Medical Response to Adult Sexual Assault

A Resource for Clinicians and Related Professionals

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Chapter 1

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

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A New Standard of Care

With the implementation of sexual assault nurse examiner (SANE) programs across the United States, a new standard of care has been implemented for sexual assault patients. It is no longer acceptable to have untrained medical personnel reading the directions of the exam while they are treating sexual assault victims and collecting evidence. As such practices would never be considered reasonable for a physician or nurse to perform in the emergency department (ED) with other patient populations, they should not be acceptable with victims of rape.

In many medical institutions, rape victims still encounter long waits and inadequate, substandard care. Some may wait up to 12 hours for a rape exam in even several of the best medical facilities.[1] On a national level, only 20% of rape victims who receive medical care after a rape are given emergency contraception (EC), and only 58% are screened or given medication to prevent sexually transmitted infections (STIs).[2] In medical facilities with SANE programs, care is far superior. Although more program evaluation and outcomes research is needed, the evidence indicates that SANE programs offer EC 97% of the time and medication to prevent STIs 99% of the time.[3]

In 1989, the California State Court of Appeals ruled that a woman who was not given the right to choose EC could sue the hospital that provided the inadequate care.[4] This kind of lawsuit takes place in a very public forum—one that a rape victim may not be willing or able to endure. Smugar et al recognize that while it can be therapeutic for some, these lawsuits will further prolong the trauma for others.[5] It should not be necessary for rape victims to sue in order to access the care they need and deserve. To prevent this from being necessary, many states have passed laws requiring sexual assault victims be provided information about EC or given these medications by health care providers. As health care providers, we are responsible to know the best practices and to have a system in place that meets the needs of this often vulnerable population.

Over the past several decades, our awareness of the magnitude and the trauma of crime victimization has increased considerably. The costs incurred by society include medical and psychological services to aid victim recovery, the apprehension and disposition of offenders, and the invisible climate of fear that makes safety a paramount consideration in

scheduling normal daily activities. In addition to the monetary costs associated with sexual victimization, the impact of such abuse on the victim has been well documented.[6,7]

This chapter reviews the social and political forces in place in the 1970s when the antirape movement began; the impact of rape victimization, which includes the history of rape trauma syndrome and posttraumatic stress disorder; and the development and implementation of victim services, specifically SANE programs and sexual assault response teams (SARTs).

The Antirape Movement: The Beginning

The women's rights movement in the 19th century was focused on the legal recognition of women to secure their rights to vote, to own and control property, and to participate in public affairs. In the 20th century, the movement focused on confronting restrictions on women's personal lives. Analysis of these restrictions began in ***consciousness-raising groups*** (CR), a new organizing tool of the women's movement whereby women discussed their experiences and the problems of being female in a modern society. Often described by men as hot beds of radical feminism, the reality was that simply attending such a discussion group was the most assertive act many of these women were capable of taking. Within the supportive environment of the CR groups, women found the courage to share private experiences never before shared, such as incest and rape.[8]

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

Police departments and rape crisis centers first began to address the crime of rape in the early 1970s when little was known about rape victims or sex offenders. The issue of rape was just beginning to be raised by feminist groups. The 1971 New York Speak-Out on Rape was held. Susan Brownmiller wrote the history of rape and urged people to deny its future.[9] The general public, however, was not particularly concerned about rape victims. Few academic publications or special services existed, funding agencies did not see the topic as important, and health policy was almost nonexistent.

The antirape movement began to attract women from all walks of life and political persuasions. Various strategies began to emerge, one of which was the self-help program now widely known as the "rape crisis center." One of the first such centers was founded in Berkeley in early 1972, known as Bay Area Women Against Rape (BAWAR). Within months of the opening of the Berkeley center, similar centers were established in Ann Arbor, Michigan; Washington, DC; and Philadelphia, Pennsylvania. Hospital-based rape counseling services began in Boston and Minneapolis.[10] Centers were soon replicated, and services flourished. Although volunteer ranks tended to include a large number of university students and instructors, they also included homemakers and working women. The volunteer makeup usually reflected every age, race, socioeconomic class, sexual preference, and level of political consciousness. Volunteers were, however, exclusively women. The most common denominators were commitments to aiding victims and bringing about social change.[8,10] As Susan Brownmiller noted, the amazing aspect of the proliferation of the grassroots women's groups was that such an approach to the problem of rape had never been suggested by men—that women should organize to combat rape was a result of the women's movement.[9]

