**Chapter 61
Sexual assault**

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**Introduction**

Sexual violence is a critical global issue that affects millions of people worldwide, claiming a victim every 45 seconds according to the American Medical Association [1]. EMS personnel are certain to encounter sexual assault victims, and are often the first to interact with the victim after the assault. It is crucial that EMS physicians and personnel, as well as EMS medical directors, understand the psychosocial, medical, and legal aspects of sexual assault.

Sexual violence has been defined as any form of sexual activity with another person without her or his consent. The assault may include forced kissing, fondling, attempted or completed penetration, forced masturbation by the victim or to the assailant, forced participation in or looking at sexually explicit photos, sexual harassment, exhibitionism, and voyeurism [2]. Both women and men can be victims of sexual assault; however, the majority of assaults are perpetrated by men against women and children [3]. Therefore, for ease of pronoun use, she or her will be used here in any reference to a victim.

The National Intimate Partner and Sexual Violence Survey reports that nearly one in five women (18.3%) and one in 71 men (1.4%) in the United States have been raped at some time in their lives, including completed forced penetration, attempted forced penetration, or alcohol/drug-facilitated completed penetration [4]. It is important to note that sexual assault is one of the most underreported crimes. Fewer than one in ten victims report the crime to the police [5]. Most women will confide in family, friends, co-workers, doctors, and/or nurses [6].

Reasons for not reporting include embarrassment, fear of being blamed or not being believed, and fear of reprisal from the assailant or court proceedings. Sexual assault is often attributed to overwhelming sexual desire. It is anything but. All forms of sexual assault are the misuse of power and control over another person with the intention of abusing and humiliating the victim [7].

**Drug-facilitated sexual assault**

Drug-facilitated sexual assault (DFSA) is the term used to describe cases of sexual assault in which the victim is unable to consent or resist because she has been rendered incapacitated or unconscious due to the effects of alcohol and/or drugs [8]. DFSA may result when drugs or alcohol are administered without the victim’s knowledge, or through the perpetrator taking advantage of a person who is already under the influence of drugs/alcohol. These crimes are less likely to be reported to law enforcement agencies because of the inability of the victim, due to drug-induced amnesia or fear, to describe the events.

**Consent issues**

Sexual assault occurs when there is no consent on the part of the other person. Consent is an active choice and constitutes a voluntary agreement between two persons of legal age to engage in sexual activity. A spouse can be charged with sexually assaulting the other spouse in cases of intimate partner violence. Previous consent to sexual activity does not mean that consent is not required the next time the other person seeks a sexual encounter.

The following are examples of situations of non-consent and sexual assault [9].

* Someone who is under the influence of medication, drugs, and/or alcohol
* A child
* Someone who expresses in words, gestures, or by his or her conduct a refusal to engage in or continue sexual activity
* Someone who submits to sexual activity because of force or threats against her or others
* Lies are used to obtain consensual sex
* A third person says “yes” for someone else
* The accused is in a position of power/authority over someone
* The accused is a blood relative
* A doctor, nurse, or other health care professional performing an unnecessary internal examination

**Myths**

Myths are used to condone or deny sexual assault. Accepting myths as reality contributes to the way society responds to and may influence the reporting of sexual assault. Some of the widely held myths are:

* the only way a rapist can really force a woman to have intercourse is by using a weapon
* women who do not actually physically fight back have not been raped
* if the attacker is drunk at the time of the assault, then he cannot be accused of rape.

Providers should understand that sexual assault can affect anyone (including males, children, and the elderly) and is not typically accompanied by physical injury or signs of trauma.

**Male sexual assault**

Use of weapons and brutality are reported more often in male sexual assault. Therefore, males may sustain more physical trauma than females [10]. The most common forms of assault that males experience are receptive anal and/or oral intercourse and forced manual genital stimulation [10]. The male patient may feel guilty about having been assaulted because of a belief that males are supposed to be able to protect themselves. This feeling can be compounded if the male also experienced an erection and/or ejaculation during the assault. Both these responses can occur as involuntary reactions to extreme stress. A male does not have to be sexually aroused to have an erection [10].

