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Adult Sexual Assault Survivors' Experiences With Sexual Assault Nurse Examiners (SANEs)

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Abstract

Sexual assault survivors often feel traumatized by the care received in traditional hospital emergency departments. To address these problems, Sexual Assault Nurse Examiner (SANE) programs were created to provide comprehensive medical care, crisis intervention, and forensic services. However, there is limited research on the actual experiences and emotional impact of sexual assault survivors who seek treatment from SANEs. This qualitative study examined twenty rape survivors' experiences with forensic nurse examiners of a Midwestern SANE program. Findings suggest that SANEs provided survivors with care and compassion, clear explanations, and choices. Taken together, these positive experiences were perceived as "humanizing". However, some survivors perceived forensic nurses as hurtful when they were not provided with choices, explanation, and/or acted cold and distant. Implications for future research on SANE care and practice are discussed.

Keywords

sexual assault, adult victims, intervention

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Sexual assault is a widespread social problem that affects between 17% to 25% of women in their adult lifetime (Fisher, Cullen, & Turner, 2000; Koss, Gidycz, & Wisniewski, 1987; Tjaden & Thoennes, 1998, 2006) and is associated with multiple negative outcomes, such as psychological distress, physical health problems, repeated victimization, and difficulties in life functioning (Campbell, Dworkin, & Cabral, 2009). Unfortunately, most sexual assault survivors do not seek medical help to address their physical and psychological needs (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Ullman, 1996a, 1996b, 2007; Ullman & Filipas, 2001a). When survivors do seek medical care, they are often first directed to the emergency department (ED) for forensic evidence collection (Martin, 2005; Resnick et al., 2000).

Hospital care for sexual assault survivors, however, has not always been commonplace. Prior to the rape crisis movement, sexual assault survivors were often denied treatment in hospitals (Ledray & Arndt, 1994), and it was not until 1992 that the Joint Commission for the Accreditation of HealthCare Organizations made it mandatory for hospitals to develop and implement official procedures for the treatment of victims of abuse (McFarlane, Greenberg, Weltge, & Watson, 1995). The development of specific protocols to help rape victims were intended to make recovery easier, but unfortunately, many problems emerged with this treatment model. As sexual assault survivors do not typically have physical injuries, they are not perceived as an "emergency" and oftentimes wait 4 to 10 hr before being treated. During this time, survivors are often told to not drink, eat, or urinate before being seen by a physician to prevent any evidence from being destroyed (Littel, 2001). Furthermore, ED personnel often lack specialized training in treating sexual assault survivors, decreasing the likelihood that they be treated in a sensitive and respectful manner (Ledray, 1992a; Lenehan, 1991; Littel, 2001). As a result, many survivors leave hospitals feeling more depressed, anxious, blamed, and reluctant to seek further help (Campbell, 2005, 2006; Campbell et al. 1999, 2001; Campbell & Raja, 1999).

Such negative incidents within the traditional hospital ED system are examples of sexual assault survivors experiencing "secondary victimization" (Campbell, 2008; Campbell & Raja, 1999; Madigan & Gamble, 1991; Martin & Powell, 1994), which has been defined as "the victim-blaming attitudes, behaviors, and practices engaged in by community services providers, which further the rape event, resulting in additional trauma for rape survivors" (Campbell et al., 2001, p. 1240). In their interactions with health care providers, survivors are often blamed or questioned about their victimization and do not routinely receive recommended care, such as pregnancy testing, contraceptives, or information on STDs (Ahrens et al., 2000; Campbell, 1998;

Campbell & Bybee, 1997; Campbell et al., 1999, 2001; Taylor, 2002). Some survivors experience secondary victimization to a greater degree, where women of lower SES and/or ethnic minorities have a harder time obtaining help, and victims of nonstereotypical rapes (e.g., date rape) experience more victim-blaming questioning (Campbell, 2008).

In light of these problems, new approaches for sexual assault patient health care have emerged. One widely implemented alternative model are Sexual Assault Nurse Examiner (SANE) programs. Since the development of the first SANE program in 1974 (Ledray & Arndt, 1994), today there are well over 500 programs throughout the United States (International Association of Forensic Nurses, 2008). Most SANE programs are hospital based, but approximately 10% are in stand-alone community sites (Campbell et al., 2005). SANEs are trained in forensic evidence collection, specialized techniques and equipment, and the treatment/prevention of STDs and pregnancy. SANEs are also trained to provide crisis intervention that enables them to properly respond to victim's emotional needs and provide referrals for counseling and medical follow-up (Ledray, 1997; Taylor, 2002).

Most of the research on SANE programs has focused on the legal and forensic aspects (see Campbell, Patterson, & Lichty, 2005 for a review), while there has been comparatively less work conducted on how SANEs attend to survivors' emotional needs following an assault. Although there is no research to date examining the long-term impact of SANEs' quality of care on survivors, the existing research has found that they do have short-term positive impact on survivors' psychological well-being. In the earliest study, Malloy (1991) surveyed 70 rape victims and found that 85% identified their nurses listening to them as the one thing that helped them the most during their crisis period. To date however, only two studies have examined SANEs' role in postassault well-being more extensively. In a qualitative study on sexual assault patients' experiences with a Canadian-based SANE program, Ericksen et al. (2002) found that rape victims felt respected, safe, in control, believed, supported, cared for, informed, and felt that they could get support after leaving the program. Although this study provided a preliminary in-depth understanding about survivors' positive experiences, it remains unclear *how* these positive experiences impacted survivors and *why* they are important for recovery. Ericksen et al. (2002) also focused on understanding survivors' experience with nurses who served as advocates, not nurses who were forensic examiners. As it is not clear how these survivors felt about the *forensic* nurses, this study cannot make claims about their exclusive role.