In retrospect, the history of the rape crisis centers in the United States has been one of enormous struggle. The struggle was to overcome indifferences, apathy, changing social

trends, and the lack of stable resources, yet the struggle was willingly undertaken from the belief in the rightness of the cause—a cause that, despite the struggles, had its share of successes. Feminists identified a social need and a way of responding to it. Rape crisis centers began to adapt their services to assist other crime victims, specifically battered women and their children. Although they never reached the goal of eradicating rape through social change, they were the instigators of social change essential to the rights of women.[8,10]

Rape Law Reform

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

United States' criminal rape laws were derived from British common law. Three elements needed to be proved in cases of rape: (1) sexual contact, (2) force/coercion or lack of consent, and (3) the identity of the assailant. In addition, most state laws today consider the sexual assault a more serious crime, because it carries more severe penalties when penetration (however slight) occurred, the victim was injured, a weapon was used, or the victim was under the age of consent. It varies by state. Two influential legal theorists were 17th-century jurist, Lord Chief Justice Matthew Hale, and the Edwardian-era scholar, John Henry Wigmore. Hale's belief that rape was "...an accusation easily made, and hard to be proved, and harder to be defended by the party accused, though ever so innocent" was reflected in both American jury instructions and standards of proof.[11] Similarly, Wigmore's concern about sexually precocious minors and unchaste women who fantasize about rape gave rise to the corroboration doctrine and influenced such practices as the routine polygraph examination of victims.[12] Though neither man's assertions were supported by empirical data, they received widespread endorsement by legal bodies. As a result, US law reflected a concept of rape as a sexual rather than a violent offense and imposed a vast array of safeguards against false accusations by the turn of the 20th century.[13]

The need for rape law reform was clearly noted by women's rights movement participants who encouraged former victims to speak publicly about insensitive and indifferent treatment they experienced in the criminal justice system. These disclosures fostered recognition for systematic change that women activists felt must begin with the law itself. Movement activists organized to develop a rape law reform agenda, solicit public support for reform, and present their case to state legislators. The political climate was favorable to these citizen-initiated efforts, but it was a growing presence of women and sympathetic men within the legal and lawmaking professions that reduced most of the resistance to change. As evidenced by the radical shift in the concept of unacceptable behavior, a review of rape law reform by Largen suggested, among other things, that in most states, social concepts of sexual assault were changing more rapidly than legal concepts.[13] Politicians also recognized the need for more research on the impact of rape on the victim and the development of programs to meet apparent needs.

Congressional Support

Financial help came from Congress. In response to a rising crime rate and growing community concern over the problem of rape, Senator Charles Mathias of Maryland introduced a bill in September 1973 to establish the National Center for the Prevention

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

By the late 1970s, the battered women's movement became an extension of the antirape movement and focused on male violence against domestic partners. Violence emerged as a public health issue with Surgeon General C. Everett Koop's convening of a workshop on violence and public health in 1985. The closing of the National Center for the Prevention and Control of Rape, however, in the late 1980s left a void for funding until 1994. Again, organized efforts were needed to keep rape crisis centers operating and lobbying for government funding. Congress once again recognized violence against women as a national problem in its 1994 passage of the Violence Against Women Act (VAWA) as part of the Violent Crime Control and Law Enforcement Act and by President Clinton's establishment of an Office on Violence Against Women in the US Department of Justice. The National Research Council established a Panel on Research on Violence Against Women in 1995 to fulfill a congressional request to develop a research agenda to increase understanding and control of violence against women. This report highlights the major literature on the scope of violence against women in the United States, the causes and consequences of that violence, the interventions needed for both women victims of violence and male perpetrators, and funding needed to meet research goals.[7]

History and Need for SANE-SART Programs

The impetus to develop SANE programs in the United States began about the same time as the first rape crisis centers were opened—the early 1970s—with nurses, other medical professionals, counselors, and advocates working with rape victims who came for medical care in traditional settings such as hospital EDs. It was obvious to these individuals that the services to sexual assault victims were inadequate, as they failed to meet the standard of care required for other medical patients.[14,15] Rape victims often had to wait 4 to 12 hours in a busy, public area, competing unsuccessfully with the critically ill for medical staff time.[14,16,17] They were often not allowed to eat, drink, or urinate while they waited for fear of destroying evidence.[18]