Given that most assaults committed against men are perpetrated by other males, a common misunderstanding for assaulted heterosexual males is that he will become homosexual after the assault.

**Psychological care of the patient**

Many victims of sexual assault do not suffer life-threatening injuries; however, they do experience psychological trauma. Therefore, after assessment for and management of physical injuries, support becomes the EMT’s priority. During a sexual assault, power and control are taken away from the person; care should be directed at restoring the person’s self-determination through decision making with respect to her care. Sexual assault is the only crime in which the victim is often considered to have some responsibility and have contributed to the assault by the way she dressed, spoke, or acted, or her location at the time of the assault. No one asks or deserves to be sexually assaulted: EMTs should always treat patients with respect. The patient will experience a multitude of emotions, including but not limited to shock, disbelief, confusion, guilt, self-blame, terror, anger, and lack of trust. These emotions may be evident or the patient may be very composed. The patient may even block out the events if they are too much for her to cope with at the time [10]. The type of response she receives from the first person to whom she discloses can affect how she views her situation and subsequently deals with it.

Some of the most important things an EMT can do in the initial interaction is to connect with the patient through introducing himself or herself, using the patient’s name, maintaining eye contact, and using a calm, even tone when speaking. It is important that the EMT proceed on the presumption that an assault has occurred; it is not the EMT’s role to decide whether or not an assault occurred. Responses to the patient should be non-judgmental and intended to reassure the patient that she is safe and that the assault was not her fault. Many victims buy into the myths surrounding sexual assault, and it is thus important to be able to help the patient distinguish between myth and reality.

People respond to crisis in a variety of ways, from crying to being calm and cooperative to laughing nervously. All are normal responses and it is important to help the patient understand this if she is concerned about how she is responding. A controlled response from a patient does not mean that the assault did not happen. She may also be concerned that she did not do enough to resist the assault; therefore, she should be reassured that she did what was necessary to prevent any further harm. If she is alone, the EMT should ask her if she would like a support person to be called.

**Physical care of the patient**

In addition to suffering severe emotional trauma, the patient is at risk of genital or other physical injuries.

Police-reported data show that the victim and accused were known to each other in 82% of sexual assault incidents [5]. Perpetrators can include a family member, friend, neighbor, or work colleague. Tactics used in these cases may focus less on physical force but rely on verbal intimidation, tricks, and administration of drugs or alcohol. Therefore, the absence of injuries is as consistent with sexual assault as their presence. In rape by a stranger, the likelihood of force is increased, either through verbal threats and physical force, or the element of surprise.

People respond differently when confronted with sexual assault. Some may succumb to escape any further injury or death, whereas others may fight to escape. Regardless of how the patient responded to the situation, it is important that the EMT reassure her that she handled the situation appropriately.

After securing the scene and ensuring provider safety, life-saving medical care is the EMT’s top priority; therefore the patient’s ABCs should always be assessed and assisted as needed.

The EMT should make detailed notes of any physical side-effects and injuries of sexual assault, among which may be:

* loss of consciousness, drowsiness, dizziness, disorientation, difficulty speaking or moving, or hallucinations. Note: it is important in cases in which DFSA is suspected that the EMT document the patient’s level of consciousness, affect, and any symptoms or signs of drug effects
* bites on the face/breasts
* suction injuries of the neck
* skeletal muscle tension and general soreness
* complications of strangulation: marks, petechiae in the face and conjunctiva
* evidence of being restrained, such as any patterned injury, rope marks around wrists/ankles, or fingertip bruising on arms or legs
* abrasions, lacerations, and bruises on a variety of areas on the body, head, behind the ears, neck, thighs, knees
* broken teeth, jaw, black eyes
* clumps of hair missing due to hair pulling [10].

