Care for the Sexual Assault Patient

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DISCLOSURES

None of the planners or presenters of this session have disclosed any conflict or commercial interest.
Care for the Sexual Assault Patient

• OBJECTIVES:
  • 1. Describe correct language and understand the importance of the use of correct language and terms related to sexual violence
  • 2. Understand the scope of the national health problem related to sexual assault
  • 3. Identify screening techniques and protocols for care of the sexual assault patient
Outline

- Definitions & language
- Brief overview of sexual violence
  - Incidence & prevalence (global and national)
- Theoretical framework to guide practice and research
- Acute care for sexual assault patients
- Primary care considerations
- Resources
Definitions and Language

Importance of clarity and understanding culture/society/ and context
Importance of definitions

“the stories we tell to explain violence against women will be affected in part by how we define and measure it” (Tjaden, 2009)

• 2002 CDC published Version 1.0 of Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements
• 2014 Update of this document – Version 2.0
  • For example the field of SV has recognized alcohol and drugs as a common tactic for perpetrating SV and the importance of distinguishing it from physical forceful tactics
Uniform definitions

- **Sexual violence** - sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse.
  - It includes: forced or alcohol/drug facilitated penetration of a victim; forced or alcohol/drug facilitated incidence in which the victim was made to penetrate a perpetrator or someone else; non-physically pressured unwanted penetration; intentional sexual touching; or non-contact acts of a sexual nature.
  - Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party.
Uniform definitions

- **Consent** - words or overt actions by a person who is legally or functionally competent to give informed approval, indicating a freely given agreement to have sex or sexual contact.

- **Inability to Consent** - freely given agreement to have sexual intercourse or contact could not occur because of the victim’s age, illness, mental or physical disability, being asleep or unconscious, or being too intoxicated through their voluntary or involuntary use of alcohol or drugs.
Uniform definitions

- **Inability to Refuse** - disagreement to engage in a sexual act was precluded because of the use or possession of guns or other non-bodily weapons, or due to physical violence, threats of physical violence, intimidation or pressure, or misuse of authority.

- **Penetration** - involves physical insertion, however slight, of the penis into the vulva; contact between the mouth and penis, vulva, or anus; or physical insertion of a hand, finger, or other object into the anal or genital opening of another person.
Definitions of involved parties:

- Victim or survivor
- Perpetrator
- Intimate partner
- Family member/ not intimate partner
- Person in position of power, authority, trust
- Friend/ acquaintance- Ex: coworker, neighbor, roommate, classmate, first date with someone you know before and after
- Person Briefly Known- someone who is know to the victim very briefly. Ex: someone just met, blind date, or just met at a bar or party
- Another Non-stranger- Ex: someone in the neighborhood, maintenance people, customer, clerks, someone met online
- Stranger
Ambiguity in definitions

- Difficulties in defining experiences might be reflected in the reporting rates as one of the multifaceted components of underreporting.
- Difficulties in research or clinical care.
- Difficulties with labeling.
- Understanding of what happened.
- Different definitions for different people.

- In a college population (N=1401): “has anyone ever had sex with you after you told or showed them you didn’t want to?” 10.4% “yes”, 86.2% “no”, 3.4% “not sure” (Fontenot & Fantasia, 2010)
Other new definitions - terms associated with circumstances and consequences of violence

- **Control of Reproductive or Sexual Health** - Includes controlling or attempting to control a partner’s reproductive health and or decision making. Includes SV behaviors by the perpetrator that increases the risk for STD or other adverse sexual health consequences.

  - Ex: not allowing use of birth control, coerced pregnancy terminations, forced sterilization because of abuse
Other new definitions- terms associated with circumstances and consequences of violence

- **Sexual Trafficking**- recruitment, harboring, transportation, provision, or obtaining of person for the purpose of a commercial sex act.

- Situation must have ONE of the following:
  1. process: recruitment, transportation, transferring, harboring, or receiving
  2. Means: threat, coercion, abduction, fraud, deceit, deception, or abuse of power
  3. Goal: prostitution, pornography, violence/sexual exploitation, or involuntary sexual servitude
MA law

• (C265, S.22) “Whoever has sexual intercourse or unnatural sexual intercourse with a person and compels such person to submit by force and against his will or compels such person to submit by threat of bodily injury, shall be punished by imprisonment in the state prison.”

