blaming (e.g., drinking alcohol prior to the assault or agreeing to go to the assailant's home);
- Whether birth control was used during the assault (e.g., victims may already have been on a form of birth control or the assailant may have used a condom);
- Capacity to cope with trauma and the level of support available from families and friends;
- The importance they place on the needs of their extended families in the aftermath of the assault;
- Whether they have dependents who require care during the exam, were traumatized by the assault, or who may be affected by decisions patients make during the exam process;
- Community/cultural attitudes about sexual assault, its victims, and offenders; and
- Frequency of sexual assault and other violence in the community and historical responsiveness of the local justice system, health care systems, and community service agencies.

Clearly, the level of trauma experienced by patients can also influence their initial reactions to an assault and to postassault needs. While some may suffer physical injuries, contract an STI, or become pregnant as a result of an assault, many others do not. The experience of psychological trauma will be unique to each patient and may be more difficult to recognize than physical trauma. People have their own method of coping with sudden stress. When severely traumatized, they can appear to be calm, indifferent, submissive, jocular, angry, emotionally distraught, or even uncooperative or hostile towards those who are trying to help.³⁷

Examination, 1998, pp. 1–4.

³⁷ Paragraph adapted from Iowa's *Sexual Assault: A Protocol for Forensic and Medical*

In addition, patients' fears and concerns can affect their initial reactions to the assault, their postassault needs, and decisions before, during, and after the exam process. For example, female patients may be worried about getting pregnant. If they are already pregnant or have just given birth, they may be concerned about how the assault will affect their children. Patients may be concerned about being infected with HIV or another STI. They may not want anyone to know about the assault, or may be afraid that family members and friends will reject or blame them. They may fear bringing shame to their families or be concerned that family members will seek revenge against the assailant. They may fear perceived consequences of reporting to law enforcement. They may be concerned how their cultural background could affect the way they are treated by responders. They may wonder if the assailant will harm or harass them or their loved ones if they tell anyone about the assault. They may worry about losing their home, children, job, and other sources of income as a result of disclosure, particularly if an intimate partner assaulted them.³⁸ They may be concerned about costs related to the exam and subsequent care of injuries.³⁹

It is important to avoid making assumptions about patients, offenders, and the assault itself. Forms used during the exam process and discussions with patients should be framed in a way that does not assume they are of a specific background. Always ask questions and actively look and listen to understand patients' circumstances and tailor the exam process to address their needs and concerns. Whatever the response, it should be respectful to patients and adhere to jurisdictional policies.

Recognize that patients control the extent of personal information they share. While it is useful for responders to get a full picture of patients' circumstances, it is up to patients to decide whether and to what extent to share personal information. During the exam process, responders may ask patients to divulge some data, such as age or whether they think the assault was drug-facilitated. Some information, such as language needs, may be obvious. There is no reason for responders to question patients about certain data, such as sexual orientation and gender identity, religious or spiritual beliefs, or previous victimization.

Be aware of issues commonly faced by patients from specific populations. It is important to realize that for some patients, certain personal characteristics (e.g., culture, language skills/mode of communication, disability, gender, and age) may strongly influence their experiences in the immediate aftermath of a sexual assault and during the exam process. Education for responders on issues facing a specific population may serve to enhance care, services, and interventions provided during the exam process. Responders should identify different populations that exist in their jurisdiction and determine what information they should have to help them serve patients from these populations. Building understanding of the perspectives of a specific population may help increase the likelihood that the actions and demeanor of responders will mitigate victim trauma. However, do not assume that patients will hold certain beliefs or have certain needs and concerns merely because they belong to a specific population. And, as pointed out earlier, recognize that patients' experiences are affected by a plethora of other personal and external factors.

