

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.
- Develop culturally responsive care and be aware of issues commonly faced by victims from specific populations.
- Recognize the importance of victim services within the exam process.
- Accommodate patients' requests to have a relative, friend, or other personal support person (e.g., religious -and spiritual counselor/advisor/healer) present during the exam, unless considered harmful by responders.
- Accommodate patients' requests for responders of a specific gender throughout the exam as much as possible.
- Prior to starting the exam and conducting each procedure, explain to patients in a language the patients understand what is entailed and its purpose.
- Assess and respect patients' priorities.
- Integrate medical and evidentiary procedures where possible.
- Address patients' safety during the exam.
- Provide information that is easy for patients to understand, in the patient's language, and that can be reviewed at their convenience.
- Address physical comfort needs of patients prior to discharge.

It is critical to respond to individuals disclosing sexual assault in a timely, appropriate, sensitive, and respectful way.³⁷ Every action taken by responders during the exam process should be useful in facilitating patient care and healing and/or the investigation (if the case was reported).

Give sexual assault patients priority as emergency cases. This includes a prompt medical screening exam. 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 offered a medical forensic exam. (For more discussion on this topic, see *C.2. Triage and Intake*.) Have plans for what to do, if the examiner is not available right away. For example, is there a quiet, private place the patient can wait? Is there a phone available so the patient can talk to an advocate or a friend or family member while waiting? Jurisdictions should consider policies and training for facility staff and administration regarding what to do while sexual assault patients are waiting.

Provide the necessary means to ensure patient 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 advocate arrives. Health care providers should provide patients with access to a phone to contact family members and/or support persons as desired, and should promptly contact law enforcement, if not already involved, if patients want to report the assault.

³⁷ The chapter was partially built on information from the *North Carolina Protocol for Assisting Sexual Assault Victims*, 2000.

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

Adapt the exam process as needed to address the unique needs and circumstances of each patient.

Patients' experiences during the crime and the exam process, as well as their post-assault needs, may be affected by multiple factors, such as:

- Age.
- Gender and/or perceived gender identity/gender expression.
- Physical health history and current status.
- Mental health history and current status.
- Disability.
- Language needs for limited English proficient patients, Deaf and hard-of-hearing individuals, and those with sensory or communication disabilities.
- 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, commercial sexual exploitation, sex and/or labor 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 and friends 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.
- 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 post-assault 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.³⁸

³⁸ Paragraph adapted from Iowa's *Sexual Assault: A Protocol for Forensic and Medical Examination*, 1998, pp. 1–4.

Examiners should ensure they do not make credibility determinations based on myths or misconceptions about victim behavior.

In addition, patients' fears and concerns can affect their initial reactions to the assault, their post-assault needs, and decisions before, during, and after the exam process. For example, female and transgender 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, ability to remain in the United States, job, and other sources of income as a result of disclosure, particularly if an intimate partner assaulted them.³⁹ They may be concerned about costs related to the exam and subsequent care of injuries.⁴⁰

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 or gender identity and gender expression. 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 alcohol- or 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, immigration status, or religious or spiritual beliefs, beyond certain information that medical providers may need for appropriate care.

Develop culturally responsive care and be aware of issues commonly faced by patients from specific populations. Develop culturally competent and sensitive care by building awareness about and sensitivity to the ways that culture can impact a person's experience in the immediate aftermath of sexual assault and across their lifespan. Be aware and responsive to the ways in which cultural identities (e.g., race, ethnicity, gender, religion, ability/disability, language (limited English proficiency), immigration status, socioeconomic status, sexual orientation, gender identity or expression, age) may influence a person's experience during the exam process as well. 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 readily available to help them serve patients from these populations, including what languages are spoken by the populations and how to access interpreters for each language needed. 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 SART/SARRTs should develop policies and plans to meet the needs of specific patient populations (e.g., to obtain necessary interpreter services and translated documents for limited English proficient patients, qualified interpreters for Deaf and hard-of-hearing patients and individuals with sensory or communication disabilities, and identify legal referrals for immigrant victims of sexual assault, domestic violence, dating violence, and stalking.) 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

³⁹ 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.

⁴⁰ Paragraph partially adapted from the *Ohio Protocol for Sexual Assault Forensic and Medical Examination*, 2002, p. 2.

