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Shifting Sexual Assault Forensic Examiners Orientation From Prosecutorial to Patient-Centered: The Role of Training

Debra Patterson,[1] Megan Pennefather,[1] and Kathleen Donoghue[1]

Abstract

Sexual assault forensic examiners (SAFEs) have a complex role that entails providing health care and medical forensic evidence collection. The literature indicates that there are two orientations that guide SAFEs in this role. A patient-centered orientation emphasizes attending to emotional needs, offering options, and respecting survivors' decisions, which has been linked to positive emotional outcomes. A prosecutorial orientation places emphasis on evidence collection and has been associated with providing fewer comprehensive services. SAFE training may play a pivotal role in guiding new SAFEs to adopt a patient-centered orientation. However, there is a paucity of research examining how training can bolster the adoption of this orientation. Thus, the current qualitative study explored if and how a national blended SAFE training influenced participants' adoption of a patient-centered orientation. Semistructured qualitative interviews were conducted with 64 health care professionals who participated in a national SAFE training. Utilizing analytic induction, the results suggest that the majority of participants entered the training with a prosecutorial orientation but shifted

[1]Wayne State University, Detroit, MI, USA

Corresponding Author:
Debra Patterson, School of Social Work, Wayne State University, 5447 Woodward Ave., Detroit, MI 48202, USA.
Email: dt4578@wayne.edu

to a patient-centered orientation. Multiple elements of the training influenced this shift including (a) content that dispelled misconceptions of survivors; (b) providing explanations of how attending to survivors' well-being can lead to positive outcomes; (c) earlier placement of patient-centered content to allow instructors to explain how patient-centered care can be applied to each component of the SAFE role including the medical forensic exam; and (d) continual emphasis on patient-centered care.

Keywords
sexual assault nurse examiners, patient-centered care, training, secondary victimization

Introduction

National epidemiological data suggest that at least 19.3% of women and 1.7% of men will experience rape in their lifetime (Breiding et al., 2014). Many rape victims/survivors do not seek help following an assault, but when they do, they are often directed to the health care system such as hospital emergency departments (EDs; Campbell, Patterson, & Lichty, 2005). However, many health care professionals lack the necessary training to meet the complex needs of sexual assault survivors. A recent survey of 1,503 ED nurses throughout the United States found that 85.5% of respondents have never received specialized training to care for sexual assault survivors even though they provided care for them (Nielson, Strong, & Stewart, 2015). This study also compared the attitudes of those with and without specialized sexual assault training and found that those who lacked training had more negative attitudes toward sexual assault survivors than those who had specialized training.

Furthermore, multiple studies have found that sexual assault survivors often experience a hurtful response or inadequate care by health care professionals who lack specialized training. These hurtful interactions have been termed "revictimization" or "secondary victimization," because survivors often describe that the interactions feel like a "second rape" (Madigan & Gamble, 1991; Martin & Powell, 1995). Examples of secondary victimization include insensitivity, blaming or doubting the survivor, trying to control survivors' decisions, ignoring their needs, and rushing through their medical care. Encountering secondary victimization can result in survivors feeling powerless, demeaned, and distressed (Campbell, 2008; Orchowski, Untied, & Gidycz, 2013; Ranjbar & Speer, 2013). As such, these hurtful experiences

have been found to impede survivors' emotional recovery and subsequent help-seeking (Orchowski et al., 2013; Ranjbar & Speer, 2013). Thus, specialized training is essential to improving the care of survivors.

