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Sexual Assault Nurse Examiners' Perceptions of Their Relationship With Doctors, Rape Victim Advocates, Police, and Prosecutors

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Abstract

In response to the negative and inefficient treatment of rape victims by emergency room personnel, the first Sexual Assault Nurse Examiner (SANE) programs began in the late 1970s. While SANEs, doctors, rape victim advocates, police officers and prosecutors work together to ensure the most comprehensive and sensitive care of rape victims, they all have very different roles and objectives. This research explores SANEs' perceptions of their relationships with other professionals who treat or interact with rape victims. Data from interviews with 39 Sexual Assault Nurse Examiners from four East Coast states indicate positive relationships are marked by open communication, respect shown towards SANEs as well as rape victims, and a sense of appreciation among SANEs. On the contrary, negative relationships result when SANEs believe police treat victims poorly, when advocates overstep boundaries and question SANEs about evidence collection or the exam, and when prosecutors fail to properly prepare them to testify during a trial.

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Introduction

In response to the negative and inefficient treatment of rape victims by emergency room personnel, the first Sexual Assault Nurse Examiner (SANE) program began in the late 1970s. SANEs are specially trained forensic nurses who provide rape victims with emotional support, medical care, and quality and timely collection of forensic evidence (Brown, 2010; Campbell, Townsend, et al., 2005; Ciancone, Wilson, Collette, & Gerson, 2000; Emergency Nurses Association, 2007). The first SANE program began in Memphis, Tennessee in 1976 (Speck & Aiken, 1995), the second in Minneapolis, Minnesota in 1977 (Ledray, 1999), and the third in Amarillo, Texas in 1979 (Antognoli-Toland, 1985). Recent estimates indicate there are over 600 SANE programs nationwide (International Association of Forensic Nurses, 2010; Ledray, 2010; Sexual Assault Nurse Examiner, Sexual Assault Response Team, 2010).

Sexual assaults represented 8% of all nonfatal violence-related injury visits to emergency departments for females in 2008 (Centers for Disease Control and Prevention, 2010a), and was the first or second leading cause for those aged 14 and below (Centers for Disease Control and Prevention, 2010b). The optimal care of rape victims who choose to report to law enforcement is achieved through victims' simultaneous access to a SANE, a rape victim advocate, and a police officer. This not only assures that victims receive thorough and comprehensive care but also limits the number of times they have to repeat the account of the rape when they choose to report to law enforcement. Although SANEs, advocates, and police officers work as a "team," often referred to as a Sexual Assault Response Team (SART), they all have very different roles and objectives. Dynamics between team members could influence victims' care and comfort level during the exam, collection of evidence, and police interview. However, thus far research that explores the tensions among members of the SART is limited (Cole & Logan, 2010).

Although previous research has explored rape victim advocates' perceptions of victims' treatment in emergency rooms (Campbell & Bybee, 1997), advocates' perceptions of SANE programs and general medical treatment of rape victims (Maier, 2008), and rape victims' experiences with the medical system (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Campbell, 2005; Campbell & Raja, 2005; Du Mont, White, & McGregor, 2009), there is a gap in the research that details the views and experiences of SANEs. The purpose of

this research is to explore SANEs' perceptions of their interaction with Emergency Department (ED) doctors, rape victim advocates, police, and prosecutors, and explore *why* interactions are positive or negative.

Review of Literature

SANEs form collaborative relationships with police departments, rape crisis centers, victims' services centers, and prosecutor's offices to facilitate a smoother process for victims. Most SANE programs are part of a SART. According to Lewis, DiNitto, Nelson, Just, & Campbell-Ruggaard (2003), "The SART approach involves joining law enforcement, medical personnel, and victim advocates in a coordinated effort to provide sexual assault survivors with comprehensive medical attention, emotional support, evidence examinations, and follow-up services" (p. 34). Research has noted the benefits of SARTs as collaboration results in better outcomes for victims (Campbell, Patterson, et al., 2005).

One component of the SART is the rape crisis center. A solid partnership between SANEs and victim advocates is important because both have distinct and necessary roles, and victims rely on both for thorough and compassionate care. SANEs provide medical care and collect forensic evidence, whereas advocates provide crisis intervention, support, and advocacy (Preston, 2003). The policy of many SART programs is to call the rape victim advocate immediately (Stevens, 2004), and victims who seek attention at hospitals with SANEs on-call or always present in the hospital are more likely to be offered an advocate in the room during the exam (Plichta, Clements, & Houseman, 2007). Victims of rape below the age of 18 are also more likely to receive a referral to a rape crisis center if a SANE is present (Bechtel, Ryan, & Gallagher, 2008). This may be because SANEs are more aware than non-SANEs of the services offered by rape crisis centers, because at times, SANEs' training includes presentations by staff or directors of rape crisis centers regarding available services.

Providing compassionate care while collecting evidence may be challenging for SANEs. SANEs are more likely than non-SANE nurses to experience role conflict when carrying out the two distinct roles of being evidence collectors as well as sensitive caregivers (Du Mont & Parnis, 2003). There have also been questions on whether SANEs are able to provide advocacy while conducting an objective examination (Ledray, Faugno, & Speck, 2001). If SANEs appear to be victims' advocates and biased toward the prosecution, the credibility of evidence and their testimony could be questioned if the case goes to trial (Scalzo, 2006; Stevens, 2004). Although SANEs

provide emotional support to victims during the exam (Cole & Logan, 2008; Ledray, 1999; Littel, 2001; Taylor, 2002), unlike advocates, they usually do not correspond with victims after the medical attention at the hospital. Logan, Cole, & Capillo (2007), found that 44% of SANE programs included in their sample follow-up with victims by phone either always or on a case-by-case basis, and other research indicates that follow-up care of victims needs improvement (Crandall & Helitzer, 2003). Also, unlike advocates, anything victims tell SANEs is *not* confidential.[1]

Despite the importance of the partnership, interaction between SANEs and advocates may not always be positive (Crandall & Helitzer, 2003; Littel, 2001). Because rape victim advocates' objectives are to support, comfort, and protect victims from revictimization or further trauma, a potential for a power struggle between SANEs and advocates could ensue. When conflicts arise, they mostly reflect control issues such as the overstepping of boundaries by advocates who question SANEs' activities during a medical exam or attempt to provide medical assistance or advice (Cole & Logan, 2008; Illinois Criminal Justice Information Authority, 2003; Littel, 2001), or advocates' perceptions that hospital staff no longer sees them as valuable as they did prior to the presence of SANEs (Cole & Logan, 2008; Crandall & Helitzer, 2003). However, research has also indicated that most SANE programs report an excellent working relationship with rape crisis centers (Cole & Logan, 2008; Logan, Cole, & Capillo, 2007).