More recently, Campbell, Patterson, Adams, Diegel, and Coats (2008) conducted a quantitative study on sexual assault survivors' experience with

SANEs. Similar to Ericksen et al. (2002), they found that rape victims felt that the nurses were compassionate, caring, and listened to them. These survivors also felt that their concerns were taken seriously, were provided clear instructions for medications, given explanations of the exam, and felt that they could contact the program if they had any future concerns. Most survivors also felt like they were in control during the exam and did not feel pressured to continue with prosecution. Although this study was able to provide some insight as to how SANEs may affect the well-being of rape survivors, there are several questions left unanswered. First, these findings may not have captured all the experiences (positive and negative) survivors had with forensic nurses. Second, this study did not examine how secondary victimization may be prevented by the quality of care provided by forensic nurses.

Taken together, although both studies present important information regarding survivors' experiences, there is limited understanding on how forensic nurses play a role in emotional well-being and recovery. Although the current work on SANEs suggests that victims have positive experiences with these programs, less is known about how forensic nursing care may help or hinder postassault recovery and how they may prevent or further secondary victimization. Having a clearer understanding of these experiences can provide validating evidence for SANEs regarding the importance of emotional care *and* forensic expertise in victim recovery. The purpose of this qualitative study was to understand adult sexual assault survivors' experiences with SANEs during their forensic examination. Specifically, what did survivors perceive as helpful and/or hurtful to their postassault recovery during their interactions with the forensic nurses, and to what extent did survivors encounter secondary victimization while being treated?

Method

Participants

This study is part of a larger project on SANEs impact in the criminal justice system (Campbell, Bybee, Ford, Patterson, & Ferrell, 2009). The target sample for this study was adult female sexual assault survivors who (a) were 18 years of age or older at the time of the assault; (b) were victimized in the focal county; and (c) received an exam by the SANE program between September 1999 (opening date of program) to June 2007 (Campbell et al.,2009). The focal SANE program is community based in a medical clinic facility rather than a hospital emergency department. Each sexual assault patient is cared

for by one forensic nurse and one sexual assault victim advocate. At the time of data collection, there were six forensic nurses who provided care for the vast majority of adult cases. These nurses were White females, with an average age of 46 years, range of 30 to 55 years old. Fifty percent have an associate's degree and the other 50% have a bachelor's degree. These nurses had on average 6.75 years experience specifically in forensic nursing (ranging from 5.5 to 9 years).

Two recruitment strategies were used to identify the target population: prospective sampling and community-based retrospective purposive sampling. For prospective sampling, the focal SANE program agreed to adjust their existing patient paperwork to include a form requesting participation in evaluation research. This form described the study and asked survivors if they would be willing to be contacted at a later date by the research team regarding their experiences with the SANE program and criminal justice system. Survivors who agreed to be contacted completed a form on how and when they can be safely contacted by the research team. Survivors were contacted by a research assistant 10 weeks later to request participation in the study. Half ($n = 10$) of the participants were recruited through prospective methods.

Retrospective recruitment methods were also used because it was expected that prospective recruitment would not be sufficient to obtain a desired sample size. Furthermore, it is not uncommon for survivors to not be ready to talk about their sexual assault experiences until later in their healing process (Campbell, Sefl, Wasco, & Ahrens, 2004). Therefore, we used community-based retrospective methods to recruit "older" cases (i.e., as early as 1999) that have gone through the same SANE program. We conducted wide-spread dissemination of information about the study throughout the community including posting advertisements at local businesses (e.g., grocery stores, hair salons), public transportation, community-wide mailings, and postings in human and health service agencies including the rape crisis center. This strategy allowed survivors to decide privately whether to contact the research team (see Campbell et al., 2004 for more discussion of this methodology). If survivors decided to contact the research team, they were screened for eligibility, and then scheduled for an interview. Half ($n = 10$) of the participants in this study were recruited through this method. Participant recruitment and interviewing continued until the sample size allowed for data saturation, where the same themes were repeated and no new themes emerged among participants (Morse 1994; Starks & Trinidad, 2007). A sample of 20 participants is a reasonable size for a qualitative study examining phenomenon in-depth (Creswell, 2007; Sandelowski, 1995).

Procedures

Interviews were conducted in-person at the administrative office of the rape crisis center affiliated with the focal SANE program by three interviewers (the PI and two research assistants). The interviewers were trained by the PI on strategies for building rapport and increasing the victims' comfort during the interviews (see Campbell, Adams, Wasco, Ahrens, & Sefl, 2009 regarding the interviewer training program). Ongoing weekly meetings were held to review interview transcripts and discuss emerging themes and logistical problems to address in subsequent interviews. Interviews ranged from 1.5 to 4 hours in length, with an average of 2 hours. The interviews were tape recorded with the permission of participants and then transcribed. Participants were paid US$30 and given a resource packet of local services. The procedures used in this study were approved by the Institutional Review Board of (Michigan State University).

Measures

The semi-structured interview protocol was developed in four stages. First, the interview was adapted in part from a prior study, which was codeveloped with advocates, sexual assault survivors, and community personnel (see Campbell et al., 2001). This helped identify appropriate phrasing of questions so that they were comprehensible and supportive to survivors. Second, the literature on medical and legal system personnel's interactions with victims was reviewed and used to inform the interview protocol. Third, key legal and medical personnel in the focal county were consulted on the content of the interview protocol and revised accordingly. Finally, the interview was pilot tested with five sexual assault survivors (not included in the sample) to assess the content and probes, and provide an opportunity for the research assistants to receive additional training on qualitative interviewing.