Sexual Assault Forensic Examiner (SAFE) programs[1] (also termed sexual assault nurse examiner programs) have been implemented in many communities throughout the United States to provide comprehensive psychological, medical, and forensic services for sexual assault victims (U.S. Department of Justice [DOJ], 2013). SAFEs receive a minimum of 40 hr of specialized training to address the complex needs of sexual assault survivors, including acute health and emotional needs, medical forensic evidence collection, and assessment of injuries (DOJ, 2013; International Association of Forensic Nurses [IAFN], 2015). SAFE programs also tend to be distinct from traditional EDs in their approach to sexual assault survivors. In particular, SAFE programs often follow a patient-centered approach (also termed victim/survivor-centered) that entails building rapport and establishing trust, putting survivors at ease, showing compassion, and adapting to each survivor's needs to make the exam process comfortable (Campbell, Patterson, Adams, Diegel, & Coats, 2008). A patient-centered approach also involves treating survivors in an empowering manner, which Campbell and colleagues (2008) defined as treating survivors with respect, withholding judgment, restoring a sense of control, offering options, and respecting survivors' decisions. This type of care is important because it promotes emotional well-being and fosters a sense of safety so survivors can feel comfortable disclosing their victimization and endure the medical forensic exam. Research has suggested that survivors who receive this type of patient-centered care report positive emotional outcomes such as feeling safe, reassured, believed, in control, and respected (Campbell, Greeson, & Fehler-Cabral, 2013; Campbell et al., 2008; Fehler-Cabral, Campbell, & Patterson, 2011). Furthermore, this patient-centered approach is important for legal prosecution because survivors might be more willing and capable of participating in the prosecution process when they are less distressed (Campbell, Greeson, & Patterson, 2011).

Although a patient-centered approach has been linked to positive emotional outcomes, it may be challenging for SAFEs to balance patient-centered care with meeting their medicolegal responsibilities (Campbell et al., 2011). A patient-centered approach requires engaging with survivors by building rapport and offering choices, which helps survivors shift from feeling vulnerable to feeling safe and having a sense of control (Campbell et al., 2008). Alternatively, the medicolegal responsibilities require objectivity and a heavy focus on complete and accurate evidence collection. These different goals and philosophical orientations may result in role conflict, which is defined as competing demands or priorities within a role (Kahn, Wolfe, Quinn, Snoek,

& Rosenthal, 1964). For instance, SAFEs who view successful prosecution as their core goal may lose focus of survivors' acute needs and may be prone to pressure survivors to complete the exam or participate in the legal process (Campbell et al., 2011; McGregor, Du Mont, White, & Coombes, 2009).

Prior research has found negative implications of SAFEs that espouse a strong prosecutorial orientation. A national random survey of SAFE programs throughout the United States surveyed SAFE directors about their programmatic goals and patient care services, and then utilized multivariate cluster analysis to identify program goal typologies (Patterson, Campbell, & Townsend, 2006). Three discrete subgroups of the SAFE programs were identified regarding their programmatic goals. First, a "community change" subgroup was identified that had a strong emphasis on creating social change, empowering survivors, and meeting their emotional needs. The second subgroup ("high prosecution") viewed their primary goal as successful prosecution of survivors' cases. The final subgroup noted a midlevel focus on goals related to patient care and social change with a low emphasis on prosecution-based goals. These findings indicate that patient-centered care is not the central focus or goal for all SAFE programs or SAFEs. Furthermore, this study found that the "high prosecution" programs were less likely to provide comprehensive services such as education on pregnancy risk and sexually transmitted infections. Utilizing the data from this national survey, Townsend and Campbell (2009) also found that SAFEs who have a strong focus on prosecution have significantly higher levels of secondary traumatic stress and burnout compared with those with a stronger focus on patient care.

Because of the potential negative outcomes of a strong prosecutorial orientation, SAFEs' primary role must be rooted in patient care (Clements & Sekula, 2005; Lawson, 2008; Lynch, 2006). SAFEs' 40-hr core training can play a pivotal role in helping SAFEs understand the importance of patient-centered care of sexual assault victims by clarifying the role for new providers and teaching them how to place survivors' needs at the center of the medical forensic exam. However, SAFE training often reserves most of its time to the forensic components of the role because these technical aspects are often new to the health care professional (Downing & Mackin, 2012). Although it is essential to learn the legal and forensic skills of the SAFE role, this strong emphasis may influence SAFEs to believe that forensics and prosecution are more important than patient-centered care. This raises the question of how SAFE training can help clinicians adopt a strong patient-centered orientation in their care of sexual assault survivors.