Research detailing SANEs' interaction with ED doctors and nurses is limited. Townsend and Campbell (2009) interviewed the most experienced SANE from 110 programs and found that 36% of SANEs working for hospital-based programs reported an excellent relationship with ED staff, and 16% of SANEs working for community-based programs reported an excellent relationship. It is important that hospital staff and SANEs work well together, given that the presence of SANEs improves victims' treatment in hospitals. Victims who are treated by SANEs face shorter wait times (Crandall & Helitzer, 2003; DiNitto, Martin, Norton, & Maxwell, 1986; Girardin, 2005; Littel, 2001; Martin & DiNitto, 1987; Stermac & Stirpe, 2002; Taylor, 2002) and receive more sensitive and thorough care (Campbell et al., 2001; Campbell, Patterson, & Lichty, 2005).

Research detailing SANEs' experiences with law enforcement and prosecutors is also limited. Logan et al.(2007) found that slightly more than half of their sample reported an excellent working relationship with police and prosecutors, and Townsend and Campbell (2009) found that at least half of their sample reported an excellent relationship with police and prosecutors.

Despite the overall lack of research exploring SANEs' experiences with law enforcement and the legal system, research demonstrates that SANE programs benefit police officers and prosecutors because better evidence is collected by SANEs (Campbell, Patterson, Bybee, & Dworkin, 2009; Ledray & Simmelink, 1997; Littel, 2001; Nugent-Borakove et al., 2006; Pennington, Zwemer, & Krebs, 2008). When evidence is collected by SANEs, defendants are more likely to plea bargain once they realize the detail of the forensic evidence (Littel, 2001; Speck & Aiken, 1995; see also Campbell, Bybee, Ford, & Patterson, 2008), and convictions are more likely (McGregor, Du Mont, & Myhr, 2002; O'Brien, 1996 as cited by Ledray, 1999). For instance, Crandall and Helitzer (2003) compared prosecutorial outcomes of rape cases before and after a SANE program was implemented in New Mexico. Their findings indicate that after the SANE program began, more victims reported rape and sexual assault to police, more victims had forensic evidence collected, more charges were filed against alleged rapists, and more rapists were convicted.

Although there is research on the benefits of SANE programs, there is a gap in the research that details the views and experiences of SANEs. As it is necessary for members of the SART to work together to provide compassionate and thorough care of victims, it is also important to understand their interactions with one another. The purpose of this research is to explore SANEs' assessment of their interaction with ED doctors, rape victim advocates, police, and prosecutors. In addition, this research allows for comparison because SANEs are asked about their interactions with doctors, advocates, police, *and* prosecutors.

Method

Data are based on interviews with SANEs working in four East Coast states. Because of the nature of the research, a qualitative methodology is necessary to fully assess the perceptions and experiences of study participants. Qualitative analysis is more appropriate for exploratory research when it is most important to grasp the meanings and nuances of an area of study. Qualitative research allows participants to articulate more clearly and in their own terms, potentially providing more accurate and valid information (Flavin, 2001, p. 40).

SANE programs in four states were selected after review of the programs listed in the database of the Sexual Assault Resource Service, funded by the U.S. Department of Justice's Office for Victims of Crime and the U.S. Department of Commerce's National Telecommunications and Information Administration (www. sane-sart.com). The four states were selected for a few

reasons. First, in 2003 and 2004 I interviewed rape victim advocates from the same four states. At that time, the states were selected because: they were geographically convenient, one of the oldest rape crisis centers was located in one of the states, there were several racially/ethnically diverse areas in the states, and I had already established relationships with rape crisis directors in two states. When expanding my research to include the perceptions of SANEs, I included the same four states not only because of geographical convenience but also because of a general familiarity with the treatment and processing of victims in those states, and because of the variety of ways SANE programs are organized in these states. In States A and D the programs are hospital-based and funded, in State B the programs are managed and funded by a state agency, and in State C programs are managed and funded by Prosecutor's Offices.[2] Although it was not necessary due to the cooperation of SANE directors in recruiting participants, I also selected the states due to my rapport with directors of rape crisis centers. If I encountered difficulty recruiting participants, I would have been able to ask advocates to put me in touch with SANEs they work with.

Beginning in October 2006, letters or e-mails requesting participation were sent to all 78 program listed on the SANE-SART website. The SANE-SART website listed eight hospital-based programs in State A, 16 programs managed by the county prosecutor's office in State C, and 48 programs in State D. Programs in State B are funded by a state agency, and there are six regional coordinators. If an e-mail address was not provided, or the e-mail was sent back to me because it was not valid, a letter requesting participation was sent via mail. Letters were sent to directors in State D because of the inability to reach them via e-mail. Data represent the views of SANEs treating rape victims at 43 hospitals in four states. According to SANEs included in this sample, the number of SANEs working at each hospital ranged widely from 1 SANE to 43 SANEs.

All directors who responded to the e-mail stated that they forwarded my letter or e-mail to other SANEs, announced the research and provided my contact information at staff meetings or trainings, or passed along the information through word-of-mouth. Because of the method of recruitment used, I am unable to determine a response rate. However, only 1 SANE initially agreed to the interview but later said she was unable to participate because her employer (county prosecutor) would "not allow" her to participate. In addition, one other SANE agreed to participate, provided a phone number to reach her, but never responded to several voice mail messages to schedule an interview time. Therefore, 42 SANEs contacted me about participating in the research and 40 were interviewed.

Observation of Training and Interviews

In addition to conducting interviews, I observed 30 of the 40 hr of training for SANEs. The training was held in one of the states where interviews were conducted and was facilitated by one of the directors of a SANE program included in this research. These observations allowed me to gain firsthand knowledge of the topics covered during training. This experience was quite beneficial because I do not have a degree in nursing or nursing experience. The training took place between April 10, 2007 and May 2, 2007. Topics included the history of forensic nursing, the importance of the SART model, the role of the advocate, the components of the evidence collection kit, DNA, legal issues of rape and sexual assault, how to best question victims, victims with special needs, diversity, how the police investigate the crime and collect evidence, anatomy, and forensic photography. In addition to the primary trainer who was a SANE, guest speakers were brought in from a rape crisis center, the special victims' unit of a police department, and the prosecutor's office. I attended five of the eight sessions including a tour of the city crime lab; three of the sessions were not relevant to the purposes of my research (explanation of anatomy, how to use a colposcope, how to take digital photographs, tour of emergency room, review session for certification exam).

Interviews were conducted between October 13, 2006 and April 20, 2007. Interviews ranged from 45 min to 2.5 hr. The average interview lasted 1 hr and 15 min. All interviews were conducted over the phone for convenience—either to accommodate the SANEs' preference or due to distance. Participants were compensated with gift cards to an establishment local to them (i.e. Starbucks, Panera). All SANEs were given US$10 gift cards as a token of appreciation for their time, and SANEs who were also serving as directors of programs were given US$15 gift cards because they were asked additional questions about the organization and funding of programs.