Emergency department services were inconsistent and problematic. The typical rape survivor faced a time-consuming, cumbersome succession of examiners, some with only a few hours of orientation and little experience. Many doctors and nurses were not sufficiently trained to do the medicolegal exam and were unwilling or unable to provide expert witness testimony if the case went to court.[19] When they had the training to complete the evidentiary exam, staff often did not complete a sufficient number of exams to maintain their level of proficiency.[20-22] Even when the victim's medical needs were met, their emotional needs were often overlooked and they, too, were often blamed by police and others when they made a report.[23]

Often, only male physicians were available to do the vaginal exam.[20] While approximately half of the rape victims in one study were unconcerned with the gender of the examiner, the other half found this extremely problematic. Even male victims indicated they preferred to be examined by a woman, as they were most often raped by a man and

experienced the same generalized fear and anger toward men that female victims experienced.[24] More research is needed, however, to explore gender issues. With the proper skills and awareness, either gender should be able to provide the highest standard of care to victims of violent crimes. The issue likely has more to do with demeanor, sensitivity, and understanding than gender.

Many anecdotal and published reports depict physicians as reluctant to do the rape exam. Key factors that have led to this reluctance include a lack of experience and training in forensic evidence collection[17,19,25]; the time-consuming nature of the evidentiary exam in a busy ED with many other medically urgent patients waiting to be seen[26,27]; and the potential that if they complete the exam they may be subpoenaed and taken away from their work in the ED to testify in court and be questioned by a sometimes hostile defense attorney.[17,18,27] Documentation of evidence was rushed, inadequate, or incomplete because of these factors.[27] Staff physicians in teaching hospitals often assigned residents to do the forensic examinations when they were available; physicians have refused to do the exam.[26] In one case, a rape victim was reportedly sent home without having an evidentiary exam completed because no physician could be found to do it.[28]

As information has become more readily available on the complex medical-forensic needs of rape victims, nurses and other professionals have realized the importance of providing the best ED care possible.[20] For 75% of victims in a study evaluating care received in the ED, the initial ED visit was the only known contact they had with medical or professional support staff.[29] Nurses became aware that while they were often only credited with "assisting the physician with the exam," in reality they were typically doing all of the medical-forensic examination except the pelvic speculum exam.[26,29] It was clear to these nurses that it was time to reevaluate the system and consider a new approach.

Pioneer Sexual Assault Nurse Examiner Programs

To better meet the needs of the sexually assaulted population, SANE programs were established in Memphis, Tennessee, in 1976,[17] Minneapolis, Minnesota, in 1977,[30,31] and Amarillo, Texas, in 1979.[32] Unfortunately, these nurses worked in isolation, unaware of other very similar programs' existence until the late 1980s. In 1992, 72 individuals from 31 SANE programs across the United States and Canada came together for the first time at a meeting hosted by the Sexual Assault Resource Service and the University of Minnesota School of Nursing in Minneapolis. At this meeting the International Association of Forensic Nurses (IAFN) was formed.[24]

Development of SANE programs today is progressing rapidly, especially with the high program visibility afforded by the publication of the US Department of Justice, Office for Victims of Crime (OVC) document, *The SANE Development and Operation Guide*.[33] While only 86 SANE programs were identified and included in the October 1996 listing of SANE programs published in the *Journal of Emergency Nursing*,[24] there are currently nearly 600 SANE programs registered on the OVC grant-funded Web site www.sane-sart.com.[34] The Joint Military Task Force on Sexual Assault (2004) also recognized the need for improved services for members of the Armed Forces and has begun the process of implementing SART teams for every military unit.