The current qualitative study is one component of a larger study that evaluated a national blended SAFE training developed by IAFN and consisted of a 12-week online didactic component combined with an in-person 2-day clinical

simulation (see Patterson, Resko, Pierce-Weeks, & Campbell, 2014 for further details on the project). The quantitative components examined rates of training completion and knowledge attainment and the factors associated with those rates. The quantitative results indicated that less than a quarter of the training participants (22%) entered the training understanding that the primary focus of the SAFE was attending to survivors' health care needs. Instead, most participants perceived the primary role as collecting forensic evidence and assisting law enforcement. Following the training, 92% of the participants answered correctly that their primary role is attending to survivors' health care needs. Because there was a substantial change in the participants' perceptions of the SAFE role, the follow-up qualitative study examined how the training created this shift in perception. How did the training help participants understand that their role extends far beyond the forensic exam to include a patient-centered approach that focuses on the well-being of survivors?

Method

SAFE Training Description

The training was developed by IAFN through a peer review process by conducting two focus groups to inform the curriculum development, and then later reviewed and revised the drafted curriculum. Focus group membership included prosecutors, detectives, crime lab analysts, community-based advocates, sexual assault forensic examiners, advanced practice nurses, and physicians. The blended training began with 12 online didactic modules (PowerPoints with audio recordings) that taught content outlined in the IAFN 2015 educational guidelines (e.g., patient-centered care, medical management, evidence collection and documentation). Subsequently, participants attended a 2-day in-person clinical simulation workshop taught in a hospital teaching lab. The participants were divided into small groups and rotated through five skill stations that were facilitated by trained SAFE instructors. Each station included a gynecological teaching associate (GTA) as a simulated patient who enacted a different scenario (e.g., survivor sexually assaulted at a party, survivor abducted and sexually assaulted by a stranger). After the instructors had demonstrated skills related to patient care and the medical forensic exam, the participants practiced the skills and received immediate feedback.

Sample

Participants were recruited for the training through multiple announcements on the IAFN and Forensic Health Online websites, and emails to over 10,000

individuals listed in the IAFN electronic database. Digital and print materials also were sent to IAFN Chapters, statewide SAFE coordinators, and state sexual assault coalitions. Candidates completed an application, which guided the selection process. Applicants were eligible for the training if they had not completed a SAFE course, had the intention of working at a SAFE program, indicated a willingness to participate in the research, practice in the United States, and had access to reliable Internet. Furthermore, participants from rural communities and lower populated cities were given the highest priority, because increasing accessibility of SAFE training was a major goal of the training project. Of the 198 participants who enrolled in the training, 151 completed the training (see Patterson & Resko, 2015 for the study examining participant attrition and sampling details for the training).

Participants who completed the blended SAFE training were eligible for the qualitative study ($N = 151$). Participants were emailed information about the qualitative study along with a research information consent form. Participant recruitment and interviewing continued until saturation occurred, where no new themes emerged ($n = 64$) (Starks & Trinidad, 2007). This is a reasonable sample size for a qualitative study examining a phenomenon in depth (Creswell, 2013). Participants' average age of those interviewed was 40.67 years, with a range of 26 to 65 years. The participants' educational level varied: 32.8% had an associate's degree, 48.4% had a bachelor's degree, and 18.8% had a master's degree. The participants had 12.33 years of health care experience on average with a range of 6 months to 41 years. More than half of the participants were from a rural area (53.1%). There were no statistically significant differences in participant characteristics (e.g., experience, timing of interview) and knowledge attainment rates between participants who did and did not participate in the qualitative interviews. The participants were interviewed approximately 5 months to 1 year following the training, with an average of 8.5 months.

Design and Procedures

Semistructured interviews were conducted by phone after verbal consent was obtained. The interviews were recorded and transcribed. Weekly research team meetings were held during the interview process to identify emerging themes and topics that needed more exploration in subsequent interviews (Creswell, 2013). The procedures used in this study were approved by the Wayne State University Institutional Review Board.

The interview protocol was informed by the literature on patient-centered care and the quantitative findings. The protocol included questions to explore the participants' perspective of the different aspects of the SAFE role, the

best approach when working with sexual assault survivors to examine participant perceptions of patient-centered care, and how the training helped participants understand this concept. The interview protocol also interviewed participants to explore how participants applied their gained knowledge and skills in their practice with survivors after the training. The interviews ranged from 25 min to 68 min, with an average of 46 min.