All participants were required to sign a consent form prior to the interview. As interviews were conducted by phone, consent forms were mailed, faxed, or e-mailed to participants at the participant's preference. Signed consent forms were returned to me by fax or mail. Most interviews were tape-recorded on the participant's consent. Only 1 respondent declined to be tape-recorded, so extensive notes were taken during the interview. The author transcribed most interviews verbatim with the help of five undergraduate research assistants.

Although this article will focus on SANEs' assessment of their interaction with ED doctors, rape victim advocates, police, and prosecutors, the interview consisted of approximately 70 open-ended questions in the following areas:

training to become a SANE; roles and responsibilities as a SANE; perceptions of rape, rape victims, and rapists; perceptions of multicultural or multiethnic issues surrounding rape; perceptions of treatment of victims by the medical, criminal justice and legal systems; and difficulties or challenges for SANEs or SANE programs. Directors of programs were also asked about the history of their SANE program, the past and present mission of the program, how the program has changed, how the program is funded, and if there are problems with SANEs "burning out." The key questions about SANEs' interaction with other key players in the treatment of rape victims were the following: Do you collaborate with other institutions such as rape crisis centers, police departments, or prosecutors' offices? Are you a member of a SART? What do you see as the role of the rape victim advocate? Describe your relationship with ED doctors, rape victim advocates from rape crisis centers, law enforcement, and those working in the legal system. If conflicts, describe and tell me how so you resolve them.

After interviews were transcribed verbatim, qualitative analysis began. The analysis included an inductive approach. Inductive research is more appropriate for exploratory research (Bernard & Ryan, 2010); in inductive research, it helps to look for recurring phrases in participants' responses (Miles & Huberman, 1994, p. 70). More specifically, this analysis included several steps including open coding and axial coding (Miles & Huberman, 1994). After reading through the transcripts several times, notes were written in margins. This first stage of analysis is referred to as open coding, because the researcher wants to "open up the data to all potentials and possibilities" (Corbin & Strauss, 2008, p. 160). All codes were written in the margins of the transcripts. At this stage, I focused on whether the SANE perceived her interaction with other professionals responding to rape victims to be positive, negative, or both positive and negative.

To systematically analyze the data and compare the responses of SANEs, the second stage of the analysis was completed using axial coding. As Miles and Huberman (1994) stress the benefits of a clear display of data, I copied and pasted all data pertaining to SANEs' perceptions of advocates' roles, as well as their perceptions of their relationship with advocates, doctors, police officers, and prosecutors into one document. At this time, I compared reasons for SANEs' positive and negative working relationships with doctors, advocates, police, and prosecutors. Codes were also further developed at this time. For example, rather than just indicating whether the participant mentioned positive, negative, or mixed interactions, I also developed codes that would better manage the data. For example, "POS" was changed to "POS-APP" to indicate that the participant revealed she had a positive relationship that resulted from

feeling appreciated. One methodological limitation is that only one researcher coded the data in its entirety, so it is possible that others would interpret participants' responses differently.[3]

The Sample

Forty in-depth interviews were conducted with SANEs working for hospitals, government agencies, or prosecutor's offices in four states on the East Coast.[4] These states had between 3 and 45 SANE programs. In States A and D all programs were hospital based, in State C SANE programs were run out of the Prosecutor's office, and in State B programs were run out of the state's Department of Public Health. However, all interviewed SANEs were required to have experience treating victims in the hospital setting so that I could gather data on SANEs' interactions and relationships with police, hospital staff, and rape victim advocates, all of whom usually interact with victims at hospitals. Of the 40 SANEs, 5 worked in State A, 7 worked in State B, 15 worked in State C, and 13 worked in State D. Of these 40 SANEs interviewed, 17 currently served also as directors of the programs and 1 had served as the director but resigned from the position prior to the interview. Four directors were from State A, two were from State B, five were from State C, and six were from State D. One SANE from State D resigned as the director of the program prior to the interview but continued to work as a SANE in the state.

The 40 SANEs interviewed were between the ages of 21 and 62 ($M = 45$ years old; $Mdn = 46.5$ years old). Five percent of respondents were in their 20s at the time of the interview, 22.5% were in their 30s, 37.5% were in their 40s, 32.5% were in their 50s, and 2.5% were in their 60s. All SANEs interviewed were women. Thirty-eight (95%) of the SANEs interviewed were White and 2 (5%) were African American.[5] Thirty-two (80%) of the SANEs interviewed were Registered Nurses (RN), 1 (2.5%) was a Nurse Practitioner, and 7 (17.5%) were not RNs because they had a Bachelor's Degree in Nursing (BSN). Five were RNs only (diploma program), 2 had an Associate's Degree in Nursing, 6 were seeking a BSN, 13 had BSNs, 1 had a Bachelor's Degree in Health, 5 were seeking a Master's Degree in Nursing (MSN) or Forensic Nursing, 7 had a MSN, and 1 had an MSN but was currently seeking a PhD. Twenty-four SANEs (60%) were employed part-time for the SANE program, and 16 (40%) were employed full-time. SANEs included in this sample received their nursing degrees between 1971 and 2005. Almost one quarter (22.5%) completed their nursing degrees in the 1970s, 32.5% completed their nursing degrees in the 1980s, 37.5% completed their nursing degrees in the 1990s, and 7.5% completed their nursing degrees between 2000 and 2005 (see Table 1).

Table 1. Demographics of Sample

Variable	%
Age	
20s	5
30s	22.5
40s	37.5
50s	32.5
60s	2.5
Race/ethnicity	
White	95
African American	5
Nursing degree	
RN	80
Nurse Practitioner	2.5
BSN	17.5
Highest level of education	
RN diploma program	12.5
ASN	5
Seeking BSN	15
BSN	32.5
BA	2.5
Seeking MSN or MA	12.5
MSN	17.5
Seeking PhD	2.5

Results

All of the SANEs interviewed stressed the importance of the "team approach," and all reported they collaborated with law enforcement, rape crisis centers, and prosecutors. Although the majority of respondents were members of a SART, even those who were not members of a SART interacted with advocates, law enforcement, and prosecutors. Although SANEs, rape victim advocates, prosecutors, and police officers work as a "team," they all have very different roles and objectives. The dynamics and conflicting goals between the members of the team could influence victims' care and comfort level during the exam, collection of evidence, and interview. Let us begin by looking at the distinct roles of SANEs and rape victim advocates, both of whom strive to provide sensitive care to rape victims.

SANEs and Rape Victim Advocates

All SANEs included in this research have interacted with rape victim advocates from rape crisis centers, and all either automatically call an advocate or offer advocacy services to victims. All SANEs who indicated advocates were called automatically thought this was a good policy because advocates were beneficial to victims (comforting and informative), and victims could still refuse to speak with advocates once they were at the hospital.