The interview consisted of four main topics: (a) the rape itself and initial disclosures; (b) victims' experiences with SANE; (c) the role of forensic medical evidence in victims' decisions to prosecute; and (d) victims' experiences with law enforcement, prosecutors, and judicial proceedings. In this manuscript, we present data regarding survivors' experiences with the forensic nurse examiner.

Data Analyses

Data analysis consisted of a two-phase process. First, consistent with Strauss and Corbin's (1990) method of "open coding" which involves, "breaking

down, examining, comparing, conceptualizing, and categorizing data" (p. 61), two analysts read the transcripts independently and identified a preliminary list of themes mentioned by participants. The analysts compared these themes, discussed and clarified the meaning of the thematic codes, and revised the coding framework until there was consensus. The second phase included "pattern coding" (Miles & Huberman, 1994; Saldana, 2009). Pattern codes are explanatory codes that further identify an emerging theme into more meaningful unit of analysis. Pattern coding involves taking the initial thematic framework that was identified during the first phase and searching for causes and explanations in the data (Saldana, 2009). The two analysts discussed, compared, and revised their explanatory codes to reach final consensus. Reliability and validity were maximized through several verification strategies, including sampling adequacy, triangulation (i.e., multiple analysts) to reduce interpretive bias and reach consensus on themes, and working in an iterative process whereby collecting and analyzing data occur simultaneously to inform the creation and modification of themes (Morse et al., 2002; Patton, 2002).

Results

The majority of sexual assault survivors were White (85%) and were assaulted by someone they knew (80%), with an average age of 28 years (ranging from 18 to 53 years). Few assaults ($N = 2$) involved the use of a weapon, but 60% of survivors suffered physical injuries and 40% suffered from anogenital injuries. Finally, 50% of the survivors made a report within 2 hr of the assault. The method of recruitment was unrelated to participants' experiences with SANE or when they sought help from the program. Most survivors (75%) sought help from SANE during 2006 and 2007 (regardless of recruitment method), making it less likely that there were any differences due to organizational changes within the program.

Survivors identified three main aspects of SANE care that they found particularly helpful: (a) they were provided a clear and thorough explanation of the exam process and findings; (b) they were given choices during the exam; and (c) they were treated with care and compassion. Because of these helpful responses, many felt that their overall experience with SANEs was "humanizing" and facilitated their emotional recovery. However, there were some survivors who noted three hurtful or unhelpful things about SANE, including the following: (a) not providing enough explanation of the exam process or findings; (b) not giving enough options or choices; and (c) acting in a distant and cold manner. First, the positive experiences with forensic nurses and their role in fostering survivors' emotional healing will be presented. Then,

the negative experiences with forensic nurses and how this impacted survivors' healing process will be discussed.

Positive Experiences With SANEs

Thorough explanations. One of the most common positive experiences cited by survivors was how nurses provided thorough explanations during the exam. This included being told what would occur prior to the exam, why each procedure was being done, and describing any visible injuries. Having this amount of explanation was important for rape survivors who just went through an extremely invasive assault, helping them feel more informed, comfortable, and in control of their bodies. Being thorough and clear also made survivors feel like the nurses were doing their jobs effectively and it made them feel validated when the nurses described visible injuries. For some, being told that there were visible injuries was like "proof" that the assault occurred and may help in prosecution:

> That's part of the reason [that I continued]. I am because I had evidence towards it . . . Because that will just show that he did things to me, and I have proof.
> I: Why is proof important?
> Because that's what people need in the world is proof.
> I: Let's say that when the nurse did the exam, that there wasn't any proof, there was no tearing, which does happen for some women. If there was no proof, do you think that would [affect] whether or not you wanted to press charges?
> I think that it would have changed, yes, because I don't think I would have believed that I had a good chance . . . . (18- year old assaulted by a coworker)

The notion of "proof" was used in future interviews to gain a better understanding of what visible injuries meant to survivors:

> Yeah, she said that, you know, she seen the cuts where he grabbed me and she saw them. She said I looked a little irritated down there, um, that's about it.
> I: When she told you that she noticed, you know, signs of irritation and things like that, how did that make you feel in terms of, I guess, I don't know if it is the right words, validating what happened and showing kind of like proof? Did you see it as proof?

Yeah, I did.
I: Can you explain to me like how you felt, like what did you think about it as proof?
I just was happy that she had found something, she had found the stains and put towards as evidence. Something that could help with the case. (26-year-old survivor raped by a stranger)

In the focal SANE program, medical forensic exams are conducted within 96 hr of the rape and because of their invasive nature; it is often difficult for survivors to be examined so soon after the assault. A forensic exam can therefore be very distressing and perceived as a second attack on the survivor's body. However, the survivors that were interviewed said this secondary trauma was alleviated as a result of the nurses being very open and honest about what was going to happen every step of the way:

It is really uncomfortable to begin with, especially after what happened and I'd rather know what they are doing and why they are doing it, then you know . . . I thought more informed of what was going on. I didn't feel so like I was in the dark about everything, you know. (24-year-old survivor raped by her boyfriend)

Choices. Survivors also reported that it was helpful when nurses provided them with choices, such as whether or not they wanted to continue or if they would be okay with certain parts of the exam. By providing choices, nurses demonstrated their patience and respect, making survivors feel more comfortable. This is seen in the following excerpt:

It made me like more comfortable with them [forensic nurse and advocate] and able to talk about what was happening and just, you know, if there's any part you don't want to do you don't have to do whereas the cops were like well you, you know, you gotta tell us everything. They weren't giving me, like, the option of slowing it down and like just tell us everything and were gonna go from there. Whereas the forensic nurses were like, OK, you gotta tell me what happened. We gotta know what, you know, play by play what happened. Just take your time talking about it so that we can, you know, take the proper steps in your exam to find everything that we can. (21-year-old survivor raped by her boyfriend)

Several survivors experienced secondary victimization with law enforcement, such as being asked to retell their stories numerous times and being

questioned impatiently about the details of the assault. For these survivors, going to SANE and being provided with choices for the first time after their assault made them feel like they were in control.

> They were very careful, caring people. They made sure you had everything you needed. If you didn't want to talk, you didn't have to. They didn't make you do anything you didn't want to do. Of course, they're all women. (23–year-old survivor raped by a stranger)

Care and compassion. Another common theme is that the nurses treated survivors with compassion and took their needs and concerns seriously. For these survivors, it was important for nurses to do their jobs as forensic experts (i.e., collecting evidence) while treating them with care. Survivors perceived nurses as caring and compassionate because they validated their experiences, reassured them it was not their fault when they would blame themselves, tried to make them as comfortable as possible, and were personable (e.g., asking what name they would like to be called, talking about everyday life, using humor appropriately). This level of care and compassion expressed by most of the survivors played a critical role in making them feel safe and validated, which is shown in the following two excerpts:

> It just seemed like their arms were open, were wide open, and if you needed a hug, they'd give you hug. If you needed somebody to hold your hand, they'd hold your hand. If you had any questions, they'd answer your questions, and they would be honest and not try to hide behind euphemisms or just patronize you or pat you on the back, and say, "You're fine now. Go away." They were very, in fact after it was over, they asked me if I needed to lay down before I went, you know, and did whatever I had to do next. So, it did really make me feel safe . . . One of the things that I'm really glad of it that they did right away, started putting the idea in my mind that I'm not a victim. It was his fault. I didn't do anything to deserve that. (53-year-old survivor raped by a neighbor)

> When she [forensic nurse] said she was on my side. It was terrible what he did to me . . . Because I was happy when people actually believed me. You can't like stress that enough 'cause I was so scared at the time.
>
> I: Why were you so scared? I hear that a lot from a lot of women so I just wanted to ask. What were you scared of?

> I just didn't think like, people would sit there and say like, they don't know what it's like, and they don't believe that they would know somebody like that, so it's like, it made me feel good that people actually believed me . . . (18-year-old survivor raped by a coworker)

Humanizing. Because forensic nurses showed care and compassion, provided choices, and explained things carefully, survivors felt respected. Rape is dehumanizing, whereby perpetrators treat their victims as objects to control, rather than as human beings. SANE nurses have the opportunity to restore victims' humanity that was taken away during the assault, and this "humanizing" experience seemed to be instrumental in facilitating victims' recovery. Many survivors contacted law enforcement prior to being referred to the SANE program and had negative experiences (e.g., asking them about the assault in detail, treating them like "just another case"). For several of these women, SANEs were often the first formal support providers who treated them like "real" people. At SANE, they felt respected, safe, and able to begin the healing process, as is described in the following two excerpts:

> Up until that time, it would have just been formalities, collecting evidence, the police doing that, and it was the first time (at SANE) where I felt like human after going through such a horrendous experience and made to feel I was just a bitch in heat . . . or a pig being led to the slaughter. It's right away, that it starts the healing. And people like the advocates and the nurse examiner, they . . . make you feel like they're more interested in you, in helping you cope with what happened, and that makes it easier, too, because they're looking at you like a person . . . I didn't feel like another body on a slab. (53-year-old survivor raped by a neighbor)

> When I walked in the doors it was the first time I felt safe. It was the first time I felt like I wasn't being violated more. I was kind of struck because they cared without wanting me to want them to care . . . It was very odd at first. Because all of a sudden I felt like I could drop my guard and the minute I did I started to cry . . . when I walked in there they made it very clear that they would make sure that I was okay and that I could stay there as long as I wanted. (41-year-old survivor raped by her ex-husband]

Besides being dehumanized during the assault, several rape victims experienced secondary victimization in the hands of other formal medical system

personnel. Although most of the survivors went to SANE as their sole medical care, some initially went to the emergency department when they did not report to the police immediately and/or were not aware of the SANE program. Unlike SANEs, survivors felt that hospital personnel oftentimes did not respect them. Being treated like a "human being again" can also help survivors continue on with the next steps in their case, such as prosecution, as this survivor explains:

> You've just gone through an experience where you have been treated like animal, and it's very dehumanizing, and being treated like a human being again, is, it's one of the most beneficial things, I would say, because you're not feeling human, especially so soon after the situation. You're not feeling like a human being.
> I: And feeling human helps you be able to get through it?
> It helps you get through the whole process . . . because by the time you get to court, then you go through the whole thing again . . . The respect that they give you, and the humanizing qualities that they try to bring to the situation, it makes it easier to take each small step at a time . . . so that by the time you get to court, you're ready to testify . . . (53-year-old survivor raped by a neighbor)

Negative Experiences With SANEs.