Data Analysis

Data were open-coded for thematic content, and then analytic induction methods were used to identify empirically supported assertions. Data analysis proceeded in a two-phase process. First, consistent with Strauss and Corbin's (1990) method of "open coding," and Miles, Huberman, and Saldaña (2013) concept of "data reduction," two analysts independently read the transcripts and identified a preliminary list of themes mentioned by participants. The analysts compared themes, discussed and clarified the meaning of the thematic codes, and revised the coding framework until there was a consensus. Once the coding framework was finalized, the transcripts were independently coded by the two analysts. Because of the larger sample size for the participant interviews, a coding matrix was created and updated each time a set of 10 transcripts were coded. The coding matrix included a summary of major findings of the codes along with corresponding memos. The memos consisted of insights about the data and emerging concepts, arising questions, and areas that need further exploration. Writing these memos consistently throughout the coding process helped the analysis move from a descriptive to an explanatory understanding of the data.

In the second phase of data analysis, we used Erickson's (1986) analytic induction method, which is an iterative procedure for developing and testing empirical assertions in qualitative research. A key advantage of this method is that it elevates the analyses from the descriptive level (the first phase) to an explanatory focus. In this approach, an analyst reviews all of the data multiple times with the goal of arriving at a set of assertions that are substantiated based on a thorough understanding of all of the data. The next task is to establish whether each assertion is warranted by going back to the data and assembling confirming and disconfirming evidence. The analyst must look for five types of evidentiary inadequacy: (a) inadequate amount of evidence; (b) inadequate variety in the kinds of evidence; (c) faulty interpretative status of evidence (i.e., doubts about the accuracy of the data due to social desirability bias); (d) inadequate disconfirming evidence (i.e., no data were collected that could disconfirm a key assertion); and (e) inadequate discrepant case analysis (i.e., no cases exist that are contrary to a key assertion) (Erickson, 1986, p.

140). Assertions were revised or eliminated based on their evidentiary adequacy until a set of well-warranted assertions remain. Final review and consensus were conducted by all three authors. Observations of the online modules and clinically simulated workshop were conducted to provide the authors with a frame of reference during the interviews and analysis, as well as inform practical implications drawn from the findings.

Results

Shifting From a Prosecutorial to a Patient-Centered Orientation

The overwhelming majority of participants credited the training with helping them view the SAFE role as patient-centered health care. In fact, most[2] participants indicated that the clarification of the SAFE role as patient care was one of the most important elements of the training, because they entered the training with a prosecutorial orientation. In particular, they perceived the SAFE role as evidence collection to aid the criminal justice system. The participants further noted that their misperceptions of the SAFE role had influenced their approach to sexual assault survivors while working in EDs prior to receiving training.[3]

> The most important thing I learned was to focus on the patient and not the kit. That was basically . . . that was the epiphany for me. The cases I did before [training], I was focused on the kit. This is what I need to do, go in there and do this kit, not how bad is my patient hurt. Emotionally how are they feeling? That stuff was not my top focus [30013].

> I know the first couple of kits that I collected before I had had any training whatsoever, when I got into the room, my goal was the [sexual assault evidence kit] box. I have to fill the box because that's what I was sent in to do [10011].

As noted above, the participants' pretraining conceptualization of the SAFE role focused heavily on evidence collection as their primary goal and minimally on the survivors' well-being. It is important to note that most participants entered the training to learn the knowledge and skills necessary to serve sexual assault survivors in the best possible way, which is the same goal that they had upon completion of the training. However, their perception of what it means to best serve survivors changed from completing the sexual assault evidence kit to attending to survivors' health and emotional needs:

> I thought that my most important job was to collect the evidence so that I could serve the patient better. After the course, I realize that my first job was to take

> care of the patient and then worry about collecting the evidence, I mean the evidence collection is important, but serving that patient's emotional needs and taking care of them as a patient is the most important thing I could ever do for them [20053].