SANEs believe rape victim advocates play a variety of roles that include providing victims with emotional support, referrals or information about community resources, and follow-up care. SANEs also believe advocates provide assistance to the other members of the SART including: collecting paperwork from victims, retrieving necessary items for SANEs or law enforcement, retrieving food or water for victims when other members of the SART are unable to do so, or answering questions or providing emotional support to victims which allows SANEs to concentrate on medical assessment or evidence collection. Advocates' provision of follow-up care is especially important, because although follow-up care for rape victims may greatly assist their emotional recovery (Preston, 2003),[6] very few victims pursue it (Holmes, Resnick, & Frampton, 1998; Logan et al., 2007). Also, follow-up care by SANEs could be viewed as problematic; in the event that a SANE testifies in a court proceeding, he or she would not want to appear to be biased. Furthermore, unlike the communication between SANEs and victims, the communication between advocates and victims is confidential, and advocates cannot be forced to testify in court in most states (Rape, Abuse and Incest National Network, 2009; U.S. Department of Justice, 1995).

So the question remains, how do SANEs view their relationship with advocates, and more importantly, what makes for positive and negative interactions? More than half of the SANEs interviewed described completely positive interactions with advocates and many described them as "wonderful," "incredible," "helpful," and "supportive." Approximately one third of SANEs interviewed noted both the positive and negative experiences with advocates, although negative experiences were rare (see Table 2 at end of results section).

Interview data reveal that positive relationships with advocates result from open communication, as well as SANEs' recognition of how helpful advocates are to them as well as to victims and their family. SANEs believe that to facilitate a good relationship, advocates must be aware of SANEs' roles and recognize that SANEs are on their "team." Janeen (all names pseudonyms) states,

> It is a good relationship [with advocates]. It is a give and take and we e-mail each other back and forth if we have questions. It is an open dialogue. There are no brick walls here. Everything is open for discussion. We respond as a team and that is how I look at us, like a team.

On the basis of this research, advocates make the jobs of SANEs much easier by allowing them to focus on the medical attention required by victims rather than also attempting to accommodate victims' emotional needs. The necessary partnership between the two is evident. As explained by Sandra, "For us they are a great benefit because they are able to take that load off [to provide emotional comfort] and enable us to concentrate on the medical aspects and collecting evidence." Judith agrees, "They are incredible . . . I don't think I could have gotten through as a SANE without them."

SANEs are also aware that advocates' provision of emotional support is beneficial to victims and their family members. Elizabeth states, "They [advocates] are wonderful. They're not just there for the client, but if there is family there, they need support and they are there for them too. They give them educational materials too."

Mary describes an advocate as the person in the room who is "100% for this victim." Due to SANEs' focus on the exam and evidence collection, they cannot stand next to victims to hold their hands, provide comfort, calm them down, answer general questions, offer them food or water, or serve as a resource, comfort, or mediator if friends or family members are present during the exam. Quite simply, advocates allow SANEs to do their jobs by being the only members of the SART focused solely on attending to the emotional needs of victims.

Whereas positive interactions are characterized by open communication and appreciation, based on interview data, negative interactions are characterized by control issues or the overstepping of boundaries. In their quest to protect victims, advocates may forget that SANEs' goal is to collect evidence in the most thorough and compassionate manner. Dana explains,

> I think that when there is a problem between an advocate and a nurse, based on my experience, they have some control issues. They [advocates] don't understand that there is nobody on the team that is more about the patient than me.

SANEs reveal that advocates may overstep boundaries when they rush SANEs, question SANEs' medical decisions about victims' treatment, push victims into having an exam or reporting to police, answer questions for

victims, interrupt exams, or become too involved in the medical aspects of the case. Donna states, "There are always a few [advocates] that just don't fit in because they get more involved in the medical part and try to give opinions and that's something you just don't do as an advocate." Eliza agrees, "They have the knowledge through some training but it [medical procedure] is not their role." Krista provides a specific example: "I had an advocate who told the patient that one of the medications we give in an injection and this is going to be very painful. Just stepping into areas that I do not think were in her arena."

Only one SANE described advocates in a completely negative way noting she has "so many bad experiences," because advocates overstep boundaries and are like "loose cannons" who "do more harm than good in the emergency room." Although this SANE relayed a very poor image of advocates, she is the only respondent who felt this way.

SANEs and Emergency Room Doctors

Although not typically members of SARTs, emergency room doctors interact with SANEs in emergency rooms. Because of this, SANEs were asked to describe their interaction with ED doctors. The majority of SANEs interviewed described a completely positive relationship with ED doctors, whereas a few (3) SANEs acknowledged that although their current relationships with doctors are positive, they had been poor when the program began, since at that time, doctors did not understand SANEs' roles and resisted SANEs' presence in "their territory." Some (5) SANEs described both positive and negative relationships; a doctor's personality could shape interactions (see Table 2 at end of results section).

As positive interactions between SANEs and advocates result from SANEs' appreciation of advocates, positive interactions between SANEs and doctors result from SANEs' perception that doctors appreciate them. SANEs who described positive interactions with ED doctors believed that doctors were "happy" SANEs were available and appreciative of the program's services, because it reduces their responsibility, and SANEs perceive that doctors believe victims receive better treatment from trained SANEs. Completing exams on victims and collecting forensic evidence can be very time consuming, and doctors working in busy EDs may not have ample time to give victims enough attention. As explained by Veronica, "I think they [ED doctors] are relieved when we show up because they don't have to do it [rape exam] then. In my experience, I think they are like 'Oh thank God the SANE nurse is here.'" Patricia agrees that doctors are happy to have SANEs, because they "take away

some of their workload." Rebecca states, "The doctors are always happy when we are there because they know the patient gets better care with the SANE nurse because we can spend more time with them." Elizabeth describes doctors as being "overwhelmingly happy that there is a program."

In addition to the appreciation, SANEs state that doctors express to them, positive interactions also result from open communication. According to Elizabeth, SANEs working at her hospital "feel comfortable asking them [doctors] questions because they stop and help the SANE nurses." Grace agrees that in her experience, doctors are "open and want to help out." Kim states, "I feel like we are working partners. I talk to the doctor about every patient." Respect and trust are also important components of the good relationships SANEs perceive with doctors. Feeling comfortable with one another because they understand the other team members' role also enhances interactions between doctors and SANEs, according to the SANEs included in this research.

Isolated negative problems arise when doctors believe SANEs are overstepping boundaries and question nurses' credibility. Such problems were more common when programs first began and doctors did not understand the roles and responsibilities of SANEs. Betty Ann explains, "It's their territory and they [doctors] are very uncomfortable with nurses doing something they've done before." Amber shares similar experiences, "A lot of times the doctors resisted because they didn't understand what we did. There were times where we would order STD medications and the doctors would take offense to this." Catherine agrees that problems arise when doctors are unfamiliar with SANEs' roles, "We've had some problems with some of the ER doctors wanting to check my exams. It's a comfort level. Once they get to know you and you become comfortable it gets easier." Other literature indicates that SANEs face challenges with doctors when doctors believe that SANEs are overstepping boundaries by taking over the care of rape patients (Stevens, 2004).