Eight of the survivors interviewed stated that their nurses acted in ways that were unhelpful. However, it was rare for any one survivor to have had an entirely negative experience. That is, seven of the eight survivors who mentioned negative experiences had mixed (both positive and negative) experiences with their nurses, while only one had a primarily negative experience.

Cold and distant. Three survivors stated that the nurse examiner was cold and distant. For instance, while the following survivor did not regret going to SANE, she felt that the nurse acted in a routine manner:

> I mean I don't want to say she wasn't compassionate or anything . . . this was just so routine for her. For me, this really wasn't. I was crying . . . I would say more like the evidence collection. It was, you know . . . She got all her stuff out, and you know, it was really pretty bizarre. I've never been through anything like that in my life . . . And so, it was more of a business type thing, you know, like, and she was trying to hurry and get me out of there, too, so . . . Yeah. She wasn't rude about it. She was just trying to get it done. (32-year-old survivor raped by her long-term partner)

When negative experiences did occur, it was hurtful to the survivors who expected and needed supportive care, as is seen in the following excerpt:

> It was okay . . . She gave me all the medicine I needed so that I wouldn't get nothing. She just didn't explain the things that I felt I should know. I just thought maybe she was, I don't know, maybe she doesn't like her job . . . She just didn't care. I don't know. I can't really explain it. She just, she was cold . . . She just made me feel like she just wanted to do her job, and go back home. That's all she talked about, how she had to get out of bed. (19-year-old survivor raped by her male friend)

The fact that some nurses acted in a somewhat cold and distant manner made these survivors feel uncared for and as if the nurse was simply there to do her job and leave.

No explanation. Four survivors mentioned that their nurse did not give them enough explanation about the exam procedures or findings. As previously mentioned, the narratives suggest that survivors felt that their sense of control and dignity were taken away during the assault. Those who were provided with thorough explanations felt more informed and in control of their bodies, both of which are important for healing. As is seen in the following excerpts, when this did not occur, survivors felt in the dark:

> They just said they were gonna perform a rape kit. They took pictures of my bruises, and then, it was just like a regular exam at the doctor's, kind of.
> I: So they only explained that they were gonna do a rape kit, they didn't really get into any details about it?
> [no]
> I: Ok. Do you feel like before you had the exam, it would have helped to know a little bit more about what the exam was?
> Probably
> I: Having gone through the exam, what do you think would have been useful for you to know?
> I just wish they would have explained everything that they were doing, and what they were doing it for . . . They didn't even tell me what was going on. I don't know if it was 'cause she was tired . . . . (19-year-old survivor raped by her male friend)

Likewise, not being told about what is found during the exam not only makes survivors feel less informed, but may also leave a survivor confused. This following excerpt comes from a survivor who explains how she felt when she wasn't told whether there was any evidence or injuries from the assault:

> You start to doubt yourself as far as like, well what really happened, like did I have like a really bad dream. Like sometimes you have dreams that you wake up and you think, oh like that happened and you don't know the difference between reality and your imagination just told you and so, yeah you start to doubt yourself. And then when you tie in like go through some kind of therapy and then you kind of think, well maybe I don't have a problem and maybe I'm not messed up and but you really are. And so, yeah, I think it would have been nice if someone had told me, you know, yeah, you were violated. But I mean, I had already known that, I kind of just, I guess it didn't bother me, but yeah, I think, there is a big believing factor. If people don't believe you, you feel even more hurt by that because it is like, like why don't you go through that and why don't you tell me how you feel about it. So, yeah, I think that's the way things are, you know, it could have been nicer, but it didn't really affect my experience. (20-year-old survivor raped by an acquaintance)

It is important for sexual assault survivors to be believed and have their experience validated by formal support providers (Ahrens, Cabral, & Abeling, 2009; Campbell, 2008). When nurses do not provide any explanations about possible injuries or the absence of injuries, survivors may begin to second guess themselves. Although the survivor quoted above did not feel that this impacted her experience in a completely negative way, she would have preferred to have some kind of validation from the nurse. Likewise, survivors wanted to know what was happening to their bodies during the exam at all times. Those who were not provided step by step explanations of the exam felt uncomfortable and uncertain about what to expect and if any injuries were actually found.

No choice. Six survivors felt that having the exam did not feel like a choice or that they were not given the option for certain exam procedures, making them feel upset and frustrated. Letting survivors know that the exam is their choice and giving them all their options is also important to help them regain control. The following excerpt is from a survivor who did not feel that she had total control of the exam:

I don't understand why I had to go through that part of it, then they had to brush my hair, which, this comb, you know, I literally had like scabs and stuff on my head from having so much hair pulled out. I didn't want my hair brushed. It wasn't like there was a stranger. They didn't have to find DNA on my body because it was, you know, I just didn't understand all that.

I: Did you feel like you had a choice?

No, not for the most part. You know, you're out getting pictures taken again, and you know, you're very uncomfortable, very degrading on you. I mean, she didn't make me, she wasn't like belittling me or anything. I'd just been through enough. I just wanted to go home, and I still had to go to the hospital after there. I was a wreck. (32-year-old raped by her long-term partner)

Lack of choice during the exam process can be very hurtful to survivors. As the previous excerpt highlights, lack of choice is not conducive to an already uncomfortable and invasive exam.