Develop policies and plans. Involved agencies and SARTs should develop policies and plans to meet the needs of specific patient populations (e.g., to obtain certified interpreters for Deaf and hard-of-hearing patients). When creating these plans, consider what barriers exist for patients from different populations to receiving a high-quality exam and what can be done to remove these barriers. Also, consider what equipment and supplies might be needed to assist persons from specific populations (e.g., a hydraulic lift exam table may be useful with victims who have a physical disability). Relevant responders need to have access to and know how to use such equipment or supplies.

Partner with those who serve specific populations. Involved responders should seek expertise from and collaborate with organizations and leaders that serve specific populations. Not only may they be willing to provide information and training on working with victims from the population they serve, but they also may be a resource before, during, and after the exam process. If responders may be involved in the immediate response to victims, they should be trained on the dynamics of sexual victimization and procedures for getting help for victims and work with the multidisciplinary response team to clarify their roles and procedures for response.

³⁸ Minors may fear being removed from their homes if suspects live with them. Persons living in residential settings, such as group homes or nursing facilities, may fear being removed from their homes if they report an assault that occurred in that setting.

³⁹ Paragraph partially adapted from the *Ohio Protocol for Sexual Assault Forensic and Medical Examination*, 2002, p. 2.

Explore the needs of specific populations. To gain a basic understanding of potential issues and concerns facing different groups of sexual assault victims, this section explores several specific populations.⁴⁰ Clearly, this exploration is not inclusive of all populations of victims, but a more comprehensive discussion on this topic is beyond the scope of this document.

Victims from various cultural groups and those with limited English proficiency

- Understand that culture can influence beliefs about sexual assault, its victims, and offenders. It can affect health care beliefs and practices related to the assault and medical treatment outcomes. It can also influence beliefs and practices related to emotional healing from an assault. In addition, it can impact beliefs and practices regarding justice in the aftermath of a sexual assault, the response of the criminal justice system, and the willingness of victims to be involved in the system.⁴¹
- Understand that some victims may be apprehensive about interacting with responders from ethnic and racial backgrounds different from their own. They may fear or distrust responders or assume they will be met with insensitive comments or unfair treatment. They may benefit from responders of the same background or at least who understand their culture.
- Be aware that cultural beliefs may preclude a member of the opposite sex from being present when victims disclose. Also, it may be uncomfortable for victims from some cultures to speak about the assault with members of the opposite sex.
- Understand that victims may not report or discuss the assault because the stigma associated with it is so overwhelmingly negative. In some cultures, for example, the loss of virginity prior to marriage is devastating and may render victims unacceptable for an honorable marriage. Even discussing an assault or sexual terms may be linked with intense embarrassment and shame in some cultures.
- Recognize that some cultures (e.g., Indian tribes) may have their own laws and regulations to address sexual assault, in addition to or in place of applicable jurisdictional laws. Responders should be familiar with procedures for coordinating services and interventions for victims from these communities.
- Be aware that beliefs about women, men, sexuality, sexual orientation, race, ethnicity, and religion may vary greatly among victims of different cultural backgrounds. Also, understand that what helps one victim deal with a traumatic situation like sexual assault may not be the same for another victim.
- Help victims obtain culturally specific assistance and/or provide referrals where they exist.⁴²
- Be patient and understanding toward victims' language skills and barriers, which may worsen with crisis.
- Make every attempt to provide interpretation services and translated materials for victims who do not speak English. Use certified interpreters when possible and not victims' families or friends.⁴³ Take the victim's country of origin, acculturation level, and dialect into account when responding or arranging interpretation.⁴⁴ Remember to speak directly to victims when interpreters are used.
- Train interpreters about issues related to sexual assault, confidentiality, and cultural concerns whenever they are needed to facilitate communication in these cases.

Victims with disabilities

- Understand that victims with disabilities may have physical, sensory, or mental disabilities, or a combination of disabilities. (For a more detailed explanation, see "Use of Terms" in the *Introduction*.)

⁴⁰ This section was adapted partially from Connecticut's *Technical Guidelines for Health Care Response to Victims of Sexual Assault*, 1998, pp. 12–14, and from Iowa's *Sexual Assault: A Protocol for Forensic and Medical Examination*, 1998, pp. 1–4.