• Includes:
  • Any vaginal, anal, or oral penetration by a penis, other body part, or object (however slight)
  • Lack of consent (may be communicated by any verbal or physical sign of resistance; is present when victims is unable to give consent due to age, mental status (i.e. Incapacitation resulting from drug or alcohol intoxication, unconsciousness, severe mental handicap)); threat or actual used of force).

Newer additions: both genders, threat of force
MA law

• (C272:S3) Drugging persons for sexual intercourse
  • “whoever applies, administers to or causes to be taken by a person any drug, matter or thing with intent to stupefy or overpower such person so as to thereby enable any person to have sexual intercourse or unnatural sexual intercourse with such person shall be punished by imprisonment in the state prison for life or for any term of years not less than ten years”
Brief Overview: Sexual Assault &
Sexual Violence

Scope of the problem- focus on U.S.
Health consequences
Scope of SV- U.S

- 8% HS students report forced sex
- Roughly 25% college women report forced sex or attempted forced sex.
- According to National Intimate Partner and Sexual Violence Survey:
  - 1 in 5 women, 1 in 59 men experienced attempted or completed rape at some point in their lives
  - 1 in 15 men reported they were made to penetrate someone during their lifetime
- 60.4% females & 69.2% males were first raped b/f age 18
  - 25% females & 41% males b/f age 12
- Likelihood of underreporting due to sensitive nature of SV

(cdc, 2014; NISVS, 2010)
NISVS (2010)

Overlap of Lifetime Intimate Partner Rape, Stalking, and Physical Victimization

**Female Victims**
- Rape, physical violence, and stalking: 12%
- Physical violence and stalking: 14%
- Rape and stalking*: 9%
- Physical violence only: 57%
- Stalking only: 3%
- Rape only: 4%

**Male Victims**
- Other Combinations*: 6%
- Physical violence and stalking: 14%
- Physical violence only: 92%

Age at Time of First Completed Rape Victimization in Lifetime Among Female Victims
- 10 years and under: 12%
- 11-17 years: 30%
- 18-24 years: 37%
- 25-34 years: 14%
- 35-44 years: 5%
- 45 years and older: 2%
Scope of the problem- MA

- This is data from the SANE Program (2011)
  - THOSE PATIENTS SEEN IN THE ER ONLY- SANE sites only
  - Cases 604 in ED, ages 10-24= 336 cases (56%)
- NISVS (2010), MA findings (life time experiences)
  - NISVS= national intimate partner and sexual violence survey
  - 1 in 2 women, 1 in 4 men will experience sexual violence other than rape
  - 1 in 3 women, 1 in 5 men in MA experienced rape, physical violence and or stalking by an intimate partner
  - 1 in 7 women in MA were raped
U.S.- SV Reporting

- 70% of women will discuss the assault with another, most likely a friend
- **Reporting to authorities is very limited ~ 4%**
- Increase in report to police or authorities if: perpetrated by a stranger, higher level of physical force used, resistance, definitive lack of consent present
- Majority of assault are a known assailant- acquaintance or seen person before.
- Need to edu population about assault and rape
What is drug-facilitated sexual assault?

- **Alcohol #1.** Alcohol use by perpetrators with intent to stupefy has become the most common form of rape drugging
- GHB
- Rohypnol (a benzodiazepine)
- Ketamine
- Soma
- Sedative hypnotics
- The effects of these drugs are quick and powerful, especially when combined with Alcohol
- Often render victims unconscious, no memories, only an awareness that they were assaulted
Health consequences of sexual violence

- Stress
- Digestive disorders
- Sleep disturbance
- Eating disorders
- Anxiety
- PTSD
- Gyn dysfunctions
- Substance abuse

- Suicide
- Pregnancy
  - Miscarriage, PTL, LBW
- STIs
- HIV*
- Chronic pelvic pain
- Head aches

- Also associated with repeat victimization for females and perpetration in males
Other consequences/ sequelae

- College students: **loss of academic success** and risk for loss of future professional success
- Personality altered- trust issues, guilt, shame, guarded, paranoid, suspicious, emotional numbness
- Work difficulties
- Parenting difficulties- fear, overprotective, depression impaired responses to children- responsiveness, sensitivity, energy
- Spirituality difficulties
- Intimacy issues- difficulty with trust, self esteem, power, control, safety, confusion with boundaries
Theoretical perspectives to guide practice and research