SANEs and Police Officers

SANEs were also asked to describe their relationships with law enforcement. Approximately, one third of SANEs interviewed described their relationships with law enforcement as only positive, and one third indicated they have had both good and bad experiences with law enforcement. Some (6) SANEs indicated they currently had positive relationships with law enforcement but it had been poor in the past. Only 2 SANEs described poor relationships with law enforcement (see Table 2 at end of results section).

Just as SANEs who perceive that doctors appreciate them had positive interactions with them, SANEs who noted positive interactions with law enforcement also felt appreciated. Debra explains the relationship is "excellent", "They are just embracing forensic nurses because of what we bring to the plate that they are unable to do. We help them out in court, interviews, and more." Teresa agrees, "The ones who know about us absolutely love it [SANE program] because they know everything is going to be done right and they are going to be in and out of here [hospital]." Judith also comments on how SANEs are helpful to officers, "They were so glad that we were there because they didn't have to do anything. They would investigate outside the hospital but they got their story—the evidence. We would do everything and we are so helpful for them."

Furthermore, SANEs who experienced a positive relationship with law enforcement reflected on officers' sensitive and supportive treatment of victims. Mary praises the police for their sensitivity:

> They are for the most part very compassionate and I give them a lot of credit because I understand that police and detectives are mainly dealing with criminals and have to switch gears to the victim-centered mode. It has got to be difficult, especially for the seasoned detectives.

SANEs who noted a positive relationship with officers also discussed how familiarity with the program and open communication facilitate a smooth relationship. When officers understand the roles of SANEs and the mission of SANE programs, they are less likely to feel threatened by SANEs and recognize how the program not only assists them but also benefits victims.

Isolated negative experiences with police officers arise when officers continue to doubt victims, don't want to pick up the evidence if the victim refuses to file an initial police report,[7] rush the exam, or get into a power struggle with the SANE during the exam or interview. Officers who doubt victims' stories or engage in victim blaming can be very frustrating to SANEs. Kathleen shares, "They [police] get annoyed with how long it [exam and evidence collection] can take or they feel like the story is completely bogus and their time is being wasted." Krista comments, "Police officers are more skeptical and I had one officer say, 'I am here to collect the evidence for the rape that didn't happen.'"

Other SANEs mentioned that officers take victims' appearance, victims' history, and lack of obvious injuries into account when determining the credibility they should give to victims. Officers also rely on SANEs to judge whether an allegation is credible. Police will ask SANEs to assess if they think the patient was raped, even though SANEs' role is to collect evidence and

provide any necessary medical treatment in a nonjudgmental way. The exam may not conclude whether a rape occurred, and SANEs are not permitted to discuss their findings with law enforcement in the hospital.

Just as with ED doctors, SANEs also mentioned that negative experiences result from officers' lack of understanding of SANEs' roles and belief that SANEs are overstepping boundaries when collecting evidence and "taking the reigns" during victims' interviews. Officers who believe it is their job to collect evidence and take victims' statements feel threatened by and resentful of SANEs who step on "their territory."

In summary, most SANES reflected on positive relationships with law enforcement and noted good relationships are built on feeling appreciated, open communication, and officers' compassionate treatment of victims. Problems arise when officers doubt or blame victims and do not understand SANEs' roles so believe they are overstepping boundaries when collecting evidence and gathering information from victims.

SANEs and Prosecutors

SANEs also interact with prosecutors before and during trials. Although SANEs are less likely to collaborate with prosecutors than they are to collaborate with rape victim advocates, doctors, or law enforcement because many cases do not go to trial, interaction with them is necessary during pretrial proceedings and when SANEs are asked to testify during criminal trials as either fact witnesses or expert witnesses. More than half of SANEs included in this research testified as fact and/or expert witnesses during a trial, and a few SANEs received subpoenas and participated in pre-trial meetings with prosecutors, but defendants accepted plea bargains before trials began. Approximately, one third of SANEs included in this research have never testified.

All SANEs, regardless of whether they have testified in court or not, talked at length about their interaction with the legal system, because many SANEs interact with prosecutors even if cases are plea bargained before reaching the trial stage, and all SANEs in State C work in prosecutors' offices. More than half of the SANEs interviewed described a positive relationship with prosecutors, whereas only a few (3) SANEs described a completely negative relationship.

SANEs who described positive relationships with prosecutors indicated that prosecutors are appreciative of SANEs' expertise, supportive, helpful, flexible, and open to questions and communication. Debra reflects on prosecutors' appreciation of SANEs, "I think we are a godsend to them. They are

very appreciative of us and work very well with us." Mary agrees that SANEs and prosecutors have positive interactions because prosecutors recognize that SANEs' work is "extremely valuable."

According to SANEs included in this research, open communication also positively influences SANEs' interactions with prosecutors. When there is open communication, prosecutors understand SANEs' roles and how they can assist them. This contributes to prosecutors' preparation of SANEs for trials. Other SANEs mentioned that they felt comfortable contacting prosecutors with any questions.

SANEs who described some negative experiences with prosecutors indicated that they wished prosecutors had better prepared them to testify. Feeling prepared to testify may be important to SANEs, given that more than half of the SANEs who have testified described their experience in court as a "stressful," "nerve-racking," "intimidating," or "scary." Donna, who has testified several times, believes she was nervous because she was not well-prepared by the prosecutor:

> It was absolutely one of the scariest things I have ever done in my life. I had absolutely no real preparation for it. I did not know what to expect and only speaking for our state, I don't think that the prosecutors did a really good job of prepping us.

Other SANEs also specifically referred to the intimidating nature of trials because of feeling unprepared by prosecutors.

Table 2. SANES' Perceptions of Their Relationships With Others Who Assist Rape Victims

	Advocates	ED doctors	Police	Prosecutors
Positive relationships	54% (21)	67% (26)	36% (14)	59% (23)
Current positive relationships, poor in past	0%	8% (3)	15% (6)	0%
Positive and negative relationships	38% (15)	13% (5)	36% (14)	3% (1)
Negative relationships	3% (1)	0%	5% (2)	8% (3)
No response	5% (2)	13% (5)	8% (3)	31% (12)

Discussion

This research fills the gap in the existing research on SANE programs by interviewing SANEs rather than just evaluating programs. Understanding SANEs' perceptions of their relationships with ED doctors, rape victim advocates, police, and prosecutors is important given the necessity of their partnership for the most comprehensive, just, timely, and compassionate treatment of rape victims through the medical, criminal justice and legal systems. The dynamics and conflicting goals between the members of the team could not only influence victims' care during the exam, collection of evidence, and interview, but could also influence the legal process.