⁴¹ Bullet drawn from A. Blue, *The Provision of Culturally Competent Health Care*, from the Web site of the Medical University of South Carolina College of Medicine (http://www.musc.edu/fm_ruralclerkship/culture.html).

⁴² For example, to raise their level of hope and comfort during the exam, some patients may benefit from talking about culturally specific models of healing (where they exist) and their application to recovery from sexual assault. To facilitate such a discussion, they may wish to speak with a religious or spiritual healer from their culture.

⁴³ Consult with jurisdictional statutes and policies regarding the use of community-based advocates as interpreters—such a dual role may jeopardize their confidentiality with victims.

⁴⁴ For example, a Cuban interpreter may encounter language and trust obstacles when trying to communicate with a victim from rural Mexico. (L. Zarate, Suggestions for Upgrading the Cultural Competency Skills of SARTs, Arte Sana Web site, www.Arte-sana.com, 2003.)

Make every effort to recognize issues that arise for victims with disabilities (both in general and in relation to their specific disability) and provide reasonable accommodations when working with them.

- Be aware that the risk of criminal victimization (including sexual assault) for people with disabilities appears to be much higher than for people without disabilities. People with disabilities are often victimized repeatedly by the same offender.⁴⁵ Caretakers, family members, or friends may be responsible for the sexual assault.
- Respect victims' wishes to have or not have caretakers, family members, or friends present during the exam. Although these individuals may be accustomed to speaking on behalf of persons with disabilities, it is critical that they not influence the statements of victims during the exam process. If aid is required (e.g., from a language interpreter or mental health professional), ideally those providing assistance should not be associated with victims.
- Follow exam facility and jurisdictional policy for assessing vulnerable adults' ability to consent to the exam and evidence collection and involving protective services. Again, note guardians could be offenders. (For a more detailed discussion on seeking informed consent of patients, including consent by victims from specific populations, see A.3. *Informed Consent*.)
- Speak directly to victims with disabilities, even when interpreters, intermediaries, or guardians are present.
- Assess a victim's level of ability and need for assistance during the exam process. Explain exam procedures to victims and ask what help they require, if any (e.g., people with physical disabilities may need help to get on and off the exam table or to assume positions necessary for the exam). Do not assume they will need special aid. Also, ask for permission before proceeding to help them (or touch them, handle a mobility or communication device, or touch a service animal⁴⁶).
- Note that not all individuals who are Deaf or hard-of-hearing understand sign language or can read lips. Not all blind persons can read Braille. Communication equipment that may be beneficial to victims with sensory disabilities include TTY machines, word boards, speech synthesizers, anatomically correct dolls, materials in alternative formats, and access to interpreter services. Responders should familiarize themselves with the basics of communicating with an individual using such devices.⁴⁷ Be aware that victims with sensory disabilities may prefer communicating through an intermediary who is familiar with their patterns of speech.
- Recognize that individuals may have some degree of cognitive disability: mental retardation, mental illness, developmental disabilities, traumatic brain injury, neurodegenerative conditions such as Alzheimer's disease, or stroke. Note that not all developmental disabilities affect cognitive ability (e.g., cerebral palsy may result in physical rather than mental impairment). Be aware that victims with cognitive disabilities may be easily distracted and have difficulty focusing. To reduce distractions, conduct the exam in an area that is void of bright lights and loud noises. Speak to victims in a clear and calm voice and ask very specific and concrete questions. Be exact when explaining what will happen during the exam process and why. It may also be helpful if examiners and others present in the exam room refrain from wearing uniforms with ornamental designs and jewelry.
- Keep in mind that victims with disabilities may be reluctant to report the crime or consent to the exam for fear of losing their independence. For example, they may have to enter a long-term care facility if their caretakers assaulted them or may need extended hospitalization to treat and allow injuries to heal.
- Recognize that it may be the first time victims with disabilities have an internal exam. The procedure should be explained in detail in language they can understand.⁴⁸ They may have limited knowledge of reproductive health issues and not be able to describe what happened to them. They may not know how they feel about the incident or even identify that a crime was committed against them.
- Some victims with disabilities may want to talk about their perceptions of the role their disability might have played in making them vulnerable to an assault. Listen to their concerns and what the experience

⁴⁵ The above two sentences are drawn from the Office for Victims of Crime, *First Response to Victims of Crime Who Have a Disability*, 2002, p. 1.