The American Nurses' Association (ANA) officially recognized forensic nursing as a new specialty in 1995.[35] SANEs make up the largest subspecialty of forensic nursing internationally. At the 1996 IAFN meeting in Kansas City, Geri Marullo, executive director of ANA, predicted that the Joint Commission on Accreditation of Health Care Organizations (JCAHO) would eventually require every hospital to have a forensic

nurse available.[36] Smugar et al also recommend that the JCAHO or legislation require health care providers to meet a higher standard of care.[5] SANE-SART programs have raised the standard of care for victims of sexual assault, but this standard is typically not being met in facilities that do not have SANE nurses.[37]

The Role of the SANE and SAFE

Since forensic nurse examiner programs began and functioned independently until the founding of IAFN in Minneapolis in 1992, different terminology has been used across the country to define this new role. At the October 1996 IAFN annual meeting held in Kansas City, the SANE Council voted on the terminology it wanted to use. The overwhelming decision was to use the title "SANE"—Sexual Assault Nurse Examiner. A SANE is a registered nurse (RN) who has advanced education in the forensic examination of sexual assault victims. In programs where physicians are also used, the more inclusive term of Sexual Assault Forensic Examiners (SAFE), or Forensic Examiners (FE) is typically used. Advanced education in sexual assault forensic evidence collection is vital.

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

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

While SANEs are not advocates, they do provide the rape survivor with information to assist her in anticipating what may happen next, to aid her in making choices about reporting and deciding whom to tell, and to ensure that she is safe and gets the support needed after she leaves the SANE facility. This usually includes a discussion between the victim and the SANE about reporting to law enforcement.

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

Typical SANE-SART Program Operation

To be optimally effective and provide the best service possible to victims of sexual assault, the SANE/FE must function as a part of a team of individuals from community organizations, usually referred to as a sexual assault response team (SART). At a minimum, the SART will include the SANE/FE, advocate, law enforcement officer, and prosecutor. It is important to understand that SARTs can function in a variety of ways, both formally and informally. To be a functioning SART, it is not necessary for all team members to respond to the survivor at the same time. In fact, most SARTs do not function this way. Research that evaluates these models of response is necessary.

There are 2 primary methods of SART operation: the *multiple-initial interview model* and the *single-initial interview model*. In the more common multiple-initial interview

model the SANE is available on call, off premises, 24 hours a day, 7 days a week. The on-call SANE is paged immediately whenever a sexual assault or abuse survivor enters the community's response system. If a rape advocate is available, the staff or SANE will also page the advocate on call. During the time it takes for the SANE to respond (usually no more than one hour), the ED or clinic staff will evaluate and treat any urgent or life-threatening injuries. If treatment is medically necessary, the ED staff will treat the patient, always considering and documenting the forensic consequences of the life-saving and stabilizing medical procedures. Once the SANE arrives, consent for the forensic medical examination is obtained, and the SANE conducts the forensic evidentiary examination. The law enforcement officer either conducts the initial interview before or after the SANE exam is completed.

In the single-initial interview model the SANE/FE, advocate, and law enforcement officer respond together and conduct one joint interview of the victim. Chapter 12 and Chapter 13 address options for effective SART operation in detail and describe the impact SANE-SART programs have had on both treatment of sexual assault victims and prosecution of cases.

The SANE Evidentiary Exam

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

The SANE's forensic medical exams include the following:

— Collection of evidence using a sexual assault evidence collection kit

— Further assessment and documentation for drug-facilitated sexual assault (DFSA)

— Assessment and documentation of injuries

— Risk evaluation and prophylactic care of STIs

— Evaluation of pregnancy risk and EC

— Crisis intervention

— Referrals for medical and psychological follow-ups.

In most agencies, a complete evidentiary exam is conducted for up to 72 hours from the time of the sexual assault, as recommended by the American College of Emergency Physicians,[38] the SANE Development and Operation Guide,[33] and the *National Protocol for Sexual Assault Medical Forensic Exams: Adults/Adolescents.*[39] As DNA recovery techniques improve, some programs have extended this time frame and now collect evidence up to 96 or even 120 hours after the assault. Research is still needed to better evaluate the value of this decision. The publication of *A National Protocol for Sexual Assault Medical Forensic Exams: Adults and Adolescents* was a major step toward encouraging consistent treatment for victims of sexual assault throughout the US.[39] Chapter 4 discusses the SANE/FE exam in detail.

The Psychological Impact of Sexual Assault

The fact that rape occurs and is an act of conquest is documented in the Bible as well as in war annals. It is endemic to humankind and was undoubtedly practiced by cavemen. But in 1972, when Burgess and Holmstrom launched their research, there were very few clinically based articles that dealt with the incidence of rape or the impact of rape

on the victim or family. There was also little information on the offender. While the violent acts and the suffering they caused had been noted since the origins of humanity, few considered these events from a health standpoint.