Unless there is severe hemorrhage or other evidence of life-threatening genital injury, this area should not be examined. Genital and/or anal injuries sustained in a sexual assault can be difficult to visualize and therefore assessment of these areas should be left to a trained sexual assault examiner in the emergency department. Unnecessary examination may leave the patient feeling revictimized and may disturb vital forensic evidence. Typical injuries include small tears, bruises, abrasions, redness, and swelling. In forced oral penetration the EMT may note similar injuries around the mouth along with petechiae on the palate and uvula and a torn frenulum [8]. Bruising behind the ears may occur from the assailant’s use of physical force in an oral assault.

It is the EMT’s responsibility to ask appropriate questions, assess, and document observations and findings. Questioning should be kept to a minimum: the EMT should only ask questions that are required to do a physical assessment. Hospital staff and law enforcement will conduct a more thorough examination and investigation.

Depending on the circumstances of the sexual assault, the patient may be at risk of sexually transmitted infections and/or pregnancy. She should be advised that medical treatment for pregnancy and human immunodeficiency virus is time-sensitive and can be obtained from a sexual assault care center or emergency department (ED).

**Culture and sexual assault**

As each individual responds to stress and violence differently, much of their reaction will be influenced or affected by their cultural background [11]. Some immigrants have a command of the English language and others may require an interpreter to assist them in communication. Remember, during times of physical/emotional stress, understanding may be decreased. In cases of sexual assault it is important to have as accurate an account of the events as possible in order to collect appropriate evidence [11].

* Limit the amount of technical language, professional jargon, and common “expressions” that may be interpreted literally.
* Speak slowly, not loudly.
* Face the patient; it may or may not be culturally appropriate to make/sustain eye contact.
* Use short, simple sentences.
* Repeat or rephrase questions and summarize often to ensure your understanding.
* Ask open-ended questions. Questions that require only a “yes” or “no” do not tell you if the questions have been understood correctly.

Touch is a major part of health care response, used to provide physical care and emotional comfort. While all humans require some degree of touch, cultural norms and context will influence what is appropriate. In cases of sexual assault, a person may not wish to be touched in any way. It is best to ask prior to touching if it is OK, i.e. “May I touch your arm, to look at the injury?” Let the patient know when you are going to touch her. Experiences of touch will vary depending on the patient’s age and sex, the body part involved, and her interpretation of touch. The interpretation could be that of a caring gesture or control [11].

In order to respond to a patient with the bigger picture in mind, it is important to understand the role of the individual, the family, and the community with respect to attitudes towards violence, sexuality, and sexual behaviour. There will be gender variations and the value of virginity to be considered. Other effects on decision making will be with respect to “saving face” and the effect this disclosure will have on the family and the community and what social supports they may have. Affecing their decision to report may be their understanding of trust, power, and privilege with respect to the authorities, their immigration and resettlement experience, and the effect of racism and fear of retaliatory violence from the perpetrator and his supporters [11].

Expect that there will be differences between cultures and within cultures when people experience sexual assault. While you may feel the most appropriate plan of care is to take the patient to the hospital and involve police, this may not be the best course of action in the long run. Focus on the patient’s strengths and avoid judgment by altering your perspective and seeing it from her point of view.

**Legal aspects**

In cases of sexual assault, there are two crime scenes where evidence can be collected immediately: the location where the assault occurred, and the victim of the assault herself. There are several aspects that need to be proven for a sexual assault to have occurred.

* Both victim and perpetrator were together at the same location.
* There was a sexual act.
* There was no consent.

Documentation should be prepared on the assumption that the information may eventually be presented in a court of law. It is imperative that the documentation be accurate, comprehensive, objective, legible, and timely, either during or immediately after giving care.

### Preservation of evidence

Evidence can be verbal or physical. The EMT should document any information that the patient volunteers, using exactly the same words the patient uses in quotes. This information may be used later in court as an “excited utterance,” which is a spontaneous statement that concerns a shocking event while under stress caused by that event. For example, the patient makes a statement such as, “He threatened to kill me if I told anyone.” This might influence the sentencing process after the perpetrator is apprehended and convicted.