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 or non-gendered body maps for transgender patients). 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.

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.⁴¹ 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

- 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.⁴²
- 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. Conversely, in smaller ethnic and racial communities, victims may be more likely to know the responder and doubt the responder's ability to maintain confidentiality.
- Be aware that cultural beliefs may preclude a member of the opposite sex from being present when victims disrobe. 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.
- Be aware that beliefs about women, men, sexuality, sexual orientation, gender identity or expression, 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.⁴³

—Victims with limited English proficiency⁴⁴

⁴¹ 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.

⁴² 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://academicdepartments.musc.edu/fm_ruralclerkship/curriculum/culture.htm).

⁴³ 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.

⁴⁴ The Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) *New & Revised Standards & EPs for Patient-Centered Communication, Accreditation Program: Hospital*, HR.01.02.01, PC.02.01.21, RC.02.01.01, RI.01.01.01, RI.01.01.03, effective January 1, 2011, http://medicine.osu.edu/orgs/ahcc/Documents/Post_PatientCenteredCareStandardsEPs_20100609.pdf (PDF); Joint

- Be patient and understanding toward victims' language skills and barriers, which may worsen with the crisis of sexual assault.⁴⁵
- Develop policies and train responders to be able to identify a victim's limited English proficiency and primary language spoken and written.
- Make every attempt to provide same language service through the use of demonstrably bilingual examiners or by providing monolingual examiners with support from professional interpretation services and translated materials for victims who are not proficient in English,⁴⁶ are LEP or who may prefer to communicate in a non-English language. Use qualified interpreters when possible and not victims' families or friends.⁴⁷ Take the victim's country of origin, acculturation level, and dialect into account when responding or arranging interpretation.⁴⁸ Remember to speak directly to victims when interpreters are used. Consider the victim's need for modesty and privacy when determining where interpreters should be located in the exam room.
- Train interpreters about issues related to sexual assault and the exam process⁴⁹ whenever they are needed to facilitate communication in these cases. Ensure that the examiners are trained in the proper utilization and ethical requirements of using an interpreter.
- Make sure that interpreters understand that they may need to testify.⁵⁰
- Understand that immigrant victims may fear that assisting law enforcement may identify them to immigration authorities for deportation.
- All sexual assault victims should be provided information regarding U-Visa relief, in the event that this information would be helpful. Even if this information is not helpful to them directly, the information is often passed on to others by word of mouth and can benefit others in the future.
- Work with law enforcement partners to develop and publicize protocols precluding detention or other immigration enforcement against victims who come forward to report a sexual assault.
- Work with law enforcement to develop and publicize U-Visa certification protocols.
- While it is not appropriate to ask a victim's immigration status, anticipate that an immigrant victim will not self-identify as undocumented for fear of deportation. Such information about their rights should be offered in a non-judgmental manner to all victims and in coordination with a referral to an immigration service provider expert in working with immigrant victim populations.

—Victims with disabilities

- Understand that victims with disabilities may have physical, sensory, cognitive, developmental, or mental health disabilities, or a combination of disabilities. 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 is much higher than for people without disabilities. People with disabilities are often victimized

Commission, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care*, Appendix B, August 2010, <http://www.jointcommission.org/assets/1/6/ARoadmapforHospitalsfinalversion727.pdf>.

⁴⁵ Carolyn Ham, Reducing Language Barriers to Combating Domestic Violence: The Requirements of Title VI, Battered Women's Justice Project, October 2004, http://new.vawnet.org/summary.php?doc_id=1621&find_type=web_desc_GC.

⁴⁶ Health care providers generally are covered by language access requirements under Title VI which requires them to take reasonable steps to provide language-appropriate health care, including the use of qualified bilingual staff, interpreters, and translators.

⁴⁷ Use of such informal and biased interpreters may result in unreliable communication, violate the patient's privacy, undermine the patient's claim of privilege, and jeopardize the use of the victim's statements in court. In cases of intimate partner sexual assault, it is particularly important not to use family members who are not likely to adopt a neutral stance or maintain the confidentiality necessary.

⁴⁸ 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, <http://www.arte-sana.com>, 2003.)

⁴⁹ Professional interpreters are expected to be familiar with confidentiality requirements and cultural issues.