When comparing their relationships with doctors, rape victim advocates, police, and prosecutors, SANEs included in this research were more likely to note positive interactions with ED doctors compared to advocates, police, or prosecutors. None of the SANEs interviewed stated they had completely negative interactions with ED doctors. It is interesting to recognize, however, that although SANEs, doctors, advocates, officers, and prosecutors have different roles, objectives, and responsibilities to victims, the reasons *why* SANEs believe their interactions with these other members of the team are positive are rather similar. According to this sample of SANEs, positive relationships result from open communication, understanding each other's roles, feeling appreciated, or appreciating the help of another member of the team. This research makes it clear why the team approach to victim care is important; SANEs appreciate advocates, although SANEs believe doctors, police, and prosecutors appreciate them.

The fact that most SANEs interviewed highly praised rape victim advocates is consistent with other research that has indicated that most SANEs report an excellent working relationship with rape crisis centers (Cole & Logan, 2008; Logan et al., 2007). Advocates are a relief to SANEs, because they provide victims with emotional comfort and allow SANEs to concentrate on medical treatment and collecting evidence.

Just as advocates remove some responsibilities (emotional care) from SANEs, SANEs reflected on doctors' appreciation and relief that SANEs are present to conduct lengthy exams and testify in court taking the responsibility off of them, a conclusion made in previous literature (Stevens, 2004). As professionals, SANEs, no doubt, felt validated by the respect received from other medical professionals. It is important that SANEs work well with ED doctors, given that research has indicated the benefits for victims treated by SANEs (shorter wait times, more sensitive, and thorough care; Campbell et al., 2001; Campbell, Patterson, et al., 2005; Crandall & Helitzer, 2003;

Derhammer, Lucente, Reed, & Young, 2000; DiNitto et al., 1986; Girardin, 2005; Littel, 2001; Martin & DiNitto, 1987; Stermac & Stirpe, 2002; Taylor, 2002). SANEs also noted that interactions with ED doctors have improved now that doctors understand the role of the SANEs and realize that they are not trying to take over their jobs. It may simply be the case that perceptions of positive relationships may be influenced by familiarity.

Furthermore, unlike when discussing positive interactions with doctors, advocates, and prosecutors, when SANEs reflected on their relationship with officers they mentioned the importance of officers treating victims with respect and sensitivity. Last, positive relationships with prosecutors are also more likely when prosecutors communicate with SANEs and prepare them to testify.

Just as SANEs discussed similar reasons for positive relationships with advocates, doctors, officers, and prosecutors, they also discussed similar reasons for negative relationships with team members in the hospital. Primarily, control issues and the overstepping of boundaries create problems. Advocates overstep boundaries by questioning SANEs about evidence collection or the exam, providing victims with medical advice or information, or interrupting exams to answer questions asked of the victim. Other research supports that conflicts between advocates and SANEs occur when advocates overstep boundaries (Cole & Logan, 2008; Littel, 2001). According to SANEs, doctors may believe SANEs step on "their territory" by conducting exams or ordering medications. A power struggle may also result when officers believe SANEs should not be involved in the victim interview. Furthermore, according to the SANES included in this research who discussed negative experiences with law enforcement, police officers can treat victims in an accusatory manner or refuse to believe them. This source of frustration to SANEs is supported by other research that indicates police may blame victims or question their credibility (see Page 2008a, 2008b). Police, who often accept stereotypical images of "real" rape victims, determine whether to initiate an investigation or an arrest based on the perception of the alleged victim as someone truly harmed and blameless (Edward & Macleod, 1999). For example, if a weapon was not used during the rape, a victim failed to quickly report the rape, or was raped by an acquaintance, then the police may view her as less credible and not a "real" victim (Estrich, 1987; Madigan & Gamble, 1991).

Last, although boundary issues are not an issue between SANEs and prosecutors, SANEs included in this research revealed that problems arise when prosecutors do not properly prepare them to testify. This preparation is necessary, given that most of the SANEs who have testified described it as stressful

or intimidating. This feeling is also shared by SANEs included in other research (Campbell et al., 2007; Seng, Sanubol, & Johnson County (Iowa) SANE Team, 2004; Stevens, 2004). Konradi (2007) also found that rape survivors do not receive extensive preparation by prosecutors.

This research has a few limitations. First, one methodological limitation is that only one researcher coded the data in its entirety, so it is possible that others would interpret SANEs' responses differently. Intercoder reliability was not conducted. Second, the sample is limited to SANEs in four East Coast states. Generalizability is limited; it is impossible to determine if these findings would have differed if interviews had been conducted with SANEs from other states or with other SANEs within the four states. It is possible that SANEs interviewed do not share the experiences of those who chose not to participate in the research or were unaware that the recruitment for research was taking place. Third, it is possible that doctors, advocates, police, and prosecutors would not describe their interactions with SANEs in the same way. Future research should explore how these individuals perceive their interactions with other professionals who treat victims. Fourth, as SANEs collaborate with advocates, doctors, police, and prosecutors, they may be reluctant to reveal negative interactions with them to a researcher. Last, positive or negative interactions between SANEs and others *may not* influence the treatment of victims. However, this may be challenging to determine as victims may not know about the interactions between those who assist them.

Despite limitations, my results add to current research on SANEs. First, SANEs' personal perspectives are often not included in research. This qualitative research includes the voices of SANEs who have experiences with all members of the team responsible for the treatment of rape victims. Second, this research provides a more complete picture of not only the nature of the relationships between SANEs and ED doctors, advocates, police, and prosecutors but also explains *why* these relationships are positive or negative. This could assist members of the team who assist rape victims in improving their interactions which could ultimately improve the treatment of victims. Based on research findings, positive interactions could be maintained or negative interactions could be improved in a few ways. First, effective communication between SANEs, doctors, advocates, police, and prosecutors is essential. Second, all members of the team should be clear on each others' roles and responsibilities and should strive to make sure team members know how much they are needed and appreciated. Third, training of rape victim advocates should cover the importance of not overstepping boundaries in emergency departments by refraining from questioning the medical procedure, providing medical information to victims, or answering questions for victims. Fourth,

police should continue to receive sensitivity training on the importance of refraining from victim blaming and discrediting. Last, prosecutors should understand the importance of properly preparing SANEs to testify during trials to assure a more positive experience for them.