Feminist perspective: A broad theoretical approach
Feminist perspective

- Feminism incorporates many ways of knowing and has enhanced research by illuminating female experiences and perspectives.
- Helps us understand concepts and forces such as power, language, oppression, gender, and patriarchal social structures.
- Gender and power are highly associated with violence.
- Now... Global women’s movement concerns of focus: addressing poverty, poor health, consequences related to globalization of women and the rise of fundamentalism (Murray 2008 - global fund for women).
Feminism and Violence

- **Involve the patients** and ask how they might facilitate meeting the needs of that particular individual.
- Understand that **each person is unique** and may need varied care to ultimately achieve the goal of returning the victim to a path of health and healing.
- Provides opportunity for the **victim to regain some control** by helping make decisions, by establishing readiness for any part of an exam, and by being given as much time as needed to process the current events during the examination time.
- **Understanding the power differentials**, perspectives, and **giving voice** to the individual is a crucial aspect of feminist care.
- Victims of violence have experienced a huge loss of power and by providing feminist focused care practitioners are **redirecting the power and helping to return it to the individual**.
Acute Care:

In the US:

What are SANEs?

Massachusetts Standards
Sexual Assault Nurse Examiner

- Certified forensic nurses who specialize in the care of **men** and **women** who may have been sexually assaulted.
- **Do not determine whether a sexual assault has occurred**, they collect evidence.
- **Adult/Adolescent SANEs** care for any victim age 12 and older. Victims under 18 are emancipated minors (meeting this criteria because of potential for pregnancy and STDs). Parents do not have to be notified of SANE examination nor can they force an exam.
- Properly obtain evidence while coordinating comprehensive care.
- **95% successful prosecution rate** with SANE testimony in MA.
SANE

- Provide forensic care within 5 days (120 hrs) post assault including:
  - Full body forensic exam and documentation
    - Trained in forensic photography
  - Limited pelvic forensic exam
  - Medications
  - Coordination of care for other RNs, MDs, and law enforcement if desired by victim

- SANE will facilitate contact with Police if desired
- Will offer as appropriate Toxicology screen (per case basis)
- Exam may take 3-5 hrs
The evidence and stories collected by SANEs are for legal documentation, can and will be used in court.

If case is reported then this Kit is opened and evidence is processed.

If foreign DNA is found then this can be matched to a known assailant or run through a CODIS system for unknown assailants.

SANE would provide legal testimony in a court of law.

Kits are kept by the crime lab for **6 months** if over 18 years of age—only processed if case is reported to police. Kept for 15 years if < 16.
Pediatric sexual assault - Pedi SANE

- Pediatric SANE: Children < 12 years.
  - Mission- compassion, coordinated, comprehensive, child-centered, culturally sensitive
  - Over riding principle DO NO HARM
  - MA first state to develop a Pediatric Evidence Collection Kit
  - Kits and all care done at the Children’s Advocacy Center
The medical staff, nurses, and SANEs are NOT the people who determine whether or not an assault has occurred. That is left to the criminal Justice System to decide.
Who Pays?

- Forensic Examination, emergency charges, and medications can be paid for by the state.
- A victim does not have to report the crime to receive this benefit.
- In MA: file as self pay, get paperwork from hospital, SANE, or BARCC to file. Then send the bill to the Office of Victims Compensation and Assistance.
- Does not cover mental health or lost wages but if report crime additional assistance is available.
- 2009 all states will have to pay for Jane Doe rape kit. Funding thru the federal Violence Against Women Act.
Patient controls exam

- Power returns to the patient
- Patient gives consent and is made aware of each step in examination
- Patient is made aware that they do not have to complete or participate in any portion of the exam if they do not wish
- Patient can stop the exam at any time
- Goal to empower and not re-victimize
Consider special populations

- Children & Adolescents
- Men
- Pregnant women
- Prisoners
- LGBTQ
Documentation Do’s and Don’t’s

- “Alleged” - implies your subjective suspicion
- “Rape” - legal term you are unable to determine this
  - May use Quote and we recommend this
    - Patient states, “I was raped”
- “Refuses” - implies lack of cooperation
  - Instead use “Unable to tolerate” or “Patient declines”
- “No weapons used, no injury evident” do not document what did not happen, only what did happen
- “Intercourse” - implies consent
  - Use the word “Penetration”, “Penetration of ____”
- Do not document the patients sexual history! It is not relevant to the legal case or evidence collection at this time
Important points to remember

