

## Use of Terms

Many terms are explained throughout the protocol to clarify the context in which they are used.<sup>17</sup> However, it may be helpful to discuss briefly the following terms in advance (in alphabetical order):

Adolescent: Adolescents are distinguished in the protocol from prepubertal children who require a pediatric exam. This document focuses on the examination of females who have experienced the onset of menarche and males who have reached puberty. However, it is important to recognize that age also plays a role in whether a person is treated as a child or adolescent. For example, some adolescent girls may not start menstruating until their later teen years. While the physical developmental level of these patients must be taken into account when performing the exam, they should otherwise be treated as adolescents rather than children. Legally, jurisdictions vary in the age at which they consider individuals to be minors, laws on child sexual abuse, mandatory reporting policies for sexual abuse and assault of minors, instances in which minors can consent to treatment and evidence collection without parental/guardian involvement, and the scope of confidentiality that minors are afforded. Involved responders should be well versed in their jurisdictional laws and policies regarding the above issues, screening procedures for determining whether a pediatric exam is needed (particularly in the case of younger adolescents), and local protocols for response to prepubertal victims. Exam sites are to follow the jurisdictional laws regarding parental/guardian consent.

Communitywide sexual assault coordinating councils: These multidisciplinary groups typically work to facilitate a communitywide response to sexual assault that is appropriate, coordinated, and comprehensive. They tend not to be involved in direct response, but rather endeavor to improve overall services, interventions, and prevention efforts. Communitywide coordinating council is a broad term for such a group,

---

<sup>16</sup> For example, evidence that identifies a suspect in a stranger case, such as DNA evidence, is critical to the continuing investigation. In cases in which the victim knows the suspect, evidence that identifies suspects is important if suspects claim they had no sexual contact with victims. In cases in which suspects claim that victims consented to the sexual contact, evidence identifying suspects is less crucial and evidence and documentation related to whether force or coercion was used against victims is often more important.

<sup>17</sup> Keep in mind that these definitions may vary from those used generally or in exam protocols developed by States, Territories, tribes, and local communities.

but possibilities are endless for what a jurisdiction may call such a group. This group may be a subcommittee of an entity that more generally promotes coordinated response to violence in the community.

Coordinated community response: This term refers to immediate and longer term community response to sexual assault that is coordinated among involved responders. The idea is that while each responder provides services and/or interventions according to agency-specific policies, they also work with responders from other agencies and disciplines to ensure that they coordinate responses. The desired result is a collective response to victims and offenders that is appropriate, streamlined, and as comprehensive as possible. Coordinated community response to sexual assault is a concept that developed out of a need to reduce the historically fragmented approach to these cases and the negative impact of fragmentation on victim well-being, offender accountability, and prevention of future assault.

Culture: This term refers to a body of learned beliefs, traditions, and guides for behaving and interpreting behavior that may be shared among members of a particular group. Aspects of a culture include its values, beliefs, customs, communication styles, behaviors, practices, and institutions.<sup>18</sup> In this document, a cultural group refers not only to an ethnic, racial, or religious group, but also to other groups with distinct cultures such as senior citizens, deaf and hard-of-hearing communities, populations with differing sexual orientations, the homeless, military personnel and their dependents, adolescents, prison inmates, and victims of sex trafficking. Individuals often belong to multiple cultural groups.

An immediate response to victims should sensitively and appropriately address their related cultural needs and concerns. It is important that responders acknowledge that victims from certain cultures in a community may be underserved, unserved, or mis-served by the systems responsible for response and should work to improve response to these populations.

Disability: For the purpose of this document, this term includes physical, sensory, or mental disabilities, or a combination of disabilities. Physical disabilities may result from injury (e.g., spinal cord injury and amputation), chronic disease (e.g., multiple sclerosis and rheumatoid arthritis), or congenital impairments (e.g., developmental conditions such as cerebral palsy and muscular dystrophy). Sensory disabilities include hearing or visual impairments. Mental disabilities include developmental conditions (e.g., mental retardation), cognitive impairment (e.g., traumatic brain injury), or mental illness.<sup>19</sup> Note that developmental disabilities have an onset prior to age 22. While there are general issues to consider when working with victims with disabilities, unique issues will arise according to the specific type of disability. The protocol takes these needs into consideration to an extent; however, it is beyond the scope to provide a comprehensive discussion of all victim issues related to specific types of disabilities.

Domestic violence: This term broadly refers to any abusive and coercive behavior used to control an intimate partner (a spouse, boyfriend/girlfriend, or former spouse or boyfriend/girlfriend) and/or a family member.<sup>20</sup> Some examples of tactics employed by abusers to control victims are use of coercion, threats, and intimidation; emotional, physical, and sexual abuse; economic manipulation; use of privilege; use of children and pets; isolation of victims; minimization and denial of violence; and blaming victims for violence.<sup>21</sup> An episode of domestic violence often includes multiple actions, and the violence typically escalates over time. In this protocol, it is important to be aware that sexual assault can be a significant part of domestic violence. Response to sexual assault occurring within a domestic violence context requires understanding of the overlapping dynamics of sexual assault and domestic violence, the complex needs of victims, the potential dangerousness of offenders, the resources available for victims, and adherence to jurisdictional policies on response to domestic violence.

