The ABCs of caring for sexual assault patients
Sexual violence is a prevalent problem in our society. According to the CDC, nearly 1 in 5 women and 1 in 71 men have experienced rape at some time in their lives. Approximately 1 in 20 women and men have experienced sexual violence other than rape, and 13% of women and 6% of men experience sexual coercion some time in their lives. With such statistics, the probability that you’ll encounter at least one sexually assaulted patient during your career is high.

According to the U.S. Department of Justice, sexual assault is defined as “any type of sexual contact or behavior that occurs without the explicit consent of the recipient.” This includes “forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape.” You may think, “I don’t work in the ED” or “I’m never going to work psych,” but it’s important to have an understanding of how to deal with the emotional aspects of sexual violence and a practical approach to caring for the sexually assaulted patient.

The ABCs of care
Becoming comfortable with the care needs of sexual assault patients starts with the ABCs. Let’s take a closer look.

Appearance
Sexual assault patients don’t always appear as expected. You may see patients arriving with physical trauma, whereas others may “look fine” but report that they were raped. You must cast judgments aside and view the patient as a human being experiencing physical and emotional trauma.

What’s the image that comes to your mind when picturing a sexual assault patient? Do you think of a bruised woman with torn clothing crying in the exam room? Do you picture a young woman dressed provocatively smelling of alcohol? What about a patient who’s relaxed, smiling, and even giggling while recounting being raped? Or how about a young man who won’t make eye contact while telling you of his suicide attempt? All of these scenarios may be correct.

Patients may appear battered or shell-shocked, bearing multiple injuries from fighting off the assault. Injuries can range from scratches, contusions, and bruises from attempted choking to fractured bones and extensive vaginal or rectal injuries. However, some patients may have no apparent injuries. Additional signs and symptoms of sexual assault may mirror those of posttraumatic stress disorder (PTSD), including exaggerated startle response, hyperarousal, flashbacks to the event, feelings of numbness and detachment, anxiety, and sleep disturbances. Trauma is defined by an individual’s perception of an experience, and his or her response to that event is individualized.

Although the majority of victims are female and the perpetrators most often male, don’t make the assumption that only men are perpetrators of sexual violence and only
women are the victims—a woman may also be the aggressor against a man or another woman or a man may be assaulted by another man. However, many men who experience sexual trauma often don’t report the incident. It’s easy for us to overlook the possibility of past trauma as influencing a man’s current response in the hospital or as his reason for presenting for care (see Understanding self-preservation strategies). Men who are sexually assaulted may experience arousal during the event. It’s vitally important to reassure the patient that this was simply his body’s response to stimulation. (This is also true for female sexual assault patients.)

Consult with the patient to determine if a gender preference of caregiver exists. Because men have a significantly low assault reporting rate, enlist the help of victim advocates in referring these patients to appropriate counseling resources at the time of presentation. This referral will assist patients in receiving the support and guidance they need to fully recover.

Avoid victim blaming
When caring for patients exhibiting signs and symptoms of sexual violence, you’ll need to inquire about potential assault history. Avoid adding additional trauma to the situation by carefully monitoring your tone and actions, and avoid anything that may be construed as victim blaming—holding the victim responsible for the assault. Obtain a thorough history, including asking about sexual trauma. Remember to listen to, advocate for, and respect your patient. You should be careful in your choice of words and the questions you ask when obtaining the assault history. Make sure to avoid asking what the patient was wearing at the time of the assault, inquiring about alcohol consumption if the assault occurred in relation to a social event, and making statements inferring that the patient behaved, dressed, or made choices that facilitated the assault (see Drug-facilitated sexual assault). Remember that many victims of sexual violence know their attackers. According to the CDC, the perpetrator may be an intimate partner, a family member, or an acquaintance, such as a friend, neighbor, or coworker among others.

If the patient interprets your questions as being judgmental, not only will you fail to obtain complete information and your relationship with the patient will be damaged, but your ability to fully care for the patient will also be affected. Keep in mind that this is a crucial time for developing a trusting relationship with your patient.

Behavior
Although you may expect sexual assault patients to be crying, hysterical, or shell-shocked, be careful to avoid judging the veracity of the patient’s claim by appearance or behavior. Some victims may be quiet and reserved or extremely talkative and appear excited. Some may even laugh, tell jokes, or comfort their loved ones as a way of coping with the assault. The nurses caring for sexual assault patients should carefully document such behavior because juries may lack an understanding of the complexities of victim response.