Discussion

SANEs are specially trained to provide forensic medical treatment with compassion and care. Therefore, they have the unique opportunity to prevent and/or alleviate the secondary victimization that sexual assault survivors are likely to have already endured in other formal systems. Although this study did not assess postassault psychological outcomes (e.g., depression, PTSD), it did provide an in-depth examination of how sexual assault survivors' positive experiences with SANEs may promote recovery and emotional well-being. Similar to Campbell et al. (2008) and Ericksen et al. (2002), patients stated that the positive and helpful aspects of SANE care were to provide compassion, choices, and clear explanations. Our study expands on these prior findings in that we now have a preliminary understanding about *how* these positive experiences with forensic nurses may impact survivors' healing process. The positive emotional care provided by forensic nurses made survivors feel safe, respected, and "humanized." It was not simply that forensic nurses were collecting evidence to help further their case—it was about the manner in which it was done that seems to have impacted their coping and emotional well-being.

Several patients also perceived a difference once they entered the SANE program. Those who had negative experiences with law enforcement and traditional EDs stated that they no longer felt that they were being

disrespected or treated like another "case" or "body on a slab." Being treated like a human being and given the choice over what happens to them during the exam helped them regain a sense of control and made them feel more confident in taking the next steps to recovery. A few survivors stated that this also helped them feel more confident to seek justice if they chose to go through prosecution. It was clear that these survivors felt relieved that a medical professional was much more than an "evidence collector." Instead, SANEs were also able to provide them with the emotional support needed to heal. In this sense, SANE's goal of reinstating dignity and preventing secondary victimization was being realized for most of the survivors in this study.

This study also presented what some survivors perceived as unhelpful interactions with their forensic nurses. Although these survivors did not regret going to SANE and found them helpful overall, they also felt that they were not provided with enough explanation, choice, and/or had nurses who were cold and distant. After an assault, survivors are likely to feel confused, scared, and may sometimes blame themselves (Campbell et al., 2009). Once they enter the system, they are likely to first contact the police and/or a traditional ED. Many survivors who entered these systems prior to SANE described it as dehumanizing, leaving them more confused, scared, and lacking control. For those survivors who felt that SANEs were not able to provide them with choices or thorough explanations of what was happening during the exam, the secondary victimization already experienced from these other systems may have been exacerbated with the negative experiences with SANE. These survivors continued to feel a lack of control of their bodies, felt unsure about what was happening during the exam, and felt that their experience as a victim was not validated. As a result, their ability to regain control and maintain the dignity needed to start the healing process seemed to have been hindered while at SANE.

What can be learned from the negative experiences described by some of these survivors? The current findings bring more attention to the emotional component in SANE practice and its impact on survivors' well-being. Nursing practice within the SANE model is not the only nursing field where human dignity is paramount. The American Nurses Association states, "a fundamental principle that underlies all nursing practice is respect for the inherent worth, dignity, and human rights of every individual" (2001, p. 3). Therefore, what is primarily important for recovery is the maintenance of respect and dignity while a patient is being treated and cared for by a nurse. In a recent study by Matiti and Trorey (2008), hospital patients describe how dignity includes being treated with respect, given choices, and control over their treatment. Lack of these important qualities in nursing care disrupts the

healing process. Furthermore, Matiti and Trorey suggest that dignity is a subjective concept perceived by the patient. It is up to the nurse to pay attention to how dignity is to be maintained given the unique needs of their patients. Applying this to SANEs, it is important for forensic nurses to understand that sexual assault survivors are a unique population of patients where the reinstatement of control and dignity is even more crucial to recovery. Unlike other patients (e.g., cancer patients), sexual assault patients are victims of abuse, where they have been devalued and disempowered. Given this, it is reassuring that the majority of survivors in this study felt respected, in control, and valued as a result of being cared for by their forensic nurses.

Overall, this study was able to provide a deeper understanding of SANE practice from the perspective of sexual assault survivors. Whereas previous research has provided a basic understanding of SANEs' role in survivors' well-being, this study was able to expand on *how* certain caring practices may help a victim recover and prevent further trauma, and how some negative practices may impede the healing process. Furthermore, as part of the larger project on SANEs impact on the criminal justice system, the six nurses were interviewed about their philosophy on victim reporting and the role of patient care on victims' participation in prosecution. Consistent with the positive experiences explained by survivors, the findings suggest that forensic nurses believe that their primary role is to provide medical care and help patients regain a sense of control by providing options (see Campbell et al., 2009 for additional details).

The negative findings regarding survivors' experiences with SANEs should be taken with caution. This study was conducted on a relatively small sample ($N = 20$) of sexual assault survivors who were treated by one community-based SANE program in the Midwest. Therefore generalizations cannot be made about SANE nursing practice nationwide. Individual nurse differences also may contribute to the various survivor experiences. However, given that these forensic nurses did not vary greatly (e.g., years in nursing profession, age, education, and so forth), it cannot be concluded that these factors made a significant difference. Future research on the emotional care of SANEs should be conducted on a larger sample in diverse settings (i.e., other cities, hospital-based programs, and so forth) from the perspectives of both survivors and nurses.

This study was also able to add to the body of knowledge regarding SANE practice. Prior research has suggested that there is an inherent conflict in the forensic nurse role, where one has to negotiate between being the comforter and evidence collector (Cole & Logan, 2008). Although nurses understand and value the concept of "care," attending to patients' needs is difficult and

complex because it is expected that nurses provide emotional care along with technical competence in a seamless process (Bassett, 2002; Bolton, 2000). Given that forensic nurses have the unique role of collecting evidence which may be used in criminal investigations, the balance between remaining "professional" and "caring" may be more difficult because they are required to maintain objectivity (Cole & Logan, 2008). The current study suggests that survivors perceived the emotional *and* forensic care to be beneficial to their well-being. Although this balance may be difficult for nurses (Cole & Logan, 2008), SANEs should include more emotional care practice (e.g., validation, compassion, choice) within their professional training as it is likely to promote recovery. Because many survivors experience negative treatment within other formal systems prior to receiving care from SANE, it is important for forensic nurses to understand systemic trauma and to appreciate their role in helping to reduce further secondary victimization through their emotional labor.