Examiner: The term refers to the health care provider conducting the sexual assault medical forensic examination. The examiner is also referred to in this document as the “sexual assault forensic examiner,” “sexual assault examiner,” and “forensic examiner.” Many communities refer to their sexual assault

---

<sup>18</sup> The first two sentences in this paragraph are 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 ([www.musc.edu/deansclerkship/recultur.html](http://www.musc.edu/deansclerkship/recultur.html)).

<sup>19</sup> This definition was drawn from M. Nosek and C. Howland, *Abuse and Women with Disabilities*, 1998, p. 1.

<sup>20</sup> Drawn from M.A. Dutton, “The Dynamics of Domestic Violence: Understanding the Response from Battered Women,” *Florida Bar Journal* 68(9), January 24, 1994.

<sup>21</sup> Drawn from the Power and Control Wheel developed by the Domestic Violence Intervention Project of Minnesota.

examiners by more specific acronyms based upon the discipline of practitioners and/or specialized education and clinical experiences.

First responder: A first responder is a professional who initially responds to a disclosure of a sexual assault (there is often more than one first responder). These professionals typically must follow agency-specific policies for responding to victims. Those who traditionally have been responsible for immediate response to adult and adolescent sexual assaults include victim advocates, 911 dispatchers, law enforcement representatives, and health care providers. A wide range of other responders also may be involved, such as emergency medical technicians, public safety officials, protective service workers, prosecutors and victim/witness staff, private physicians, staff from local health care facilities, mental health providers, social service workers, corrections and probation staff, religious and spiritual counselors/advisors, school personnel, employers, certified interpreters, and providers from organizations that address needs of specific populations (e.g., persons with disabilities, racial and cultural groups, senior citizens, the poor and homeless, runaways and adolescents in foster care, and domestic violence victims). Families and friends of victims also can play an important role in the initial response, because victims may first disclose the assault to them, ask for their help in seeking professional assistance, and want their ongoing support. However, they are not considered first responders in this document, because they are not responding to these disclosures in an official capacity.

Forensic scientist: The forensic scientist is responsible for analyzing evidence in sexual assault cases. This evidence typically includes DNA and other biological evidence, toxicology samples, latent prints, and trace evidence. Some forensic scientists specialize in the analysis of specific types of evidence. In this protocol, forensic scientists working in jurisdictional crime laboratories are often referred to as “crime lab/laboratory personnel” and “crime lab/laboratory scientists.” Forensic scientists analyzing drug and alcohol samples are also referred to as “toxicologists.”

Health care facility: Emergency health care facilities, such as those in hospitals, traditionally have been the setting for provision of medical forensic services to sexual assault patients. However, nonemergency health care programs, such as hospital-based or community-based examiner programs, community clinics, mobile health clinics, local health departments, military hospitals or clinics, and college and university health centers, may also offer full or partial sexual assault medical forensic services. Sexual assault forensic examiners also may conduct exams at additional health care and non-health care sites. The facility conducting the exam may be referred to in this protocol as the “exam site,” in recognition of the fact that not all sites performing the exam are health care facilities. Clinical staff providing care at exam sites are broadly referred to in this document as “health care providers,” “health care staff,” “health care personnel,” and “health care clinicians.”

Jurisdiction: This term is used in two ways in the protocol. One is to broadly describe a community that has power to govern or legislate for itself. For example, a jurisdiction may be a local area, a State, a Territory, or tribal land. A jurisdiction may also be referred to in the protocol as a “community.” The term also describes the authority to interpret and apply laws and is used in this context mainly when identifying who has “jurisdiction” over a particular case.

Law enforcement representative: Different types of law enforcement agencies exist at the local, State, Territory, tribal, and Federal levels (e.g., county or tribal sheriff and/or police, State police, sworn police on college campuses, the FBI, criminal investigators from the Bureau of Indian Affairs (BIA), and military police). Any of these agencies could potentially be involved in responding to sexual assault cases. Also, in areas without a local law enforcement agency, public safety officials may assist in immediate response to sexual assault victims. Some agencies may have staff with specialized education and experience in sexual assault investigations. In this protocol, personnel from law enforcement agencies are referred to as “law enforcement officers” or “law enforcement representatives,” unless more specificity is required.

Prosecutor: Different types of prosecution offices exist at the local, tribal, State, Territory, and Federal level (e.g., tribal prosecutor’s office, county prosecutor’s office, district attorney’s office, State attorney’s office, United States Attorney’s office, and military judicial branches). Any of these offices could be involved in responding to sexual assault cases. In addition, some offices may have personnel with specialized education

and experience in sexual assault prosecutions. In this protocol, attorneys from prosecution offices will be referred to as “prosecutors” unless more specificity is required.