When considering physical evidence, every effort must be made to preserve that which might link the perpetrator to the victim and the sexual assault. DNA evidence can be collected from blood, hair, saliva, semen, and skin. Therefore any areas on the patient that may have been exposed to any of the aforementioned body fluids or substances must be protected. For example, if the perpetrator kissed, licked, or bit any area of the patient, care should be taken not to disturb this area. If the patient is aware of having scratched the assailant, then the fingernails should be protected by either advising the patient not to scratch or do anything with her hands or by wrapping them in a paper bag or linen of some sort to preserve whatever evidence might be present. Do not use plastic (i.e. plastic gloves) because plastic may cause biological evidence to deteriorate [12].

Do not remove clothing or disturb bodily evidence unless necessary for medical assistance due to injuries [12]. Clothing and other items removed during examination should be placed in separate paper bags. The appearance of the clothing should be carefully documented (e.g. torn, stained). Bullet holes or other defects mechanically inflicted should be cut around and not through because these may be instrumental in determining the angle or distance from which a weapon was used [13].

Characteristics of wounds (e.g. location, type, size, color) should be documented as they appeared before any medical interventions. If a ruler or measuring tape is not available for precise measurement of any wounds, a well-known comparison should be used (e.g. size of a quarter, length of a dollar bill). Any foreign debris or objects embedded in the wound should be noted. Debris removed from a wound should be inserted into a paper bag or clean container. Tubes or drains should not be inserted into wounds. Therapeutic puncture sites should be indicated with circular markings so that these areas can be distinguished from injuries received during the assault.

Should the patient need to urinate, defecate (if she cannot wait), or vomit, this evidence should be preserved. Generally a sterile or clean container will suffice (e.g. urine specimen container). This is especially important if a DFSA is suspected. Any containers the patient believes may have been used in the drugging, such as a water bottle or coffee mug, should also be collected.

Food or drink should not be given to any patient who has been orally assaulted. Patients should avoid brushing teeth or gargling until evidence has been collected. Forensic evidence deteriorates quickly; the highest quality evidence is collected within 72 hours of the sexual assault [10]. If at all possible, it is important to get the patient to a sexual assault care center for evidence collection as soon as possible, should she decide to involve law enforcement. The EMT must be aware of legal obligations and requirements with respect to reporting to law enforcement. Some jurisdictions require EMTs responding to an injury sustained during a crime to report to police; others will let the patient decide the best action to take.

### Chain of custody

Evidence collected from the patient becomes part of a chain of custody. This is the method of obtaining, transporting, and storing evidence that demonstrates proof that evidence collected at the crime scene or from the patient is the same as that being presented in court [13]. Paper bags, sterile containers, tamper-resistant tape, and chain of custody forms are rarely carried on ambulances. If these are not available, the EMT should devise a way to preserve evidence in which the item is sealed. The date and time the item was collected and removed, a description of the item, the location from where it was collected, and the EMT’s initials should be documented on the item. Items collected should be placed in an area where their integrity can be maintained, allowing the EMT to testify that there has been no opportunity for tampering with the item. Once law enforcement is involved, the item(s) should be signed over to the police. This may include the ambulance stretcher sheet because there may have been a transfer of hair, debris, or other fibers from the patient/perpetrator. This sheet should be carefully folded on itself and provided to the police or ED.

## Sexual assault nurse examiners/sexual assault response teams programs

Many states and provinces have sexual assault response teams (SART) or sexual assault care centers (SACC) that have specially trained sexual assault nurse examiners (SANE) available 24 hours a day. These nurses attend to the medicolegal needs of a sexual assault patient. They provide prophylactic treatment for sexually transmitted infections and pregnancy along with a thorough physical assessment and evidence collection. EMS physicians and EMTs should be aware of the treatment centers in their area.

## Conclusion

The manner in which the EMS physician and EMT react to a disclosure of sexual assault will affect how the patient will view her situation, respond to treatment, and engage in the recovery process. The life of a person who is sexually assaulted is changed forever. A thoughtful and supportive response along with appropriate evidence preservation by the EMT can be the first step in a patient’s journey to recovery and prosecution of the perpetrator. Local sexual assault crisis hotline numbers should be readily available and the patient encouraged to seek counseling or to speak to someone she feels would be supportive.

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