⁴⁶ Examples of service animals include guide dogs and hearing-assistance dogs, and therapy dogs.

⁴⁷ Note that individuals may have their own assistive devices, but words needed to communicate may have to be programmed.

⁴⁸ Drawn from A. Conrad, *SANE/SAFE Organizing Manual*, 1998, p. 7, developed for the New York State Coalition Against Sexual Assault.

was like for them.⁴⁹ Assure them that it was not their fault they were sexually assaulted. If needed, encourage discussion in a counseling/advocacy setting on this issue as well as on what might help them feel safer in the future.,

- Recognize that the exam may take longer to perform with victims with disabilities. Avoid rushing through the exam—such action not only may distress victims, it can lead to missed evidence and information.

□ Male victims⁵⁰

- Help male victims understand that male sexual assault is not uncommon and that the assault was not their fault. Many male victims focus on the sexual aspect of the assault and overlook other elements such as coercion, power differences, and emotional abuse. Broadening their understanding of sexual assault may help reduce their self-blame.
- Because some male victims may fear public disclosure of the assault and the stigma associated with male sexual victimization, emphasis may need to be placed on the scope of confidentiality of patient information during the exam process.
- Offer male victims assistance in considering how friends and family members will react to the fact that they were sexually assaulted (e.g., by a male offender or a female offender).
- Male victims may be less likely than females to seek and receive support from family members and friends, as well as from advocacy and counseling services. Their ability to seek support may vary according to the level of stigmatization they feel, the circumstances of the assault, the sensitivity of care they initially receive, and the appropriateness of referrals provided.
- Encourage advocacy programs and the mental health community to build their capacity to serve male sexual assault victims and increase their accessibility to this population. Requests by male victims to have an advocate of a particular gender should be respected and honored if possible.⁵¹

□ Adolescent victims⁵²

- Adolescents may be brought to the exam site by their parents or guardians. The presence of parents or guardians creates an additional challenge for those involved in the exam process because they are often traumatized by their child's victimization.
- Understand that parents or guardians may blame victims for the assault if the victim disobeyed them or engaged in behaviors perceived as increasing risk for victimization.
- Health care providers must assess the physical development of adolescent victims and take their age into consideration when determining appropriate methods of examination and evidence collection.⁵³ Involved professionals should be well versed in jurisdictional policies related to response to minor victims.
- Be aware of jurisdictional laws governing minors' ability to consent to forensic exams and medical treatment. Follow exam facility and jurisdictional policy in obtaining appropriate consent. (For a more detailed discussion on seeking informed consent of patients, including consent by victims from specific populations, see A.3. *Informed Consent*.)
- Recognize that the sexual assault medical forensic exam may be the first time an adolescent female victim has an internal exam. There may be a need to go into detail when explaining what to expect.⁵⁴
- Adolescence is often a time of experimentation. Reassure these victims that regardless of their behavior (e.g., using alcohol and drugs, engaging in illegal activities, or hitchhiking), no one has the right to sexually assault them, and they are not to blame for the assault.

⁴⁹ Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, pp. 82–85.

⁵⁰ Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 79.

⁵¹ A national resource for male patients is Male Survivor: The National Organization Against Male Sexual Victimization. Contact information: PMB 103, 5505 Connecticut Avenue, NW, Washington, DC 20015–2601, 800–738–4181, www.malesurvivor.org.