⁵⁰ Interpreters would not be expected to act as witnesses as to what was said in the examination room if they are present solely to facilitate direct communication between the patient and examiner.

repeatedly by the same offender.⁵¹ Caretakers, family members, or friends may be responsible for the sexual assault. In such cases, 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.

- Respect victims' wishes to have or not to 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), 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 that 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 assistance to get on and off the exam table or to assume positions necessary for the exam, or may need an alternative to the standard table). But, do not assume they will need special aid. Ask for permission before proceeding to help them (or touch them, handle a mobility or communication device, or touch a service animal).⁵²
- 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.⁵³ Let the individual specify the preferred method of communication. 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, traumatic brain injury, neurodegenerative conditions such as Alzheimer's disease, or stroke. 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. 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. 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 a variety of reasons, including fear of not being believed, fear of getting in trouble, and 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. The perpetrator may also be their caregiver and the only person they rely on for daily living assistance.
- 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.⁵⁴ 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

⁵¹ 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.

⁵² Examples of service animals include guide dogs and hearing-assistance dogs, and therapy dogs.

⁵³ Note that individuals may have their own assistive devices, but words needed to communicate may have to be programmed.

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

experience was like for them.⁵⁵ 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 victims⁵⁶

- 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.⁵⁷

—Adolescent victims⁵⁸

- 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.⁵⁹ 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.⁶⁰

⁵⁵ Drawn from L. Ledray, *SANE Development and Operation Guide*, 2000, pp. 82–85.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.

⁵⁶ Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 2000, p. 79.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.

⁵⁷ 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, <http://www.malesurvivor.org>.

⁵⁸ Adapted partially from the *West Virginia Protocol for Responding to Victims of Sexual Assault*, 2011, pp. 26–27.

<http://www.fris.org/Resources/PDFs/Books/WVProtocol.pdf>.

⁵⁹ For example, the size of the speculum used with adolescent female victims and exam positions of victims may vary.

⁶⁰ Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 2000, p. 7.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.

- 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.
- 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 from the medical facility for medical treatment provided or an explanation of benefits from their insurance provider).⁶¹
- Be aware of mandatory reporting laws regarding minor victims and explain to the victim any mandatory reporting obligations.

—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 in the days, weeks, and months following an attack. Older victims may feel common trauma reactions such as being physically vulnerable, reduced resiliency, and mortality. Fear, anger, and depression can be especially severe in older victims who are isolated, have little support, and live on a fixed or limited income.⁶²
- Be aware that caretakers may sexually assault older adults. Older adults may be dependent on these sexual offenders for emotional or financial support or housing. Offenders may bring victims to the exam site. Some offenders may be charming to staff while others may be threatening or menacing. 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 may be more physically fragile than younger victims and thus may be at risk for tissue or skeletal damage and exacerbation of existing illnesses and vulnerabilities.⁶³
- Hearing impairment and other physical conditions attendant to advancing age, coupled with the initial trauma reaction to the assault, may render some older victims unable to make their needs known, which could result in prolonged or inappropriate treatment.⁶⁴
- Do not mistake disabilities (such as hearing loss or aphasia) or acute stress reaction following assault for senility. Use of appropriate communication remedies, for example, a personal listening device, may enable an older adult with a severe hearing loss to communicate effectively. Also, be aware that older adults typically process information more slowly than younger adults and take longer to put their thoughts into words. This is a normal age-related change and should not be viewed as evidence of lack of mental capacity. Health care professionals treating elders need to speak slowly and clearly and give elders ample time to process information provided and formulate responses. If questions about the victim's capacity arise, contact trained experts to conduct an assessment.
- If a forensic medical exam has been requested by a law enforcement officer, guardian, or other authority, it is still important to obtain the victim's consent and cooperation to forensic evidence-gathering procedures. Those making the request may argue that evidence collection may be especially important because the victim may be unable to provide a statement or testify. However, when victims lack capacity and are unable to provide consent and cooperation, they should not be

⁶¹ Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 2000, p. 98.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.

⁶² Ibid.

⁶³ 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 partially from L. Ledray, *SANE Development and Operation Guide*, 2000, p. 86-87.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.)

⁶⁴ Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 2000, p. 87.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.

forcibly examined or subjected to forensic procedures that are not necessary for their own health and safety.