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References

Ahrens, C., Cabral, G., & Abeling, S. (2009). Healing or hurtful: Sexual assault survivors' interpretations of social reactions from support providers. *Psychology of Women Quarterly, 33*, 81-94. doi:10.1111/j.1471-6402.2008.01476.x

Ahrens, C., Campbell, R., Wasco, S., Aponte, G., Grubstein, L., & Davidson, W. (2000). Sexual Assault Nurse Examiner programs: Alternative systems for service delivery for sexual assault victims. *Journal of Interpersonal Violence, 15*, 921-943. doi:10.1177/088626000015009002

American Nurses Association. (2001). *Code of ethics for nurses with interpretive statements* [Brochure]. Silver Spring, MD: Author. Retrieved from http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.aspx

Bassett, C. (2002). Nurses' perceptions of care and caring. *International Journal of Nursing Practice, 8*(1), 8-15. doi:10.1046/j.1440-172x.2002.00325

Bolton, S. C. (2000). Who cares? Offering emotion work as a "gift" in the nursing labour process. *Journal of Advanced Nursing, 32*, 580-586. doi:10.1046/j.1365-2648.2000.01516

Campbell, R. (1998). The community response to rape: Victims' experiences with the legal, medical and mental health systems. *American Journal of Community Psychology*, *26*, 355-379. doi:10.1023/A:1022155003633

Campbell, R. (2005). What really happened? A validation study of rape survivors' help-seeking experiences with the legal and medical systems. *Violence & Victims, 20*(1), 55-68. doi:10.1891/vivi.2005.20.1.55

Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems: Do rape victim advocates make a difference? *Violence Against Women, 12*(1), 1-16. doi:10.1177/1077801205277539

Campbell, R. (2008). The psychological impact of rape victims. *American Psychologist*, *63*, 702-717. doi:10.1037/0003-066X.63.8.702

Campbell, R., & Bybee, D. (1997). Emergency medical services for rape victims: Detecting the cracks in service delivery. *Women's Health, 3*, 75-101.

Campbell, R., Bybee, D., Ford, J.K., Patterson, D., & Ferrell, J. (2009). *A systems change analysis of SANE programs: Identifying mediating mechanisms of criminal justice system impact*.Washington, DC: National Institute of Justice.

Campbell, R., Dworkin, E., & Cabral, G. (2009). An ecological model of the impact of sexual assault on women's mental health. *Trauma, Violence, & Abuse, 10*, 225-246. doi:10.1177/1524839008334456

Campbell, R., Patterson, D., Adams, A., Diegel, R., & Coats, S. (2008). A participatory evaluation project to measure SANE nursing practice and adult sexual assault patients' psychological well-being. *Journal of Forensic Nursing, 4*(1), 19-28. doi:10.1111/j.1939-3938.2008.00003

Campbell, R., Adams, A.E., Wasco, S.M., Ahrens, C.E., & Sefl, T. (2009). Training interviewers for research on sexual violence: A qualitative study of rape survivors' recommendations for interview practice. *Violence Against Women, 15*, 595-617.

Campbell, R., Patterson, D., & Lichty, L. F. (2005). The effectiveness of Sexual Assault Nurse Examiner (SANE) program: A review of psychological, medical, legal, and community outcomes, *Trauma, Violence, & Abuse, 6*, 313-329. doi:10.1177/1524838005280328

Campbell, R., & Raja, S. (1999). Secondary victimization of rape victims: Insights from mental health professionals who treat survivors of violence. *Violence & Victims, 14*, 261-275. Retrieved from http://www.springerpub.com/journal.aspx?jid=0886-6708

Campbell, R., Sefl, T., Barnes, H. E., Ahrens, C. E., Wasco, S. M., & Zaragoza-Diesfeld, Y. (1999). Community services for rape survivors: Enhancing psychological well-being or increasing trauma? *Journal of Consulting and Clinical Psychology, 67*, 847-858. doi:10.1037/0022-006X.67.6.847

Campbell, R., Sefl, T., Wasco, S. M., & Ahrens, C. E. (2004). Doing community research without a community: Creating safe space for rape survivors. *American Journal of Community Psychology, 33*, 253-261. doi:10.1023/B:AJCP.0000027010.74708.38

Campbell, R., Townsend, S. M., Long, S. M., Kinnison, K. E., Pulley, E. M., Adams, S. B., & Wasco, S. M. (2005). Organizational characteristics of Sexual Assault Nurse Examiner (SANE) programs: Results from the National Survey of SANE Programs. *Journal of Forensic Nursing, 1*(2), 57-64. Retrieved from http://www.wiley.com/bw/journal.asp?ref=1556-3693

Campbell, R., Wasco, S. M., Ahrens, C. E., Sefl, T., & Barnes, H. E. (2001). Preventing the "second rape": Rape survivors' experiences with community service providers. *Journal of Interpersonal Violence, 16*, 1239-1259. doi:10.1177/088626001016012002

Cole, J., & Logan, T. (2008). Negotiating the challenges of multidisciplinary response to sexual assault victims: Sexual Assault Nurse Examiner and Victim Advocacy programs. *Research in Nursing & Health, 31* (1), 76-85. doi:10.1002/nur.20234

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: SAGE.