⁵² Adapted partially from the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2002, p. 11.

⁵³ For example, the size of the speculum used with adolescent female victims and exam positions of victims may vary.

⁵⁴ Drawn from A. Conrad, *SANE/SAFE Organizing Manual*, 1998, p. 7, developed for the New York State Coalition Against Sexual Assault.

- Ideally, attending health care providers should gather information from adolescents without parents or guardians in the room, subject to victims' consent. The concern is that parents or guardians may influence or be perceived as influencing victims' statements.
- Inform victims, particularly those who do not involve parents or guardians in the exam process, of facility billing practices (e.g., that their parents may get a bill or statement of services provided).⁵⁵

~Older victims

- Keep in mind that the emotional impact of the assault may not be felt by older victims until after the exam when they are alone and become aware of their physical vulnerability, reduced resilience, and mortality.⁵⁶ Fear, anger, and depression can be especially severe in older victims who are isolated, have little support, and live on a meager income.⁵⁷
- Be aware that caretakers may sexually assault their older dependents. Offenders may bring victims to the exam site, and jurisdictional and facility policies should be in place to provide guidance on how staff should screen for and handle situations that are threatening to patients or facility personnel.
- Note that older victims are generally more physically fragile than younger victims and thus may be at risk for tissue or skeletal damage and exacerbation of existing illnesses and vulnerabilities.⁵⁸
- Hearing impairment and other physical conditions attendant to advancing age, coupled with the initial reaction to the assault, may render older victims unable to make their needs known, which could result in prolonged or inappropriate treatment.⁵⁹ Do not mistake this confusion and distress for senility.
- Health care personnel should follow facility policy for assessing a vulnerable adult's ability to consent to the exam and evidence collection, as well as involving adult protective services.
- Some older victims may want to talk about their perceptions of the role their age and physical condition might have played in making them vulnerable to an assault. Listen to their concerns and what the experience was like for them.⁶⁰ Assure them that it was not their fault they were sexually assaulted. If needed, encourage further discussion on this issue in a counseling/advocacy setting.
- Older victims may be reluctant to report the crime or seek treatment because they fear the loss of independence. Although sometimes relatives wish to place older victims in an assisted living situation after an assault occurs, such an action is not always necessary or useful to a victim's recovery. When a change in living environment is truly needed, assist victims and their relatives in making plans that maximize independence yet enhance safety.⁶¹
- Encourage use of followup medical, legal, and nonlegal assistance. Older victims may be reluctant to seek these services or proceed with prosecution. For example, they may rely on family members for transportation and may not want to burden them by asking to be taken to postexam followup appointments.

Recognize the importance of victim services within the exam process. In many jurisdictions, sexual assault victim advocacy programs and other victim service programs offer a range of services before, during, and after the exam process (see below for a description of typical services). Ideally, advocates should begin interacting with victims prior to the exam, as soon after disclosure of the assault as possible. Victims who come to exam sites in the immediate aftermath of an assault are typically coping with trauma, anticipating the exam, and considering the implications of reporting. Most responders that victims come in contact with are focused on objective tasks. Law enforcement officials gather information and collect crime scene evidence to

⁵⁵ Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 98.

⁵⁶ Drawn from Iowa's *Sexual Assault: A Protocol for Forensic and Medical Examination*, 1998, p. 3.

⁵⁷ Ibid.

⁵⁸ Older women are at an increased risk for vaginal tears and injury when they have been vaginally assaulted. Decreased hormonal levels following menopause result in a reduction in vaginal lubrication and cause the vaginal wall to become thinner and more friable. Because of these physiological changes, a Pedersen speculum, which is longer and thinner than the Graves speculum, should be used during the pelvic exam for evidence collection. Special care should also be taken to assess for intravaginal injury. In some older women, examiners will need to simply insert the swabs and avoid the trauma of inserting a speculum. If there are external tears in the introitus, internal injuries must also be considered. The recovery process for older victims also tends to be longer than for younger victims. (Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 86–87.)