- Do not call the police unless the patient consents
- You are not making a medical diagnosis, there are not differentials
- Believe the patient
- Treat with care to avoid re-traumatization
- Visual signs of injury is not present in a majority of cases! This does not mean that assault did not occur!
Mandatory Reporting

- PSCR - Provider sexual crime report
  - MA State police and the local public safety authority (where crime occurred)
- 51A - Children under age 18
- 19A - Persons age 60 and older
- 19C - Disabled persons 18-59
Medications post sexual assault
Factors associated with risk of acquiring an STD following assault

- Underlying prevalence of STDs
- Type and site of assault
  - Presence of mucosal trauma
- STD involved
- Number of assailants
Empiric treatment

- Reasons to treat empirically:
  - Follow-up maybe poor after sexual assault
  - Give all in 1 dose if possible
  - Infection acquired during assault may not be established immediately
Meds to consider post assault

- **Plan B** (emergency contraception) - Works by inhibiting fertilization and/or ovulation. Must be given within **120 hours** post assault, give in one dose
  - Ceftriaxone **250 mg IM** (Gonorrhea)
  - **Azithromycin 1gm pill** (Chlamydia)
  - **Metronidazole 2gm pill** (Bacterial Vaginosis/Trichomamnosis)
  - Tetnus Booster (depending on circumstances)
  - Hepatitis B Vaccine (college students should already have had)
  - HIV Prevention medication - (if assault w/in **72 hrs**, and depending circumstances)
  - Consider Antiemetics - (above meds may cause N/V)
  - **Initiating or recommend HPV vaccine** (males and females ages 9-26)
HIV post exposure prophylaxis (PEP)

- Exposure has to be **within 72 hrs** for HIV PEP
- Decision to use is made on a **case by case basis**. Provider and patient- make together after consideration of risks and benefits
- Primarily used in occupational exposure- studies shown 79% decrease in # of workers who seroconverted
- Considerations: known HIV status of assailant or assailant risks (drug use- IV drug use), **unprotected penile penetration** (oral, vaginal, or anal***), **genital injuries involving blood**, threats or suggestions that assailant is positive
- Would need follow up with infectious disease generally within 3 days for additional meds and testing. This is done with what ever hospital starts the med. All hospitals have a system for F/U.
## Exposure Risks (HIV positive source)

<table>
<thead>
<tr>
<th>Exposure Type</th>
<th>Risk Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percutaneous (blood)</td>
<td>0.3%</td>
</tr>
<tr>
<td>Mucocutaneous (blood)</td>
<td>0.09%</td>
</tr>
<tr>
<td><strong>Receptive anal intercourse</strong></td>
<td>1 - 2%</td>
</tr>
<tr>
<td>Insertive anal intercourse</td>
<td>0.06%</td>
</tr>
<tr>
<td><strong>Receptive vaginal intercourse</strong></td>
<td>0.1 – 0.2%</td>
</tr>
<tr>
<td>Insertive vaginal intercourse</td>
<td>0.03 – 0.14%</td>
</tr>
<tr>
<td>Receptive oral (male)</td>
<td>0.06%</td>
</tr>
<tr>
<td>Female-female orogenital</td>
<td>4 case reports</td>
</tr>
<tr>
<td>IDU needle sharing</td>
<td>0.67%</td>
</tr>
<tr>
<td>Vertical (no prophylaxis)</td>
<td>24%</td>
</tr>
</tbody>
</table>

Primary care:

Considerations for practice:
Focus of primary prevention
Screening for violence
Considerations for primary care providers
Screening for violence

- Validates violence as a Health Care issue
- Identifies those at risk
- Opens a dialogue
- Provides an opportunity for education
- “Plant a seed”
- Provides services for those at risk
- Conduct a safety/lethality assessment
- Conduct incidence and prevalence studies that may be used for a needs assessment (support groups, interventions, education etc.)
Screening tools

- Many screening tools exist, each with its own strength and limitations. Each of these tools are short, easy to administer, score, and sufficiently sensitive to elicit info regarding potential or actual abuse.

- SVAWS - Severity of Violence Against Women Scale - reliability testing

- HITS scale, WAST, Women’s Experience with Battering Scale - all validated in the family practice settings

- Conflict Tactics Scale - used for Clinical Screening, research, identifies women experiencing IPV

- AAS - has been adapted to screen women with disabilities, Spanish speaking, pregnancy. Content and criterion related validity. Widely used.

