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Post-Assault Medical Care for Adult Sexual Assault Survivors: Developing a new Standard of Care

By Rebecca Campbell, Ph.D.

Sexual assault victims have extensive post-assault medical needs, including injury detection and care, medical forensic examination, screening and treatment for sexually transmitted infections (STIs), and pregnancy testing and emergency contra-ception. Al-though most victims are not physically injured to the point of needing emergency care (Ledray, 1999), tradition-ally, police, rape crisis centers, and social service agencies have advised victims to seek treatment in hospital emergency departments for a medical forensic exam (Martin, 2005). The survivor's body is a crime scene and due to the invasive nature of rape, a medical professional is needed to collect the evidence. The "rape exam" or "rape kit" usually involves plucking head and pubic hairs; collecting loose hairs by combing the head and pubis; swabbing the vagina, rectum, and/or mouth to collect semen, blood, or saliva; and obtaining fingernail scrapings in the event the victim scratched the assailant. Blood samples may also be collected for DNA, toxicology, and ethanol testing (Martin, 2005).

Victims often experience long waits in hospital emergency departments because sexual assault is rarely an emergent health threat, and during this wait, victims are not allowed to eat, drink, or urinate so as not to destroy physical evidence of the assault (Littel, 2001). When victims are finally seen, they get a cursory explan-ation of what will occur and it often comes as a shock that they have to have a pelvic exam immediately after such an egre-gious, invasive violation of their bodies (Martin, 2005). Many victims describe the medical care they receive as cold, imper-sonal, and detached (Campbell, 2005, 2006). Furthermore, the exams and evidence collection procedures are often performed incorrectly (Martin, 2005). Most hospital emergency department personnel lack training in sexual assault forensic exams, and those trained usually do not perform exams frequently enough to maintain proficiency (Plichta et al., 2006).

Forensic evidence collection is often the focus of hospital emergency department care, but sexual assault survivors have other medical needs, such as information on the risk of STIs/HIV and prophylaxis (preventive medications to treat any STIs that may have been contracted through the assault). The American Medical Association (19 95) and Centers for Disease Control and Prevention (2002) recommend that all sexual assault victims receive STI prophylaxis and HIV prop-hylaxis on a case-by-case basis after risk assessment. However, analyses of hos-pital records have shown that only 34% of sexual assault patients are treated for STIs (Amey & Bishai, 2002). Yet, data from victims suggest much higher rates of STI prophylaxis: 57-69% of sexual assault victims reported that they received antibiotics during their hospital emergency department care (Campbell, 2005, 2006; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; National Victim Center, 1992). But not all victims are equally likely to receive STI-related medical services. Victims of non-stranger sexual assault are signify-

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cantly less likely to receive information on STIs/HIV or STI prophylaxis (Campbell et al., 2001), even though knowing the assailant does not mitigate one's risk. In addition, one study found that Caucasian women were significantly more likely to get information on HIV than ethnic minority women (Campbell et al. 2001).

Post-assault pregnancy services are also inconsistently provided to sexual assault victims. Only 40-49% of victims receive information about the risk of pregnancy (Campbell et al., 2001; National Victim Center, 1992). The AMA (1995) and American College of Obstetricians and Gynecologists (19 98) recommend emergency contraception for victims at risk for pregnancy, but only 21-43% of sexual assault victims who need emergency contraception actually receive it (Amey & Bishai, 2002; Campbell, 2005, 2006; Campbell et al., 2001). To date, no studies have found systematic differences in the provision of emergency contraception as a function of victim or assault characteristics, but hospitals affiliated with the Catholic church are significantly less likely to provide emergency contraception (Smugar, Spina, & Merz, 2000).

In addition to the challenges they face obtaining needed services, sexual assault victims also encounter substantial victim blaming from medical system personnel. In the process of the forensic exam, STI services, and pregnancy-related care, doctors and nurses ask victims about their prior sexual history, sexual response during the assault, what they were wearing, and what they did to "cause" or "provoke" the assault (Campbell, 2005). Medical professionals may view these questions as necessary and appropriate, but sexual assault survivors find them upsetting. For example, Campbell (2005) found that as a result of their contact with emergency department doctors and nurses, most sexual assault survivors stated that they felt bad about themselves (81%), depressed (88%), violated (94%), distrustful of others (74%), and reluctant to seek further help (80%). Only 5% of victims in Ullman's (1996) study rated physicians as a helpful source of support, and negative responses from formal systems, including medical, significantly exacerbate victims' PTSD symptomatology (Campbell et al., 1999; Ullman & Filipas, 2001). Victims who do not receive basic medical services rate their experiences with the medical system as more hurtful, which has been associated with higher PTSD levels (Campbell et al., 2001).

To address these shortcomings in post-assault medical care for sexual assault victims, communities through-out the United States have been developing Sexual Assault Nurse Examiner (SANE) programs. SANE programs were created by the nursing profession in 1970s and grew in rapid numbers during the 1990s (Ledray, 1999; Littel, 2001). These programs were designed to circumvent many of the problems of traditional hospital emergency department care by having specially trained nurses, rather than doctors, provide 24/7 crisis intervention and medical care to sexual assault victims in either hospital emergency department or community clinic settings (Ledray, 1999). Influenced by psychiatric and community mental health nursing, SANE programs place strong emphasis on treating victims with dignity and respect in order to decrease post-assault psychological distress (Ledray, 1999). Many SANE programs work with their local rape crisis centers so that victim advocates can also be present for the exam to provide emotional support, combining the potential benefits of both service programs (Littel, 2001).

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The medical forensic exam performed by SANEs is more thorough than what victims receive in traditional emergency department care. Most SANE programs utilize specialized forensic equipment (e.g., colposcope), which allows for the detection of micro-lacerations, bruises, and other injuries (Ledray, 1999). With respect to STI/ HIV and emergency contraception care, national surveys of SANE pro-grams find service provision rates of 90% or higher (Campbell et al., 2006). As with traditional emergency department medical care, SANE pro-grams affiliated with Catholic hospitals are significantly less likely to conduct pregnancy testing or offer emergency contraception (but do so at higher rates than non-SANE, Catholic-affiliated emergency departments) (Campbell et al., 2006). In a quasi-experimental longitudinal study, Crandall and Helitzer (2003) compared medical service provision rates two years before to four years after the implementation of a hospital-based SANE program, and found significant increases in STI prophylaxis care (89% to 97%) and emergency contraception (66% to 87%).

Victims' experiences receiving post-assault medical care in SANE programs are markedly different than traditional hospital emergency departments. For example, in a qualitative study of a Canadian "specialized sexual assault service" (similar to an American SANE program), Ericksen et al. (2002) found that patients felt respected, safe, reassured, in control, and informed throughout their crisis period.

Similarly, Campbell, Patterson, Adams, Diegel, and Coats's (2008) evaluation with 52 sexual assault patients in a midwestern SANE program found that survivors felt very sup-ported, respected, believed, and well-cared for by their SANE nurses. In a qualitative follow-up study with the same SANE program, survivors noted that they appreciated the joint efforts of both the SANE nurse and the rape crisis center victim advocate (Campbell, Bybee, Ford, & Patterson, 2008). Victims noted that the nurses and advocates worked well together as a team to provide comprehensive psychological support to them as well as their families. Although more evaluation research is clearly needed, SA NE programs represent a promising practice model of post-assault medical care for sexual assault survivors.

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