⁵⁹ Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 87.

⁶⁰ Drawn from L. Ledray, *SANE Development and Operation Guide*, 1998, p. 82–85.

⁶¹ Ibid.

facilitate the investigation. Health care personnel assess medical needs, offer treatment, and collect evidence from victims. Victims must make many related decisions that may seem overwhelming. Advocates⁶² can offer a tangible and personal connection to a long-term source of support and advocacy. Communitybased advocates, in particular, have the sole purpose of supporting victims' needs and wishes. Typically, these advocates are able to talk with victims with some degree of confidentiality, depending on jurisdictional statutes, while statements victims make to examiners become part of the medical forensic report.⁶³ When community-based advocates support victims, examiners can more easily maintain an objective stance.⁶⁴

Be aware of the extent of services. Services offered by advocates during the exam process may include: ⁶⁵

- Accompanying the victims through each component (advocates may accompany victims from the initial contact and the actual exam through to discharge and followup appointments);
- Assisting in coordination of victim transportation to and from the exam site;
- Providing victims with crisis intervention⁶⁶ and support to help cope with the trauma of the assault⁶⁷ and begin the healing process;
- Actively listening to victims to assist in sorting through and identifying their feelings;
- Letting victims know their reactions to the assault are normal and dispelling misconceptions regarding sexual assault;
- Advocating for victims' self-articulated needs to be identified and their choices to be respected, as well as advocating for appropriate and coordinated response by all involved professionals;
- Supporting victims in voicing their concerns to relevant responders;
- Responding in a sensitive and appropriate manner to victims from different backgrounds and circumstances and advocating for the elimination of barriers to communication;
- Serving as an information resource for victims (e.g., to answer questions, explain the importance of prompt law enforcement involvement if the decision is made to report, explain the value of medical and evidence collection procedures, explain legal aspects of the exam, help them understand their options in regard to treatment for STIs, HIV, and pregnancy, and provide referrals);
- Providing replacement clothing when clothing is retained for evidence, as well as toiletries;
- Aiding victims in identifying individuals who could support them as they heal (e.g., family members, friends, counselors, employers, religious or spiritual counselors/advisors, and/or teachers);
- Helping victims' families and friends cope with their reactions to the assault, providing information, and increasing their understanding of the type of support victims may need from them; and
- Assisting victims in planning for their safety and well-being.

Postexam, advocates can continue to advocate for victims' rights and wishes, offer victims ongoing support, counseling,⁶⁸ information, and referrals for community services, assist with applications for victim compensation programs, and encourage victims to obtain followup testing and treatment and take medications as directed. They can also accompany victims to followup appointments, including those for related medical care and criminal and civil justice related interviews and proceedings. They can work closely

⁶² To prepare them to competently provide sexual assault victim services, community-based advocates are typically trained according to the policies of the sexual assault advocacy agency where they are employed/volunteer and receive supervision related to their interactions with victims. In addition, many jurisdictions have specific requirements that community-based advocates must meet in order to fit within jurisdictional confidentiality or privilege laws. Advocates should meet these requirements. System-based advocates may be required to have specific credentials based on system and jurisdictional policies and laws.

⁶³ K. Littel, *SANE Programs: Improving the Community Response to Sexual Assault Victims*, 2001, p. 6.

⁶⁴ *Ibid.*

⁶⁵ This bulleted section was drawn partially from Iowa's *Sexual Assault: A Protocol for Forensic and Medical Examination*, 1998, p. 7, and the 1989 *Volunteer Manual of Virginians Aligned Against Sexual Assault (VAASA)*.

⁶⁶ Crisis intervention counseling is short term in nature, aimed at returning individuals to their precrisis state through the development of adaptive coping responses. Broadly, it entails establishing a relationship with the individual in crisis, gathering information about what is occurring, clarifying the problem, helping the individual identify options and resources and decide what needs to happen next, and clarifying actions that will be taken. (Adapted from the 1991 Women Helping Women *Volunteer Training Manual*, Cincinnati, Ohio.) Note: Crisis intervention is not intended to address longer term counseling and advocacy needs.