- 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. Others may be traumatized by being harmed sexually by a family member or trusted caregiver. Listen to their concerns and what the experience was like for them.⁶⁵ 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.
- Some older victims may be reluctant to report the crime or seek treatment because they fear losing their independence. Some older sexual assault victims may need a significant amount of time to recover from injuries that are the result of the abuse or attack. When a change in a living environment, such as placement in a residential facility, is truly needed, older victims who have not been adjudicated as lacking mental capacity and requiring guardians have the legal right to make their own decisions regarding choice of residence. Health care providers must avoid colluding with relatives who want to force older adults into unwanted lifestyle changes subsequent to assault.
- Older adults who have been sexually assaulted in care facilities often experience intense feelings of vulnerability in those facilities following sexual assault and desperately want to be relocated. Elders who rely upon others for care are likely to need the assistance of relatives and involved professionals in being safely relocated.
- Encourage use of follow-up medical, legal, and nonlegal assistance. Older victims may be reluctant to seek these services or proceed with prosecution. If barriers to accessing services or ongoing health care exist, such as lack of transportation, work with local service providers to identify potential remedies.

—Victims in the military⁶⁶

- The military offers victims the option of restricted reporting or unrestricted reporting.⁶⁷ Restricted reporting allows a sexual assault victim to confidentially disclose the details of his or her assault to specified individuals and receive medical treatment and counseling without triggering the official investigative process or command notification. Restricted Reporting can be voided if the medical facility contacts law enforcement or other professionals other than advocates, chaplains, and military sexual assault response coordinators.
- Exam sites that provide exams for military installations are encouraged to draft Memoranda of Understanding to address such issues as confidentiality and storage of evidence.

—American Indian and Alaska Native victims

- Keep in mind that American Indian and Alaska Native victims may have unique cultural or language needs, whether they are assaulted in Indian Country or an Alaska Native village or in an urban area.
- Recognize that Indian tribes may have their own laws and regulations, as well as their own police, prosecutors, advocates, courts, and service providers to address sexual assault. Responders should be familiar with procedures for coordinating services and interventions for victims from these

⁶⁵ Drawn partially from L. Ledray, *SANE Development and Operation Guide*, 2000, pp. 82-85.

<http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf>.

⁶⁶ The Office for Victims of Crime (OVC) has developed a resource to assist address sexual assault in the military. *Strengthening Military-Civilian Community Partnerships to Respond to Sexual Assault* is a training curriculum and tool kit for community-based civilian rape crisis centers and state sexual assault coalitions to use in their work with the military installations in their regions. Funding for this project was provided by OVC and the Office on Violence Against Women (OVW), and was developed by the Pennsylvania Coalition Against Rape (PCAR) and the National Sexual Violence Resource Center (NSVRC) in coordination with the Department of Defense's Sexual Assault Prevention and Response Office. Through OVC's Training and Technical Assistance Center (OVC TTAC) the curriculum and tool kit will be available for communities to use in their regions to train on enhancing community response, and effectively responding to the needs of sexual assault victims in the military.

⁶⁷ For more information on reporting in the military, please see <http://www.sapr.mil/>.

communities and should work with community groups to develop plans for providing exams to members of Indian tribes. These plans should address evidence preservation and provide examination payment and reimbursement information. Responders within tribal communities should share resources and information to enable them to develop their own protocols and programs that address the community's unique needs.

- Promote partnerships among tribal and relevant federal and state agencies so they better coordinate responses and resources, learn from past mistakes, and strive towards a shared vision of aiding and empowering victims.
- Be aware that tribal jurisdictions may have their own SAFE protocol in place that addresses the tribe's unique needs and incorporates its cultural traditions, practices, and language.
- As in many cultures, American Indian/Alaska Native women are of central and primary importance to the family and the community. Be mindful that sexual violence against a Native woman may be seen as an assault on both the individual and her community.
- Be sensitive to victims' cultural beliefs and practices. The best practice is to always ask victims rather than assume what they need to be safe, address their health concerns, be supported in inner healing, and feel a sense of justice.
- Be aware of the tribe's history. Responders should have an understanding of the impact of history on American Indian/Alaska Native people as it may influence victims' reactions and needs. Adequate self-education combined with training by tribal members can prepare non-Native responders to be sensitive to the historical context in which victimization occurs and to avoid assumptions about victims' cultural practices.
- Recognize that there are multiple ways for victims to seek justice—through criminal justice interventions, tribal justice systems, and use of more traditional practices of the tribe related to holding perpetrators accountable, and/or other victim-identified strategies.
- Include American Indian/Alaska Native populations in Limited English Proficiency protocols for victims of sexual assault.