> I think as much as I like to think of myself as a holistic person, I think that I really prior [to the training] thought of the S.A.N.E. role as collecting evidence, and that's your role. If someone had said, "What is a sexual assault nurse examiner to you prior," I think I probably would have said, "Well, we collect DNA evidence to send off to a crime lab to help with prosecuting . . ." I wouldn't say that now. We have a much more comprehensive view of how we respond to victims of sexual assault in a way that ensures their physical, mental and emotional well-being [10049].

Thus, one important component of the training was helping participants conceptualize good patient care within the scope of SAFE practice.

Factors That Influenced the Orientation Shift

The participants noted that the training helped them gain this new conceptualization in multiple ways such as placing a continual emphasis on patient-centered care, dispelling misconceptions of survivors, and explaining the role of patient-centered care on survivors' well-being.

Continual emphasis on patient-centered care. Several participants noted that the SAFE instructors espoused a strong consistent message throughout the training that the SAFE is a health care provider who attends to survivors' well-being first and foremost while evidence collection is a secondary goal. This strong message helped the participants shift their definition of the SAFE role from an "evidence collector" to a health care provider who attends to survivors' needs:

> They made it a huge point to remember you are not just there to collect evidence. You're there to care for the patient as a whole. You're a nurse first before you're an exam nurse. So the piece stuck in my mind as basically the top priority of teaching patient interaction is to remember that piece . . . that you're there to care for them in every aspect, not just collecting evidence [30053].

> Just remembering that our role is not just to try to collect evidence . . . that really our job is to make sure that people are safe and mentally and physically safe. I think that was really repeated a lot during the training and helped our perception and everyone else's perception of what the role is [3007].

> It's about patient care, and that was like one of the first thing they pounded in our head in the very beginning which was a very good thing to learn [30013].

> A lot of the common themes [were] to not forget that you're there as a nurse, you're not just there to gather evidence for law enforcement. I think because you get caught up with a lot of the hands-on skills and it being kind of a specialty area in nursing that you want to almost focus on that [evidence collection] . . . So I think it would be kind of easy to get caught up with that [evidence collection] [3005].

As noted in these quotes, the participants believed that this consistent message helped them understand that the SAFE's primary goal was attending to survivors' health and emotional needs.

Similarly, some participants noted that their attention was easily absorbed with learning the medical forensic skills as this is a new specialty for them. As such, the consistent message helped remind the participants that their core role is providing patient-centered care even while performing medical forensic evidence examinations.

Dispelling misconceptions of survivors. The training also provided statistical and demographic information about victims and offenders, which led some participants to realize that they had misconceptions about sexual assault victims that could influence their patient care. The following quote offers an example of how dispelling these misconceptions helped the participant understand the importance of treating all sexual assault survivors with dignity and respect regardless of their race, socioeconomic status, or the context (e.g., alcohol use).

> I think really one of the most helpful things for me was like the beginning when it was talking about all the different demographics of people, because sometimes you don't stop and think about that. . . . It's not going to always be the nice college girl that was walking home to their dorm. . . . I mean obviously that's happened, but it just kind of gave me a sense that it's all people, and regardless of what their walk of life is, they need to be treated the same way with dignity, so I thought that was real helpful [Student 1001].

> It just made me more aware of the things that these women, and sometimes men, are going through. The stigma, and trying to put myself in their position. How would I want to be treated? It helped me to change the attitude of others in my department because, as an ED nurse, we get jaded. And you know, "Well, they just asked for it. They were drunk." You know, I don't care if you're out on the corner naked and drunk, you don't deserve to be assaulted in any way. So it has helped to change and helped to explain . . . [20055].

> Getting that sort of on my radar from the training and getting information on how to be more aware and culturally sensitive to different groups and more comfortable asking . . . just asking questions to kind of clarify where people are in life and where they're coming from and not assume [Student 10049].

Similarly, these participants believed this information helped them realize that sexual assault can happen in any context, and survivors who do not fit a stereotypical sexual assault (e.g., stranger) deserve compassionate nonjudgmental patient care.

Explaining the impact of patient-centered care on survivors' well-being. Another way that the training helped participants conceptualize good patient care was teaching them about sexual assault survivors' concerns and needs. For example, several participants emphasized the importance of learning that sexual assault survivors may experience vulnerability and a fear of judgment when they seek help. By understanding these concerns, the participants understood why a respectful compassionate approach is essential to helping survivors feel safe and less vulnerable.