In a setting where nurses are busy, adhering to protocols and efficiently performing tasks may be a priority. However, with this population of patients, your responsibility is

Understanding self-preservation strategies
Coping strategies of individuals who’ve dealt with sexual trauma are as varied as the individuals themselves. There’s no doubt that violence impedes quality of life, especially when there’s repeated episodes. A study of men and women who experienced sexual violence revealed that many were diagnosed with depression or engaged in violence or substance abuse. In addition, the victims reported sleep difficulties, appetite disturbances, concentration issues, shame, and feelings of personal failure. Individuals who experience sexual violence seem to make strides toward their recovery when they seek care early and report the trauma, participate in counseling, and have unconditional emotional support from loved ones. Not all victims are successful in recovery; many will struggle with PTSD, substance abuse, and dangerous risk-taking behaviors. In addition, nonconsensual sex has been linked to chronic disease development, such as increased cholesterol levels; increased risk of stroke; and increased risk of heart disease, especially in women.
foremost to advocate for the patient’s needs above the needs of the department. Providing a safe, comfortable environment may mean having only one nurse caring for the patient and taking extra time with him or her.

Also be mindful that asking the patient to undress may be a harder task than with other types of patients and it may be necessary to ease into the exam process, including basic admission procedures such as vital signs. Be aware of your facial expressions and body language because they often convey as much meaning as any verbal communication. Your interaction with the patient should be guided by the three Cs.

Control, compassion, and confidence
Using the three Cs will enable you to provide optimum care while assisting the sexual assault patient to take the first steps toward recovery or continue along their path of recovery.

Of supreme importance is empowering the patient to regain some sense of control. This is accomplished by assisting patients in regaining control of their bodies. Establishing a trusting relationship is always a vital step in the nurse-patient relationship and it’s no different with victims of sexual assault. At the beginning, instruct the patient that his or her permission will be obtained for every part of the treatment, the treatment or exam will be stopped upon request, and it’s his or her choice to report the assault. Because the perpetrator took away control of the patient’s body, this step is vital in starting the patient down the path of recovery. For those patients whose assault occurred in the past, even distantly in the past, performing medical procedures while giving the patient control may avoid stimulating triggers.

Be compassionate. Voice your regret that the attack occurred and your sincere apology that the patient is enduring the situation. Allow your humanity to show while maintaining professionalism. This will reassure the patient that you aren’t blaming the victim.

Drug-facilitated sexual assault
Drug-facilitated sexual assault has become a widespread problem. Substances used to facilitate sexual assault include alcohol, flunitrazepam (also known as rohypnol or the date-rape drug), gamma hydroxybutyrate or GHB, ketamine, MDMA (ecstasy), and carisoprodol. Victims of drug-facilitated sexual assault may report periods of memory loss, loss of consciousness, disorientation, or a feeling “that something happened,” or have awakened in a state of undress or misdress.

These drugs are colorless, odorless, and tasteless, so reassure patients that these substances are undetectable and they shouldn’t feel as if they “should have known.” It’s imperative to obtain a thorough history, listen carefully to the story that the patient shares, and remain nonjudgmental during the telling.

After listening to the patient’s story, if you suspect drugs were used to incapacitate or control the patient, draw blood and send it for screening. Although many think that only women are victims of drug-facilitated sexual assault, men can also be drugged by a perpetrator to incapacitate them or alter their decision-making ability.

What’s a rape kit?
The rape kit, or sexual assault evidence kit, is used to collect evidence from an individual who has been sexually assaulted. This kit is often collected by a SANE (a nurse who has received specialized training in collecting evidence). If the patient requires medical care, such as X-rays or sutures, another practitioner provides the care.

The actual kit may vary slightly by state, but generally includes:
- instructions
- bags for evidence collection
- swabs
- comb
- envelopes
- blood collection devices
- documentation forms.

The examiner will complete a head-to-toe exam, including careful screening of the patient’s entire body. Samples are obtained from the genital and anal regions, and also any area where there’s evidence of secretions that can be tested for DNA. In addition to samples, photos are also obtained. All of the patient’s clothing is collected as evidence. After the exam, the patient is allowed to shower, if available, and may be given clean clothing to wear home.

Evidence can be collected and saved even if the patient is unwilling to press charges. It’s important to note that none of these samples are sent to the hospital lab. The evidence envelopes and swabs are returned to the kit, labeled, and turned over to the police following a chain of command.