—Lesbian, gay, bisexual, or transgender (LGBT) victims

- Intake forms and other documents that ask about gender or sex should allow patients to write in a response, or include transgender and intersex options. Make sure questions appropriately distinguish between sexual orientation (the gender(s) someone is attracted to), gender identity (the internal sense of being woman, man, or gender non-conforming), and their sex.
- Always refer to victims by their preferred name and pronoun, even when speaking to others. If unsure of what to call the person or what pronoun to use, ask.
- Treat the knowledge that the person is LGBT as protected medical information subject to all confidentiality and privacy rules. Be aware that companions of LGBT victims may not know their gender identity or sexual orientation.

Additional suggestions specific to victims who are transgender or gender non-conforming:

- It is critical to not show surprise, shock, dismay, or concern when you are either told or inadvertently discover that a person is transgender. Be especially careful about your body language – gasping, sighing, a sharp intake of breath, or widening eyes can all be very upsetting to someone who may worry that you are making a judgment or assessment of their body.
- Understand that transgender people have typically been subject to others' curiosity, prejudice, and violence. Keep in mind that transgender victims may be reluctant to report the crime or consent to the exam for fear of being exposed to inappropriate questions or abuse. If the victim does consent to an exam, be especially careful to explain what you want to do and why before each step, and respect their right to decline any part of the exam.
- Be aware that transgender individuals may have increased shame or dissociation from their body. Some use nonstandard labels for body parts, and others are unable to discuss sex-related body

- parts at all. Reflect the victim's language when possible and use alternative means of communication (such as anatomically correct dolls or paper and pen for the victim to write or draw) if necessary
- Vaginas that have been exposed to testosterone or created surgically are more fragile than vaginas of most non-transgender women and may sustain more damage in an assault. There may be additional layers of psychological trauma for patients with a male identity or a constructed vagina when they have been vaginally assaulted.
 - Transgender male individuals who still have ovaries and a uterus can become pregnant even when they were using testosterone and/or had not been menstruating.
 - Transgender people may engage in self-harm as a coping mechanism. However, cutting and genital mutilations are also frequently part of anti-transgender hate crimes. Be nonjudgmental and careful when documenting such injuries.
 - Some transgender victims may want to talk about their perceptions of the role their gender identity might have played in making them vulnerable to an assault. Because of their value in possible prosecutions under hate crime laws, document any anti-transgender statements the victim says were made during the assault. Otherwise, listen to the victim's concerns and what the experience was like for them. 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.
 - Ensure that all referrals given to a transgender victim have been trained on or have significant experience with the special needs of transgender survivors of sexual assault.
 - Include opportunities for LGBT individuals to influence the development of sensitive responses for victims of sexual assault.

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 in a language the victims understand 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 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. Advocates⁶⁸ can offer a tangible and personal connection to a long-term source of support and advocacy. Community-based 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.⁶⁹ When community-based advocates support victims, examiners can more easily maintain an objective stance.⁷⁰ In addition, civil attorneys may be able to help victims assess legal needs and options, including privacy, safety, immigration, housing, education, and employment issues.

Be aware of the extent of services. Services offered by advocates during the exam process may include:⁷¹

- Accompanying the victims through each component (advocates may accompany victims from the initial contact and the actual exam through to discharge and follow-up appointments).
- 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

⁶⁸ 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.

⁶⁹ K. Littel, *SANE Programs: Improving the Community Response to Sexual Assault Victims*, 2001, p. 6.

⁷⁰ Ibid. See also IAFN position statement Dated Nov 19, 2008: Collaboration with Advocates <http://iafn.org/associations/8556/files/IAFN%20Position%20Statement-Advocate%20Collaboration%20Approved.pdf>.

⁷¹ 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).

treatment options for STIs, HIV, and pregnancy; serve as a resource and follow-up point of contact for any future inquiries such as payment method for the exams; and provide referrals).