Ericksen, J., Dudley, C., McIntosh, G., Ritch, L., Shumay, S., & Simpson, M. (2002). Clients' experiences with a specialized sexual assault service. *Journal of Emergency Nursing, 28*, 86-90. doi:10.1067/men.2002.121740

Fisher, B. S., Cullen, F. T., & Turner, M. G. (2000). *The sexual victimization of college women*. Washington, DC: National Institute of Justice, U.S. Department of Justice.

International Association of Forensic Nurses. (2008). Data base of the International Association of Forensic Nurses, Retrieved from http://www.forensicnurse.org

Koss, M. P., Gidycz, C. A., & Wisniewski, N. (1987). The scope of rape: Incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *Journal of Consulting and Clinical Psychology, 55*, 162-170. doi:10.1037/0022-006X.55.2.162

Ledray, L. (1992a). The sexual assault nurse clinician: A fifteen-year experience in Minneapolis. *Journal of Emergency Nursing, 18*, 217-222.

Ledray, L. (1997).SANE program staff: Selection, training, and salaries. *Journal of Emergency Nursing, 23*, 491-495. doi:10.1016/S0099-1767(97)90152-5

Ledray, L. E., & Arndt, S. (1994). Examining the sexual assault victim: A new model for nursing care. *Journal of Psychosocial Nursing and Mental Health Services, 32*(2), 7-12.

Lenehan, G. (1991). Sexual assault nurse examiners: A SANE way to care for rape victims. *Journal of Emergency Nursing, 17*(1), 1-2.

Littel, K. (2001). Sexual Assault Nurse Examiner programs: Improving the community response to sexual assault victims. *Office for Victims of Crime Bulletin, 4*, 1-19.

Madigan, L., & Gamble, N. (1991). *The second rape: Society's continued betrayal of the victim.* New York, NY: Lexington.

Malloy, M. (1991). *Relationship of nurse identified therapeutic techniques to client satisfaction reports in a crisis program* (Unpublished master's thesis). University of Minnesota, Minneapolis.

Martin, P.Y. (2005). *Rape work: Organizations and rape victims*. New York, NY: Routledge.

Martin, P. Y., & Powell, R. M. (1994). Accounting for the "second assault": Legal organizations' framing of rape victims. *Law & Social Inquiry, 19*, 853-890.

Matiti, M. R., & Trorey, G. M. (2008). Patients' expectations of the maintenance of their dignity. *Journal of Clinical Nursing, 17*, 2709-2717. doi:10.1111/j.1365-2702.2008.02365

McFarlane J, Greenberg L, Weltge A, & Watson M. (1995). Identification of abuse in emergency departments; effectiveness of a two question screening tool. *Journal Emergency Nursing*, *21*, 391-394. doi:10.1016/S0099-1767(05)80103-5

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. Thousand Oaks, CA: SAGE.

Morse, J. M. (1994). "Emerging the data": The cognitive processes of analysis in qualitative inquiry. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 22-43). Thousand Oaks, CA: SAGE.

Patton, M. Q. (2002). *Qualitative research and evaluation methods.* Thousand Oaks, CA: SAGE.

Resnick, H. S., Holmes, M. M., Kilpatrick, D. G., Clum, G., Acierno, R., Best, C.L., & Saunders, B. E.(2000). Predictors of post-rape medical care in a national sample of women. *American Journal of Preventive Medicine, 19*, 214-219. doi:10.1016/S0749-3797(00)00226-9

Saldana, J. (2009). The *coding manual for qualitative researchers*. London, UK: SAGE.

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health, 18*, 179-183.

Schaefer, K. M. (2002). Reflections on caring narratives: Enhancing patterns of knowing. *Nursing Education Perspectives, 23*, 286-293. Retrieved from http://www.ovid.com/site/catalog/Journal/241.jsp

Starks, H., & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*, 1372-1380. doi:10.1177/1049732307307031

Strauss A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: SAGE.

Taylor, W. K. (2002). Collecting evidence for sexual assault: The role of the Sexual Assault Nurse Examiner (SANE). *International Journal of Gynecology and Obstetrics, 78*, S91-S94. doi: 10.1016/S0020-7292(02)00051-6

Tjaden, P., & Thoennes, N. (1998). *Prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey* (NIJ Publication No. 183781). Washington, DC: National Institute of Justice, U.S. Department of Justice. Retrieved from http://www.ncjrs.gov/pdffiles1/nij/183781.pdf

Tjaden, P., & Thoennes, N. (2006). *Prevalence, incidence, and consequences of rape victimization: Findings from the National Violence Against Women Survey* (NIJ Publication No. 210346). Washington, DC: National Institute of Justice, U.S. Department of Justice. Retrieved from http://www.ncjrs.gov/pdffiles1/nij/210346.pdf

Ullman, S. E. (1996a). Do social reactions to sexual assault victims vary by support provider? *Violence and Victims, 11*, 143-156.

Ullman, S. E. (1996b). Correlates and consequences of adults sexual assault disclosure. *Journal of Interpersonal Violence, 11*, 554-571. doi:10.1177/088626096011004007

Ullman, S. E. (2007). Mental health services seeking in sexual assault victims. *Women and Therapy, 30*(1-2), 61-84. doi:10.1300/J015v30n01_04

Ullman, S. E., & Filipas, H. H. (2001). Correlates of formal and informal support seeking in sexual assault victims. *Journal of Interpersonal Violence, 16*, 1028-1047. doi:10.1177/088626001016010004

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