⁶⁷ See A. Burgess and L. Holmstrom, Rape Trauma Syndrome, *American Journal of Psychiatry*, 131, for a summary of the psychological, somatic, and behavioral impact of sexual assault on victims.

⁶⁸ Many advocacy agencies offer ongoing peer counseling to victims. Some also provide professional mental health counseling, but many refer victims to community or private agencies.

with involved responders to ensure that postexam services and interventions are coordinated in a complementary manner and are appropriately based on victims' needs and wishes.

Contact the victim service/advocacy program immediately. Utilize a system in which exam facility personnel, upon initial contact with a sexual assault patient, call the victim service/advocacy program and ask for an advocate to be sent to the exam site (unless an advocate has already been called).⁶⁹ Prior to introducing the advocate to a patient, exam facility personnel should explain briefly to the patient the victim services offered and ask whether the victim wishes speak with the onsite advocate. Note that some jurisdictions require that patients be asked whether they want to talk with an advocate before the advocate is contacted.⁷⁰ Ideally, a patient should be assisted by the same advocate during the entire exam process.⁷¹

Accommodate patients' requests to have a relative, friend, or other personal support person (e.g., religious and spiritual counselor/advisor) present during the exam.⁷² An exception would be if responders consider the request to be potentially harmful to the patient or the exam process.⁷³ Patients' requests not to have certain individuals present in the room should also be respected (e.g., adolescents may not want their parents present). Examiners should get explicit consent from patients to go forward with the exam with another person present. When others are present, appropriately drape patients and position additional persons. (It is also important to inform patients of confidentiality considerations regarding the presence of support persons during the medical forensic history. For a discussion of this topic, see C.4. *The Medical Forensic History.*)

Strive to limit the number of persons (beyond the patient, examiner, advocate, personal support person, and any necessary interpreters) in the exam room during the exam. The primary reason is to protect patients' privacy, but also because exam rooms often cannot accommodate more than a few individuals. Law enforcement representatives should not be present during the exam. When additional health care personnel are needed for consultation (e.g., a surgeon), patients' permission should be sought prior to their admittance. In cases in which examiners are supervising an examiner-in-training/licensed health care student, patients' consent should be obtained prior to the student's admittance to examine patients or observe the exam. It is inappropriate to ask patients to allow a group or nonlicensed medical students to view the exam.

Accommodate patients' requests for responders of a specific gender throughout the exam as much as possible. For a variety of reasons, some patients may prefer to work with a male or female law enforcement official, advocate, and/or examiner.

Prior to starting the exam and conducting each procedure, explain to patients what is entailed and its purpose. In addition, it is important to explain the exam process and the purpose of the exam more generally (e.g., how the evidence may be used by the criminal justice system). Be sure that communication needs of patients are met and that information is conveyed in a manner they will understand. A clear explanation is particularly important for individuals who may not previously have had a pelvic exam or medical care, or who have difficulty understanding what has happened and why they are being asked to undergo a medical forensic exam. Remember that some exam procedures may be uncomfortable and painful to patients, considering the nature of the trauma they have experienced. By taking the time to explain procedures and their options, patients may be able to better relax, feel more in control of what's occurring, and make decisions that meet their needs. After providing the needed information, seek patients' permission

⁶⁹ Use community-based sexual assault victim advocates where possible. If not available, victim service providers based in the exam facility, criminal justice system, social services, or other agencies may be able to provide some advocacy services if educated to provide those services. Patients should be aware that government-based service providers typically cannot offer confidential communication.

⁷⁰ In very small communities, patients may know some or all advocates. Some patients may feel comfortable being supported by an advocate known to them while others may not. Patients concerned about anonymity should be provided with as many options as possible. For example, ask if they would like to speak with an on-call advocate on the phone prior to making their decision about whether they want an advocate present during the exam. Another option may be for the local advocacy program to partner with an advocacy program in a neighboring jurisdiction, so they can provide one another with backup to handle situations such as this one.