- Assisting in coordination of victim transportation to and from the exam site.
- Providing victims with crisis intervention⁷² and support to help cope with the trauma of the assault⁷³ 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 culturally and linguistically sensitive and appropriate manner to victims from different backgrounds and circumstances and advocating for the elimination of barriers to communication.
- 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.
- 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,⁷⁴ information, and referrals for community services; assist with applications for victim compensation programs;⁷⁵ and encourage victims to obtain follow-up testing and treatment and take medications as directed. They can also accompany victims to follow-up appointments, including those for related medical care and criminal and civil justice-related interviews and proceedings. They can work closely with the responders involved 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).⁷⁶ Prior to introducing the advocate to a patient, exam facility personnel should explain briefly, in a language the patient understands, the victim services offered and ask whether the victim wishes to 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.⁷⁷ If possible, victims should be allowed to meet with advocates in a private place prior to the exam. Ideally, a patient should be assisted by the same advocate during the entire exam process.⁷⁸

⁷² 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 so that they are able to make an informed decision as to what, if any, actions 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.

⁷³ See A. Burgess and L. Holmstrom, Rape Trauma Syndrome, *American Journal of Psychiatry*, 131: 981-986, September 1974, for a summary of the psychological, somatic, and behavioral impact of sexual assault on victims.

⁷⁴ Many advocacy agencies offer ongoing support and advocacy to victims. Some also provide professional mental health counseling, but many refer victims to community or private agencies.

⁷⁵ For more information on crime victim's compensation, please see <http://www.ovc.gov/publications/factsheets/compandassist/welcome.html>.

⁷⁶ 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.

⁷⁷ In very small communities, patients may know some or all advocates (e.g., a small, close-knit community that speaks an uncommon dialect). 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.

⁷⁸ 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.

Understandably, immigrant victims may be reluctant to discuss or report the victimization. It is inappropriate to ask patients about aspects of their health, body, legal status, or identity that are not related to the assault. It is, however, appropriate to ensure that all victims are provided with information regarding U-Visas, in the event that this relief would be appropriate.⁷⁹

Accommodate patients' requests to have a relative, friend, or other personal support person (e.g., religious and spiritual counselor/advisor/healer) present during the exam, unless considered harmful by responders.⁸⁰ An exception would be if responders consider the request to be potentially harmful to the patient or the exam process.⁸¹ Patients' requests to not 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 of nonlicensed medical students to view the exam. It is also inappropriate to ask patients about aspects of their health, body, legal status, or identity that are not related to the assault.

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

Address and respect patients' priorities. 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 evidentiary 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.*) Consider the

⁷⁹ Legal Momentum has extensive resources available regarding U-Visas. See: <http://www.legalmomentum.org/our-work/immigrant-women-program/u-visa.html>. Additionally, immigrant women are entitled to emergency medical and post-assault healthcare. For a state-by-state breakdown of the benefits afforded see: http://www.legalmomentum.org/assets/pdfs/4_nilc_table_10.pdf.

⁸⁰ Paragraph partially drawn from the *California Medical Protocol for Examination of Sexual Assault and Child Sexual Abuse Victims*, 2001, p. 15.

⁸¹ 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.

implications of the evolving law on hearsay exceptions when determining the level and nature of coordination. See *Appendix C* for more information on the relevant case law and how it relates to medical forensic examinations.

Address patients' safety during the exam. 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. Some victims, including transgender people, may also fear assault or belittlement by health care professionals' and/or law enforcement officials' responses to their gender identity or expression and/or transgender body. 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 Follow-up.*)

Provide information that is easy for patients to understand, in the patient's language, and that can be reviewed at their convenience.⁸² Information should be tailored to patients' communication skill level/modality and language. This includes providing interpreter services and the translation of documents into languages other than English for limited English proficient (LEP) patients. 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.⁸³ 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.
- Civil, criminal, and immigration legal 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 follow-up instructions.
- Planning for the victim's safety and well-being.
- Examination payment and reimbursement information.
- Steps and options in the criminal justice process.
- Civil and immigration remedies that may be available to sexual assault victims.
- Procedures for victims to access their medical record or applicable law enforcement reports.

Address physical comfort needs of patients prior to discharge. For example, provide them with the opportunity to wash in privacy (offering shower facilities if at all possible⁸⁴), 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.

⁸² 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.

⁸³ 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.

⁸⁴ It would be useful for the exam room to have an attached bathroom with a shower.