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Notes

1. Cole (2011) found that rape victim advocates were more likely than medical or criminal justice professionals to believe that maintaining victim confidentiality can be challenging. Medical and legal professionals may not truly understand that anything a victim says to an advocate is privileged information (Cole, 2011).
2. Also, my intention was to compare the financial struggles of rape crisis centers to the financial struggles of SANE programs. The financial issues faced by SANE programs are the focus of another manuscript.
3. While it is not accurate to claim that a colleague (whose research expertise is in violence against women) coded a subset of the interviews, she was asked to review very small sections of three transcripts where responses were vague or complex.
4. One director who resigned as director in State C four months prior to the interview was interviewed. However, data from that interview cannot be included because the micro cassette broke before transcription was complete. Although the participant's responses for most questions were transcribed, questions pertaining to collaboration were not since they were asked towards the end of the interview. Therefore the results will be based on the responses of 39 SANEs rather than the total 40 who participated in this research. In addition, one Director of Emergency Services (Registered Nurse) for a hospital in State D, and one medical director of Forensics/SANE Program from State A, were interviewed about the goals and structure of the

program. Although the research was open to male participants, the medical director from State A was the only male who participated. This is most likely due to the lack of male SANEs.

5. This sample only includes two participants of color. This is most likely due to the fact that nurses from minority groups are under represented in general healthcare (Ahmann, 2002), and most SANEs are White (Campbell, 2005; Patterson, Campbell, & Townsend, 2006).
6. Many rape crisis centers ask victims at the time of the exam if they want a follow-up phone call, and if they consent, then a follow-up call is placed by someone from the rape crisis within seven to 10 days (Preston, 2003, p. 245). My research conducted in 2003-2004 also found that follow-up calls are made as long as the victim consents to one at the time of the medical exam. Regardless of whether victims consent to a follow-up call, all receive brochures and literature from the rape crisis center regarding available services.
7. As of January 2009 SANEs can still collect evidence and treat victims who chose not to report to police or cooperate with police or prosecutors. This is referred to as a "Jane Doe" rape kit.

References

Ahmann, E. (2002). Developing cultural competence in health care settings. *Pediatric Nursing, 28*(2), 133-137.

Antognoli-Toland, P. (1985). Comprehensive program for examination of sexual assault victims by nurses: A hospital-based project in Texas. *Journal of Emergency Nursing, 11*(3), 132-136.

Bechtel, K., Ryan, E., & Gallagher, D. (2008). Impact of sexual assault nurse examiners on the evaluation of sexual assault in a pediatric emergency department. *Pediatric Emergency Care, 24*, 442-447.

Bernard, H. R., & Ryan, G. W. (2010). *Analyzing Qualitative Data: Systematic Approaches*. Thousand Oaks, CA: SAGE.

Brown, K. (2010). Forensic nursing in the emergency department. In R. Riviello (Ed.), *Manual of forensic emergency medicine: A guide for clinicians* (pp. 4-9). Sudbury, MA: Jones & Bartlett.

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

Campbell, R., & Bybee, D. (1997). Emergency medical services for sexual assault victims: Detecting the cracks in service delivery. Women's Health: Research on Gender, *Behavior, and Policy, 3*, 75-101.

Campbell, R., Bybee, D., Ford, J. K., & Patterson, D. (2008). *Systems change analysis of SANE programs: Identifying the mediating mechanisms of criminal justice system*

impact. U.S. Department of Justice. Retrieved from http://www.ccasa.org/documents/Campbell%20study-SANE%20and%20CJS.pdf

Campbell, R., Long, S. M., Townsend, S. M., Kinnison, K. E., Pulley, E. M., Adames, S. B., & Wasco, S. M. (2007). Sexual assault nurse examiners' experiences providing expert witness court testimony. *Journal of Forensic Nursing, 3*(1), 7-14.

Campbell, R., Patterson, D., Bybee, D., & Dworkin, E. R. (2009). Predicting sexual assault prosecution outcomes: The role of medical forensic evidence collected by sexual assault nurse examiners. *Criminal Justice and Behavior, 36*, 712-727.

Campbell, R., Patterson, D., & Lichty, L. F. (2005). The effectiveness of Sexual Assault Nurse Examiner (SANE) Programs. *Trauma, Violence, & Abuse, 6*, 313-329.

Campbell, R., & Raja, S. (2005). The sexual assault and secondary victimization of female veterans: Help-seeking experiences in military and civilian social systems. *Psychology of Women Quarterly, 29*, 97-106.

Campbell, R., Townsend, S. M., Long, S. M., Kinnison, K. E., Pulley, E. M., Adames, S. B., & Wasco, S. M. (2005). Organizational characteristics of sexual assault nurse examiner programs: Results from the national survey of SANE programs. *Journal of Forensic Nursing, 1*, 57-64.

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.

Centers for Disease Control and Prevention. (2010a). Web-based Injury Statistics Query and Reporting System [online]. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from www.cdc.gov/ncipc/wisqars/ default.htm.

Centers for Disease Control and Prevention. (2010b). *20 leading causes of nonfatal violence-related injury, United States*. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Retrieved from http://webappa.cdc.gov/sasweb/ncipc/nfilead2001.html

Ciancone, A., Wilson, C., Collette, R., & Gerson, L. W. (2000). Sexual Assault Nurse Examiner programs in the United States. *Annals of Emergency Medicine, 35*, 353-357.

Cole, J. (2011). Victim confidentiality on Sexual Assault Response Teams (SART). *Journal of Interpersonal Violence, 26* (2), 360-376.

Cole, J., & Logan, T. K. (2008). Negotiating the challenges of multidisciplinary responses to sexual assault victims: Sexual Assault Nurse Examiner and victim advocacy programs. *Research in Nursing & Health, 31*, 76-85.

Cole, J., & Logan, T. K. (2010). Interprofesssional collaboration on Sexual Assault Response Teams (SART): The role of victim alcohol use and a partner-perpetrator. *Journal of Interpersonal Violence, 25*, 336-357.

Corbin, J., & Strauss, A. (2008). *Basics of Qualitative Research, 3/e*. Thousand Oaks, CA: SAGE.

Crandall, C., & Helitzer, D. (2003). *Impact evaluation of a Sexual Assault Nurse Examiner (SANE) program* (NCJ 203276). Washington, DC: National Institute of Justice.

Derhammer, F., Lucente, V., Reed, J. F., & Young, M. J. (2000). Using a SANE interdisciplinary approach to care for sexual assault victims. *Journal on Quality Improvement, 26*, 488-495.

DiNitto, D., Martin, P. Y., Norton, D., & Maxwell, M. (1986). After sexual assault: Who should examine sexual assault survivors? *American Journal of Nursing, 86*, 538-540.

Du Mont, J., & Parnis, D. (2003). Forensic nursing in the context of sexual assault: Comparing the opinions and practices of nurse examiners and nurses. *Applied Nursing Research, 16*, 173-183.

Du Mont, J., White, D., & McGregor, M. J. (2009). Investigating the medical forensic examination from the perspectives of sexually assaulted women. *Social Sciences & Medicine, 68*, 774-780.

Edward, K., & Macleod, M. (1999). The reality and myth of rape: Implications for the criminal justice system. *Expert Evidence, 7*, 37-58.