> You know they have had something taken away from them that they didn't want to give away and so there is just a load of emotions going on, plus physical violation . . . So there is just a whole lot of different psychological factors that are going on, that are going to go with them for the rest of their lives, and if their first interaction with the health care provider is not a good interaction, the chances of them following up are not going to be good [20053].

> They are like a raw nerve. And can respond any way. And the experience can be made so much worse or so much more healing based on how you experience them and they experience you [10050].

> And what I really came away with was giving them their control back of their body. Asking them, "Is it ok, if I do this?" They say "yes" or "no" and that was really pivotal in many aspects of nursing. "Is it ok if I do this?" You know, but especially it is allowing them to say, "Yes, its ok." Because of course they feel like they've just lost control of their own body, being assaulted" [10016].

> Just how vulnerable patients are in so many situations, but particularly in one where there's been trauma or assault and how important it is to help them feel safe and give them as much control as possible [20031].

As these quotes demonstrate, the training raised participants' awareness of the emotional needs of survivors. Furthermore, this new knowledge helped them understand that their interactions with survivors can have a positive or

negative impact on the survivors' healing and willingness to seek follow-up care. Consequently, the participants understood the rationale of why attending to survivors' needs was the primary goal while evidence collection was secondary.

Overall, the training helped shape the participants' perceptions of the SAFE role by underscoring the importance of patient care taking precedence over evidence collection, which helped shape a more compassionate approach.

Benefits of Patient-Centered Orientation on SAFEs

While most participants noted that a patient-centered orientation improved their patient care, a few participants also mentioned that this orientation benefitted them as well. In particular, a few participants noted that they felt more confident about practicing as SAFEs once they understood the health care focus of a SAFE's role. Once these participants learned that the SAFE role is another iteration of their role as health care providers, it helped them navigate expectations of that role more assuredly.

> But once I realized that my job was not just to come in and tell her, "I need to do this, this and this and take photos," and be done. I'm also there to support her emotionally and to be not just a body coming in to do another thing to her. That made it feel more comfortable because I was like, "I can relate to a patient. I can understand and do that conversation piece prior to collecting all that." I felt better about that and I felt more confident in knowing that number one, as long as it's up to the patient as to what exactly she wants. And that my role is to support and help her through that too . . . I think it may be easier for me because I have lots of years experience with patient care and in helping the emotional aspects and those sorts of things. I think that fell into place easier for me, once that part was brought forward nice and clear [30050].

> I think they kind of just brought like a professional, clinical [focus] like this is just . . . you can be compassionate. It's just like any other kind of nursing. It's like . . . you can do a good job and you can have good bedside rapport with your patient. It's just a skill and you'll figure it out . . . But just being relieved too. Like, ok, it wasn't as bad as I thought it was going to be. And now I know what to look for [10010].

> I guess because of the specialty of this particular thing, it intimidated a lot of nurses. So when I came back and said, "No, it's not as intimidating . . . it's no different than the way you would approach any other patient, but you just have a step-by-step method of collection that you're fully trained for." It has eased the intimidation factor of it [20047].

As these participants pointed out, there was some anxiety at the prospect of learning entirely new fields of knowledge, like evidence collection. Similarly, other participants noted that it was easy to "lose sight" of the health care perspective, because they were new to learning about medical forensic evidence exams. As such, the common anxiety of learning new skills may influence new SAFEs to focus too heavily on the evidence collection. Therefore, reiterating that patient care was the SAFE's primary role may help ease some of the anxiety for new SAFEs, because they can draw upon their professional experience.

A few students also mentioned that the training increased their respect for the SAFE role when they learned how SAFEs can positively impact sexual assault survivors' well-being. These participants noted that they held a higher regard or value of the SAFE role when they began viewing it as primarily health care, which motivated them to become SAFEs.