Be confident. This confidence will convey to the patient that you believe his or her story, are there to effectively care for the patient, and are skilled in performing
In the ED

Providing care using best practices for sexual assault patients of both sexes is achievable with careful planning and attention. The environment in which you care for these patients strongly influences development of best practices. The ED is the most probable environment in which you’ll encounter sexual assault patients who often present for a forensic exam (rape kit) accompanied by a victim advocate (someone trained to support the victim during the postassault process). See What’s a rape kit? for more information.

Most victim advocates are nonmedical personnel. Their duties include support for the victim and assistance with accessing resources, such as counseling and legal services. Sometimes they’re accompanied by law enforcement; however, reporting of all sexual assault isn’t a mandatory requirement.

If the victim is an adult with decision-making abilities, it’s his or her decision to report the assault to law enforcement. No nurse should make a report to law enforcement officials unless initiated by the victim’s desire to report. Mandatory reporting regulations only apply to sexual abuse and assault of minors, the older adult, and those incapacitated or incapable of making decisions.

In the ED, a sexual assault nurse examiner, or SANE, with specialized forensic training may conduct the forensic exam to collect any available evidence, provide medical treatment, and dispense prophylactic medications for sexually transmitted infections (STIs) and emergency contraception, such as “the morning after pill.” The timing of the assault is crucial in guiding further care because most postexposure prophylaxis guidelines recommend that treatment begin within 72 hours of the assault. For all patients, care must be individualized for their specific needs and according to their medical histories.

For assaults perpetrated by an individual with unknown HIV status, the CDC doesn’t

---

Cognitively or physically impaired individuals

Having a cognitive or physical disability places an individual at increased risk for sexual assault. According to one study, 83% of women with disabilities are assaulted in their lifetimes and more than 50% of deaf individuals are sexually abused. Individuals with a physical disability may be at risk for assault because of an inability to defend themselves. Perpetrators may victimize individuals with communicating disabilities, such as blindness or deafness, knowing that the individual’s ability to report the incident and identify the perpetrator is limited.

Being confined to a bed or wheelchair makes an individual even more vulnerable to abuse. Individuals who are dependent on a caregiver for food, clothing, shelter, finances, medications, and medical care may also be victimized by that caregiver and feel that they have no one to turn to for help. Be vigilant for signs of suspected abuse and refer these patients to social services and law enforcement if appropriate.

Male victims

Male victims of sexual assault are highly underreported, but the CDC reports that 1 in 71 men have been raped. Or put another way, 6% of men have been sexually coerced at some time in their lives. The bottom line? Sexual coercion or assault of men occurs for the same reasons as assault of women: control, humiliation, and power or authority. Male victims of sexual coercion, assault, or rape fall into numerous categories; there’s no “typical” victim.

Large numbers of male victims come from military personnel and prisons, and are assaulted by heterosexual men. One study reported that over 45,000 servicemen have reported being sexually assaulted, usually by senior personnel. Within the male prisoner population, victims tend to be young, White, and first-time offenders. Perpetrators may be prison guards, other personnel, or other prisoners.

the exam. Most important, it communicates to the patient that you’re confident in his or her ability to survive and recover. Stress that the event is now in the past and praise the patient for surviving it. Although the details that the patient shares may be disturbing, it’s important to maintain an attitude of nonjudgmental acceptance. Believing the patient is especially important when he or she expresses some degree of memory loss or loss of consciousness, which may occur during a drug-facilitated assault.
currently recommend the 28-day antiretroviral treatment. Postexposure prophylaxis for STIs usually involves IM ceftriaxone; oral metronidazole; and oral azithromycin or doxycycline, twice daily for 7 days. Again, appropriate medications are prescribed on an individual patient basis.

Until a SANE is available for the exam, regular ED staff should be available to provide the patient with a private exam room and maintain strict confidentiality of the patient’s reason for presenting for care. You should minimize the number of staff members who enter the patient’s room. It’s extremely important for the regular ED staff to refrain from offering the patient anything to eat or drink to preserve any evidence in the event of an oral assault until directed to do differently by the SANE. If a SANE isn’t available for the exam, a rape kit may be collected by a regular ED nurse with the assistance of a physician for certain steps of the exam.