In the early 1970s, there were 2 common stereotypes of the rapist that, in turn, greatly influenced how the rape victim was viewed. At one extreme, he was regarded as a perfectly healthy, "red-blooded," sexually aggressive, macho male whose offense was simply an extreme product of his cultural conditioning elicited by a provocative and seductive but punitive woman. At the other extreme, he was thought of as a bizarre, demented, oversexed "fiend" filled with lust and perverted desire who stalked his prey at night when the moon was full. In the former situation, the offender was seen as a totally normal individual who was essentially a victim of circumstance; in the latter, he was an inhuman creature whose predatory assaults were his only source of gratification. Both stereotypes reflected the erroneous but popular belief that rape was motivated primarily by sexual desire—the normal desires of a healthy male or the warped impulses of a sex fiend. This mistaken notion was an insidious assumption, for it followed from such a premise that if the offender was sexually aroused, then it must have been the victim who aroused him as it was toward her that these impulses were directed. From that point on, responsibility and accountability for the offense, to a large extent, shifted from the offender to the victim, and she became the accused by police, family, friends, and even herself. In court, it became the central aim of the defense attorney to impeach the victim's credibility by showing that by her dress, conduct, conversation, or behavior she invited the assault and, either deliberately or unintentionally, that she aroused the sexual urges of her assailant. He was seen as the victim of her provocative behavior. Some high-profile cases have continued to foster this notion.

Rape, until the 1970s, thrived on prudery, misunderstanding, and silence. It was not until the 1980s that academic and scientific publications on the subject multiplied. A review of articles on the psychological effects of rape and interventions for rape victims in the posttraumatic period located 78 references between 1965 and 1976, with 36 on the effects of rape and 42 on intervention.

History of Rape Trauma Syndrome

Rape trauma syndrome was one of 3 typologies identified by Burgess and Holmstrom in 1974 and published in the *American Journal of Psychiatry*.[40] The typologies were the result of personal interviews of 146 people who ranged in age from 3 to 73 years at the time of admission to the Boston City Hospital Emergency Department. The individuals were all admitted with the complaint, "I've been raped." Three types of sexual trauma were conceptualized from the sample of 146 and based on consent (or not) to have sex: rape trauma (no consent), pressured sex (coerced sex), and sex stress (initial consent but then denial of consent). Of the 146 individuals, 92 women age 18 to 73 years were classified as rape trauma victims, and their responses to the assaultive experience formed the basis for the rape trauma syndrome. These women were interviewed at the emergency ward of the hospital and followed 4 to 6 years later in regard to the problems they experienced as a result of being forced into nonconsensual sex.[41]

One of the conclusions reached by Burgess and Holmstrom as a result of studying 92 adult rape victims was that victims suffer a significant degree of physical and emotional trauma during a rape. This trauma can be noted immediately following the assault and over a considerable time period afterward. Victims consistently described certain symptoms that included flashbacks; intrusive thoughts of the rape, fear, anxiety, nightmares, and daymares; and development of phobias. A cluster of symptoms that

most victims experienced was described as the rape trauma syndrome. This syndrome has 2 phases: the immediate or acute phase, in which the victim's lifestyle is completely disrupted by the rape crisis, and the long-term process, in which the victim must reorganize this disrupted lifestyle. The syndrome includes physical, emotional, and behavioral stress reactions that result from the person being faced with a dire threat to life or integrity.

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

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

The Burgess and Holmstrom study was twofold, with a clinical focus on victim response and an institutional focus. The study made clear that rape does not end with the assailant's departure; rather, the profound suffering of the victim can be diminished or heightened by the response of those who staff the police stations, hospitals, and courthouses. Ironically, the institutions that society has designated to help victims may in fact cause further damage.[42] The clinical findings from the Burgess and Holmstrom study were published and used by rape crisis staff as well as mental health staff.