Sexual assault: Generally speaking, sexual assault is the sexual contact of one person with another without appropriate legal consent. This definition includes, but is not limited to, a wide range of behavior classified by State, Territory, Federal, and tribal law as rape, sexual assault, sexual misconduct, and sexual battery. Refer to applicable statutes for precise definitions in a specific jurisdiction.<sup>22</sup>

Sexual assault medical forensic examination: The sexual assault medical forensic exam is an examination of a sexual assault patient by a health care provider, ideally one who has specialized education and clinical experience in the collection of forensic evidence and treatment of these patients. The forensic component includes gathering information from the patient for the medical forensic history, an examination, documentation of biological and physical findings, collection of evidence from the patient, and followup as needed to document additional evidence. The medical component includes coordinating treatment of injuries, providing care for STIs, assessing pregnancy risk and discussing treatment options, including reproductive health services, and providing instructions and referrals for followup medical care. This exam is referred to as the “forensic medical examination” under the Violence Against Women Act (VAWA).

Sexual assault response team (SART): A SART is a multidisciplinary team that provides specialized immediate response to victims of recent sexual assault. The team typically includes health care personnel, law enforcement representatives, victim advocates, prosecutors (usually available on-call to consult with first responders, although some may be more actively involved at this stage), and forensic lab personnel (typically available to consult with examiners, law enforcement, or prosecutors, but not actively involved at this stage). However, SART components vary by community.

Suspected sex offender: A suspected sex offender is an individual suspected of committing a sexual assault. In this document, the suspected sex offender is typically referred to as a “suspect.” When litigation is discussed, the suspected sex offender may be referred to as a “defendant.” When talking more broadly about sex offenders, they may be referred to as “sex offenders,” “assailants,” or “perpetrators.”

Victim: A sexual assault victim is someone who has been sexually assaulted. In this document, a victim can be a female or male; either adult or adolescent. There may be instances where individuals, such as unconscious persons or persons with cognitive disabilities, do not actually disclose that they have been assaulted, but others suspect that this may be this case and may be lawfully able to seek help for them. The term “survivor” is used in this document when referring to victims who are involved in long-term healing or have healed from sexual assault. It is important to note that because this document addresses a multidisciplinary response, the term “victim” is not used in a strictly criminal justice context. The use of “victim” simply acknowledges that persons who disclose they have been sexually assaulted should have access to certain services and interventions designed to help them be safe, recover, and seek justice. The term “patient” is also used when discussing the role of medical providers.

Victim service provider/advocate: A victim service provider/sexual assault victim advocate (also referred to as “victim advocate” and “advocate”) may offer victims and their significant others a range of services during the exam process. These services may include support, crisis intervention, information and referrals, and advocacy to ensure that victims’ interests are represented, their wishes respected, and their rights upheld. In addition, advocates and other victim service providers may provide followup services, such as support groups, counseling, accompaniment to related appointments, and legal advocacy to help meet the needs of victims, their families, and friends.

A number of agencies may offer some or all of the services described above, including community-based sexual assault victim advocacy programs,<sup>23</sup> criminal justice system victim-witness offices, patient advocate programs at health care facilities, campus or military victim service programs, tribal social services, adult

---

<sup>22</sup> Drawn from the American College of Emergency Physicians’ *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, 1999, Overview, p. 7.

<sup>23</sup> In some areas, the community-based sexual assault victim advocacy program is a component of an umbrella organization serving additional populations (e.g., a dual sexual assault/domestic violence advocacy agency, a center for women, or a mental health agency). In others, the community-based sexual assault victim advocacy program is a stand-alone organization.

protective services, and others. Where they exist, community-based sexual assault victim advocacy programs are typically best positioned to provide these specific services. Community-based advocacy programs may use paid and/or volunteer advocates to provide services 24 hours a day, every day of the year. It is important to know that information victims share with government-based service providers usually becomes part of the criminal justice record, while community-based advocates typically can provide some level of confidential communication for victims. In addition, community-based advocates commonly receive education specific to the medical forensic exam process and sexual assault issues in general.

Victim-centered: A “victim-centered” approach as used in this protocol recognizes that sexual assault victims are central participants in the medical forensic exam process, and they deserve timely, compassionate, respectful, and appropriate care. Victims have the right to be well informed in order to make their own decisions about participation in all components of the exam process. Responders need to do all that is possible to explain possible options, the consequences of choosing one option over another, and available resources.

Vulnerable adults: This term is used in this document to refer to adult individuals with impaired and/or reduced mental capacity who have difficulty or cannot comprehend events that occurred or will occur (e.g., the assault itself or initial response by professionals), questions they will be asked during the exam, or the exam process itself. Exam sites should have internal policies based on jurisdictional statutes governing consent for treatment for and evidence collection from such patients.