- Campbell’s Danger Assessment - screening about escalating abuse and danger.
Barriers to screen

- Inadequate preparation and education
- Providers believing IPV does not affect their patient population
- Time constraints
- Discomfort with the subject and assessing danger
- Lack of belief in usefulness of screening
- Inadequate rapport with patient
- Personal history of abuse
- Fear of being offensive or endangering patients
- Lack of effective interventions, resources, protocols, support staff, or confidence in the legal system
- Lack of knowledge or access of screening tools
- Belief that only physical violence is legitimate health concern
- Belief that it is a private issue and patients should come forward on their own
- Dilemma of caregiver abuse of an elderly or disabled person
- Language and cultural differences
Screening tool box questions for adolescents:

- Does your boyfriend or girlfriend:
  - Talk openly with you when there are problems? Give you space and time with friends and family? Act supportive and respectful?

- Does your boyfriend or girlfriend:
  - Control where you go, what you wear, or what you do? Try to stop you from seeing or talking to family or friends? Call you derogatory names, put you down, or criticize you? Threaten or scare you? Hit, slap, push, or kick you? Force you to do something sexual when you don’t want to?
Considerations for primary care visits:

- **Encourage and educate about risk reduction:**
  - Become comfortable with talking about sex and sexual behaviors with your patients
  - Encourage safe sex and safe sexual behaviors
  - Screen for and educate patients re: forced and unwanted sex
  - Discuss safety in groups, bar safety, alcohol safety for at risk populations
  - Review what rape and assault is (definitions) and where to seek help
  - Discuss supportive environments and need for counseling (family included)
  - Eliminate myths and blaming culture
  - Discuss need for clear consent for any sexual encounters- both sexes!
Considerations for patient visits:

- **IF Chief Complaint of SA in Primary Care:**
  - When working as a PCP - consider straight referral to ED for chief complaint of sexual assault within 120 hrs. Do not change clothes, wash, brush teeth.
  - If charting do not make judgments or inferences. Use factual info on appearance and behavior. IE: disheveled, eyes puffy/swollen, restless, pacing, avoiding eye contact, soft-spoken, flat affect, jumpy, apprehensive, fearful, tears, on edge, ect…
  - Use body maps when charting.
  - Never do cultures immediately post event, **treat as exposed** (for ages 12 and older)
  - Pediatric patients refer to ED/ Children’s Advocacy Centers- medications may be different
  - Always refer to counseling
  - **Always assess safety and develop safety plans!**
Resources
Resources

- Sexual Assault Unit Advocacy Services of the Suffolk county DA’s office 617-619-4350
- Attorney General’s Office, Victims Compensation 617-727-2200, ext 2595
- Victim and Witness Assistance Board 617-727-5200
- Boston Area Rape Crisis Counseling (BARCC) 1800-223-5001 hotline, 617-492-6434
Resources

- National abuse hotline 1-800-4-a-child
- www.safeyouth.org
- www.stopbullyingnow.hrsa.gov
- www.cdc.gov
- National center on elder abuse: www.ncea.aoa.gov
- Jane doe
- Child at risk hotline 1800-792-5200 (MA)
- Department of disabled persons protection commission, hotline 1800-426-9009 (MA)
Resources

- National Clinicians’ Postexposure Prophylaxis Hotline (PEPline)
  - 888-448-4911
  - http://www.ucsf.edu/hivcntr

- Needlestick!
  - Web-based tool to manage BF exposures
  - http://www.needlestick.mednet.ucla.edu

- Hepatitis Hotline
  - 888-443-7232
  - http://www.cdc.gov/hepatitis

- CDC reporting (HIV seroconversions and PEP failures)
  - 800-893-0485

- HIV/AIDS Treatment Information Service
  - http://www.hivatis.org

- Boston Area Rape Crisis Center Hotline (24hrs)
  - 617-492-RAPE (7273)

- SafeLink: Statewide Domestic Violence Hotline (24hrs)
  - 877-785-2020
Pediatric SANE sites

- Children’s Advocacy Centers: Suffolk, Berkshire, Norfolk, Plymouth, Cape Cod, Essex, Bristol
- 24/7 ED response at Lawrence General Hospital
Contact Info

- Boston Crime lab 617-343-4690, State Police Crime Lab 617-358-3100
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