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

History of Psychological Trauma

Rape trauma syndrome preceded the term *posttraumatic stress disorder* (PTSD) by 6 years. When the American Psychiatric Association's Work Group on Anxiety Disorders was considering how to classify a number of traumatic events (eg, combat stress, natural disasters, rape trauma), it decided to make PTSD an umbrella term under which the various life-threatening events could fall.[43]

The term PTSD came into the official nosology of the American Psychiatric Association in 1980 with the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).[43] The history of the development of this term is believed to date back to an account of Merlin of King Arthur's court. He was said to be have been a wild man who went away to live alone in the woods for some years because he was affected by the sounds and sights of terrible battle. He avoided people and lived as a hermit for several years, only to return refreshed and with his special powers. In 1666, Samuel Pepys described his intense emotional reaction to having observed the London fire.

The theme of traumatic memories haunting people after experiencing overwhelming terror has been used in literature from Homer to Shakespeare's *Macbeth.* By the late 1850s, Briquet suggested a link between the symptoms of hysteria and childhood histories of trauma. During this time, a small Anglo-Saxon literature emerged documenting responses to accidents (eg, "railway spine" after train accidents) and war trauma ("soldier's heart"). The relationship between trauma and psychiatric illness, however, only began to be explored in the last two decades of the 19th century when neurologist Charcot lectured on the functional effects of trauma on behavior.[44]

Charcot's student Pierre Janet undertook one of the first systematic studies of the relationship between trauma and psychiatric symptoms and delivered a major paper at the Harvard Medical School in 1906. Janet realized that different temperaments predisposed people to deal with trauma with different coping styles. He coined the term "subconscious" to describe the collection of memories that form the mental schemes that include the person's interaction with the environment. He suggested it was the interplay of memory systems and temperament that made each person unique and complex.[44]

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

There are 4 main criteria of PTSD symptoms. A diagnosis of PTSD requires the presence of all categories of symptomatic responses:

1. ***Reexperiencing the trauma:*** flashbacks, nightmares, intrusive memories, and exaggerated emotional and physical reactions to triggers that remind the person of the trauma.
2. ***Emotional numbing:*** feeling detached, lack of emotions (especially positive ones), loss of interest in activities.
3. ***Avoidance:*** avoiding activities, people, or places that remind the person of the trauma.
4. ***Increased arousal:*** difficulty sleeping and concentrating, irritability, hypervigilance (being on guard), and exaggerated startle response.

There have been several revisions to the PTSD diagnosis.[43,45] The last major revision was the fourth edition ("DSM-IV"), published in 1994, although a text revision was produced in 2000. The fifth edition ("DSM-V") is currently in consultation, planning, and preparation, and is due for publication in May 2012.[43,45]

Terminology

Rape or Sexual Assault?

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

He or She?

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

Victim or Survivor?

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

SANE or SAFE?

Because today the majority of medical practitioners with advanced training in sexual assault management and evidence collection are nurses, we will primarily use the term SANE. When we refer to the SAFE, we are also referring to a non-nurse, usually a physician or physician assistant, who has also had advanced training in sexual assault management and evidence collection.

Sexual Assault Response Team

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

Role of Nursing

Nursing is and will continue to be a major player in the trauma field. The antirape movement helped catapult nursing to the status of a major provider of health care services to victims of abuse. The Joint Commission on Accreditation of Health Care Organizations has suggested that, in the future, forensic nurses be staffed in EDs. The requirement to educate nurses in the fundamentals of forensic science was firmly established in 1997 when the JCAHO published its revised standards for patient assessment. The guidelines required that all staff members be educated to identify victims of abuse, violence, and neglect, and be able to collect and safeguard physical evidence associated with a known or potential criminal act.[46] It opened doors for nurses to develop interdependent relationships with other health care providers, initiate courses and programs of research in victimology and traumatology, influence legislation and health care policy, provide expert testimony in criminal and civil legal cases, and define the new specialty of forensic nursing. However, sexual violence still affects hundreds of thousands of women's and children's lives each year, and health care professionals could be even more influential in case finding and treatment of trauma as well as in designing research and outcome protocols for the interventions aimed at preventing abuse and decreasing the number of victims. Such interventions must target the perpetrators or potential perpetrators of sexual assault. The foothold of skilled investigator nurses in EDs and their preparation for collecting and presenting evidence as well as testifying in judicial proceedings is a major contribution. The advance of the nurse to become a certified SANE-A or SANE-P has firmly established a forensic nursing role.