Emergency Nurses Association. (2007). *Care of sexual assault and rape victims in the emergency department.* Retrieved from http://ena.org/about/position/position/Sexual_Assault_and_Rape_Victims_-_ENA_White_Paper.pdf

Estrich, S. (1987). *Real rape.* Cambridge, MA: Harvard University Press.

Flavin, J. (2001). Feminism for the mainstream criminologist: An Invitation. *Journal of Criminal Justice, 29*, 271-285.

Girardin, B. W. (2005). The sexual assault nurse examiner: A win-win solution. *Topics in Emergency Medicine, 27*(2), 124-131.

Holmes, M. M., Resnick, H. S., & Frampton, D. (1998). Follow-up of sexual assault victims. *American Journal of Obstetrics and Gynecology, 179*, 336-342.

Illinois Criminal Justice Information Authority. (2003, December). *The Efficacy of Illinois' Sexual Assault Nurse Examiner (SANE) Pilot Program.* Chicago, IL: Author.

International Association of Forensic Nursing. (2010). *Clinical Forensic Program Registry*. Retrieved from http://www.iafn.org/displaycommon.cfm?an=1&subarticlenbr=141

Konradi, A. (2007). *Taking the stand: Rape survivors and the prosecution of rapists.* Westport, CT: Praeger.

Ledray, L. (1999). *Sexual assault nurse examiner (SANE) development & operation guide*. Washington, DC: Office for Victims of Crime, U.S. Department of Justice.

Ledray, L. (2010). Expanding evidence collection time: Is it time to move beyond the 72-hour rule? How do we decide? *Journal of Forensic Nursing, 6*, 47-50.

Ledray, L., Faugno, D., & Speck, P. (2001). SANE: Advocate, forensic technician, nurse? *Journal of Emergency Nursing, 27*, 91-93.

Ledray, L., & Simmelink, K. (1997). Efficacy of SANE evidence collection: A Minnesota study. *Journal of Emergency Nursing, 23*, 75-77.

Lewis, C. M., DiNitto, D., Nelson, T. S., Just, M. M., & Campbell-Ruggaard, J. (2003). Evaluation of a rape protocol: A five year follow-up with nurse managers. *Journal of the American Academy of Nurse Practitioners, 15*(1), 34-39.

Littel, K. (2001). *Sexual Assault Nurse Examiners (SANE) Programs: Improving the community response to sexual assault victims*. Washington, DC: U.S. Department of Justice, Office for Victims of Crime.

Logan, T. K., Cole, J., & Capillo, A. (2007). Sexual assault nurse examiner program characteristics, barriers, and lessons learned. *Journal of Forensic Nursing, 3*(1), 24-34.

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

Maier, S. (2008). "I have heard horrible stories . . ." Rape advocates' perceptions of the revictimization of rape victims by the police and medical system. *Violence Against Women, 14*, 786-808.

Martin, P. Y., & DiNitto, D. (1987). The sexual assault exam: Beyond the hospital emergency room. *Women's Health, 12*, 5-28.

McGregor, M. J., Du Mont, J., & Myhr, T. L. (2002). Sexual assault forensic medical examination: Is evidence related to successful prosecution? *Annals of Emergency Medicine, 39*, 639-647.

Miles, M. B., & Huberman, M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook, 2/e*. Thousand Oaks, CA: SAGE.

Nugent-Borakove, M. E., Fanflik, P., Troutman, D., Johnson, N., Burgess, A., & O'Connor, A. L. (2006). *Testing the efficacy of SANE/SART programs: Do they make a difference in sexual assault arrest & prosecution outcomes?* Washington, DC: U.S. Department of Justice.

O'Brien, C. (1996). Sexual assault nurse examiner (SANE) program coordinator. *Journal of Emergency Nursing, 22*, 532-533.

Page, A. D. (2008a). Gateway to reform? Policy implications of police officers' attitudes toward rape. *American Journal of Criminal Justice, 33*, 44-58.

Page, A. D. (2008b). Judging women and defining crime: Police officers' attitudes toward women and rape. *Sociological Spectrum, 28*, 389-411.

Patterson, D., Campbell, R., & Townsend, S. M. (2006). Sexual assault nurse examiner programs' goals and patient care practices. *Journal of Nursing Scholarship, 38*, 180-186.

Pennington, E. C., Zwemer, F. L., & Krebs, D. (2008). Unique sexual assault examiner program utilizing mid-level providers. *Journal of Emergency Medicine, 38*(1), 95-98.

Plichta, S. B., Clements, P.T., & Houseman, C. (2007). Why SANEs matter: Models of care for sexual violence victims in the emergency department. *Journal of Forensic Nursing, 3*(1), 15-23.

Preston, L. D. (2003). The Sexual Assault Nurse Examiner and the rape crisis advocate: A necessary partnership. *Topics in Emergency Medicine, 25*, 242-246.

Rape, Abuse and Incest National Network. (2009). *Confidentiality laws.* Retrieved from http://www.rainn.org/public-policy/sexual-assault-issues/confidentiality-laws

Scalzo, T. (2006). Tips for testifying as an expert witness in a violence against women prosecution. *Voice, 1*(6). American Prosecutors Research Institute's National Center for the Prosecution of the Violence Against Women: Alexandria, VA. Retrieved December 29, 2008 http://www.ndaa.org/pdf/the_voice_vol_1_no_6_2006.pdf

Seng, J. S., Sanubol, M., & Johnson County (Iowa) SANE Team. (2004). The first year as Sexual Assault Nurse Examiner: Role transition and role-related stress within a new SANE team. *Journal of Emergency Nursing, 30*(2), 126-133.

Sexual Assault Nurse Examiner, Sexual Assault Response Team. (2010). *SANE program locator.* Retrieved from http://www.sane-sart.com/staticpages/index.php?page=20031023141144274

Speck, P., & Aiken, M. (1995). 20 years of community nursing service. *Tennessee Nurse,58*(2), 15-18.

Stermac, L. E., & Stirpe, T. S. (2002). Efficacy of a 2-year-old sexual assault nurse examiner program in a Canadian hospital. *Journal of Emergency Nursing, 28*, 18-23.

Stevens, S. (2004). *Forensic nurse: The new role of the nurse in law enforcement.* New York, NY: St. Martin's Press.

Taylor, W. K. (2002). Collecting evidence for sexual assault: The role of the sexual assault nurse examiner (SANE). *International Journal of Gynecology & Obstetrics, 78*(Suppl. 1), S91-S94.

Townsend, S. M., & Campbell, R. (2009). Organizational correlates of secondary traumatic stress and burnout among sexual assault nurse examiners. *Journal of Forensic Nursing, 5*(2), 97-106.

U.S. Department of Justice. (1995). *Report to Congress: The confidentiality of communications between sexual assault or domestic violence victims and their counselors*. Retrieved from http://www.ncjrs.gov/pdffiles1/nij/grants/169588.pdf

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