Other care settings
Although ED staff members expect to encounter sexual assault patients at some point in their career, all nurses should be prepared to encounter these patients in various healthcare settings. In offices, patients may present with a complaint unrelated to sexual assault but divulge the event to the practitioner in a confidential setting. These patients are those who are especially fearful of divulging the assault and may only be doing so out of fear of complications, such as contracting STIs or unwanted pregnancy. It’s extremely vital that the nurse encountering this type of patient strives to develop a trusting relationship with the patient so that the assault and potential medical needs can be appropriately addressed.

In one study, investigators concluded that sexual assault patients were less likely to have a primary care physician and routine physicals. Therefore, it’s imperative to engage these patients upon disclosure of the assault and effectively address their medical needs at the time of presentation.

In other healthcare settings, such as on medical-surgical units, nurses may care for patients who experienced sexual assault in the past and are at some point in their recovery. These patients, hospitalized for myriad reasons, may experience triggers of past assault(s) during procedures such as urinary catheterizations, enemas, those requiring application of temporary restraints, and those requiring manipulation of the patient’s genitals. Such triggers may be visual, olfactory, auditory, or tactile in nature. An I.V., a call light cord on the bed, oxygen tubing touching the face and neck, and drains in place are things that we view as a normal part of a hospital stay, but they may feel very threatening to the patient.

There may be things in the environment that we can’t anticipate: a smell, a sound, or the feel of equipment. Once triggered, the patient may experience flashbacks, especially

Sex trade workers
Sex trade workers are at high risk for sexual assault. Although it’s easy to assume that sex workers choose to work in this high-risk industry, we must not forget that many of these individuals are forced to sell their bodies to survive. Trapped and at the mercy of those who control their finances, these individuals are constantly in danger and especially vulnerable to violent sexual acts and exposure to alcohol, drugs, and weapons. Members of this group range from underage young men and women to middle-age adults, and include heterosexual, homosexual, and transgender individuals.

Many are unable to see a way out of their situation and are reluctant to seek help from nurses or police out of fear of prosecution and judgment. When encountering these individuals in various healthcare settings, be especially careful to communicate in a nonjudgmental manner and seize the opportunity to connect them with community resources and services.

LGBTQ community
LGBTQ individuals are at risk for sexual assault within relationships, as well as from heterosexual individuals as a type of hate crime. Transgender individuals may face the greatest risk of violence, which seems to be dependent on the extent to which the individual presents himself or herself.

Teenagers
Another underreported group is youth victimized by other youth. This may be in the form of date rape or assault, which occurs while one or both individuals are under the influence of drugs or alcohol.
if he or she suffers some degree of PTSD from past assault(s).

A common misperception is that a flashback is remembering or recalling the event when, in fact, the individual is reliving the event and may even temporarily lose touch with reality. During this time, be present and reassuring to the patient, and understand that you may need to protect the patient from self-harm.

Obtaining a thorough history of past abuse and assault is imperative when caring for such patients to avoid additional trauma during medical procedures. Histories revealing chronic pain issues may be linked to sexual assault history. Some patients speak of “body memories” in which the stress of the memory is experienced as a physical complaint, such as chronic pelvic pain, migraines, sleep disorders, gastrointestinal problems, lightheadedness, dyspareunia (painful intercourse), and autoimmune disorders.

**Overcoming discomfort**

**Sexual assault patients deserve the same high-quality care as all patients. However, many nurses struggle to care for this patient population because of their own discomfort with the situation. Overcoming personal discomfort and uncertainty when caring for sexual assault patients is possible for all nurses to achieve using some very simple steps.**

**Avoid expectations about the stereotypical appearance of victims. Be aware that sexual assault patients don’t all behave in a predictable manner. This will positively influence your ability to develop a trusting, therapeutic relationship with the patient. Provide care while giving patients control of their bodies, which is vital to the recovery process. Use compassion and confidence to color your interactions and avoid inflicting additional harm. Be aware that drug-facilitated sexual assault is a growing problem and know the signs and symptoms of this assault component.**

Regardless of your practice environment, be prepared to encounter patients of both sexes with sexual assault histories. Preparing yourself for such an encounter will enable a positive healthcare experience for your patient and facilitate the patient’s recovery process.

**Learn more about it**


Jauk D. Gender violence revisited: lessons from violent victimization of...


Reid EA. The Prison Rape Elimination Act (PREA) and the importance of litigation in its enforcement: holding guards who rape accountable. Yale Law J. 2013;122(7):2082.