⁷¹ Continuity of advocates can be challenging when response by other professionals is delayed, the exam process is lengthy, or travel to the exam site is considerable. Volunteers may or may not be able to continue providing services after the end of their on-call shift.

⁷² Paragraph partially drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 15.

⁷³ For example, in cases involving adolescents or vulnerable adults, caretakers should not be allowed in the exam room if they are suspected of committing the assault or of being otherwise abusive to the patient.

to proceed with exam procedures. (For a more detailed discussion on seeking informed consent of patients, see *A.3. Informed Consent*.)

Respect patients' decisions. Although medical care and evidence collection may be encouraged during the exam process, responders should provide patients with information about all of their options and assess and respect their priorities.

Integrate medical and forensic exam procedures where possible. Medical care and evidence collection procedures should be integrated to maximize efficiency and minimize trauma to patients. For example, draw blood needed for medical and evidentiary purposes at the same time. Also, coordinate information gathering by health care and legal personnel to minimize the need for patients to repeat their statements. (For more information on coordination in information gathering, see *C.4. The Medical Forensic History*.)

Address patients' safety during the exam process. When patients arrive at the exam site, health care providers should assess related safety concerns. For example, a caretaker, partner, or family member who is suspected of committing the assault may have accompanied the patient to the facility. Follow facility policy on response to this and other types of threatening situations. Also, exam sites should have plans in place to protect patients from exposure to potentially infectious materials during the examination. (See *B.1. Sexual Assault Forensic Examiners*.) Prior to discharge, assist victims in planning for their safety and well-being. Planning should take into account needs that may arise in different types of cases. For example, patients who know the assailants may not be concerned only about their ongoing safety but also about the safety of their families and friends. Local law enforcement may be able to assist facilities in addressing patients' safety needs. (See *C.10. Discharge and Followup*.)

Offer patients information that they can review at their convenience.⁷⁴ Information should be tailored to patients' communication skill level/modality and language. Developing material in alternative formats may be useful, such as information that is taped, in Braille, in large print, in various languages, or uses pictures and simple language.⁷⁵ A victim booklet or packet that includes information about the following topics may be helpful:

- The crime itself (e.g., facts about sexual assault and related criminal statutes);
- Normal reactions to sexual assault (stressing that it is never the victim's fault), and signs and symptoms of traumatic response;
- Victims' rights;
- Victim support and advocacy services;
- Mental health counseling options and referrals;
- Resources for the victim's significant others;
- The examination—what happened and how evidence/findings will be used;
- Medical discharge and followup instructions;
- Planning for their safety and well-being;
- Examination payment and reimbursement information;
- Steps and options in the criminal justice process;
- Civil remedies that may be available to sexual assault victims; and
- Procedures for patients to access their medical record or applicable law enforcement reports.

⁷⁴ Many local sexual assault advocacy programs and state coalitions of sexual assault programs offer publications that speak to victims' concerns in the aftermath of an assault. However, any involved agency, SART, or coordinating council could develop such literature.

⁷⁵ For example, one sexual assault advocacy program offers a booklet "for those who read best with few words" designed for people with developmental disabilities who have been sexually assaulted. For more information on this publication, contact the Los Angeles Commission on Assaults Against Women by phone (213-955-9090) or e-mail info@lacaaw.org.

Address physical comfort needs of patients prior to the investigative interview and discharge. For example, provide them with the opportunity to wash in privacy (offering shower facilities if at all possible⁷⁶), brush their teeth, change clothes (clean and ideally new replacement clothing should be available), get food and/or a beverage, and make needed phone calls. They may also require assistance in coordinating transportation from the exam site to their home or another location.

⁷⁶ It would be useful for the exam room to have an attached bathroom with a shower