> Yeah. I mean, it's helped me want to continue within the work. I feel good about the fact that when I see . . . when I do encounter someone, I have health care to offer them. You know, it's worth . . . I guess my time. I have lots of things [health care delivery to other patients] I'm trying to do. . . . But knowing how the assault can impact a person's health over their lifetime, and the fact that I'm able to offer an intervention, then I feel like it's well worth my time [1009].

> I don't know how to explain it; they gave me more of a purpose for being there for the person, not just collecting evidence for the police. I'm there for the patient and that made me feel better . . . [30018].

> This is an important thing that's being accomplished here . . . it was inspiring. That's what I would say. I was inspired [30038].

> I just realized there was more and more to do and once I finished the program, I said, "I've got to do this. It's just something I believe in." Because I believe it's an excellent aspect of nursing care. Not just for the sense of taking evidence and getting someone put in jail for it, but just the patients themselves and getting them taken care of. That, to me, is just so huge [20020].

As noted in these quotes, these participants viewed the SAFE role as more valuable when they understood the positive impact that they can have on survivors' well-being. Consequently, these participants expressed feeling inspired to continue their careers as SAFEs.

Discussion

Despite the benefits of a patient-centered approach toward sexual assault survivors, research has suggested that some SAFEs have a prosecutorial orientation

whereby they place more emphasis and value on evidence collection than patient care (Fehler-Cabral et al., 2011; Logan, Cole, & Capillo, 2007; Patterson et al., 2006). It is possible that training may influence new SAFEs to adopt a patient-centered orientation in their practice (Zerr, 2012). The current qualitative study explored how a SAFE training influenced new SAFEs to adopt a patient-centered orientation.

Although most of the participants were aware of the concept of patient-centered care in the context of general health care, the current study found that most of the participants entered the training with a prosecutorial orientation as they viewed the SAFE role as aiding the legal system. These participants described their pretraining care of survivors as focusing primarily on completing the sexual assault evidence kits with a minimal focus on survivors' well-being. This finding is similar to prior research that noted SAFEs with a prosecutorial-orientation tend to focus on evidence collection rather than focusing on survivors' needs and emotional well-being (McGregor et al., 2009).

The current study also found that these participants were not apathetic toward sexual assault survivors. In fact, most of the participants were drawn to the training because they wanted to attain the knowledge and skills required to improve their care of sexual assault survivors. However, these participants initially believed that the best way to meet sexual assault survivors' needs was by focusing their attention on completing the medical forensic evidence exam. Thus, the training's focus on a patient-centered philosophy was an important realization as the overwhelming majority of participants shifted from a prosecutorial to patient-centered care orientation. Given that most participants entered the training with a prosecutorial orientation, it is important for SAFE training to include a learning objective focused on role clarification even if the training participants have performed medical forensic exams before the training. Furthermore, it can be advantageous to communicate this training objective to participants because prior research has found that participants' awareness of the training objectives can increase their motivation to learn (Salas, Tannenbaum, Kraiger, & Smith-Jentsch, 2012). Communicating this training objective might be particularly motivating for participants who entered the training to improve sexual assault patient care.

The findings also identified multiple elements of the training content and design that had influenced participants' adoption of a patient-centered orientation. First, the training content included the rationale for why survivors' well-being should be SAFEs' primary focus. For example, participants learned about sexual assault survivors' help-seeking concerns, such as feeling vulnerable when seeking help and fear that health care providers will judge, blame, or disbelieve them. Furthermore, they learned that a patient-centered

care approach could assuage these concerns by helping survivors feel safe and restore their sense of control during the exam process. The training content also included information to dispel common myths about sexual assault. For example, participants learned that sexual assault is often committed by someone known to the survivor (Markowitz, 2012; Planty, Langton, Krebs, Berzofsky, & Smiley-McDonald, 2013). Participants also noted that the prevalence rates of different demographic groups dispelled their misconceptions of survivors and reiterated the importance of treating all survivors in a compassionate nonjudgmental manner. This information is important to include because health care providers who believe sexual assault stereotypes are more likely to engage in victim blaming and express disbelief of the survivor's story if it does not align with these stereotypes (Du Mont & White, 2007). Together, this content helped the SAFEs realized that patient-centered care was essential in the SAFE role because of the positive impact it can have on survivors' emotional healing.

Second, several participants noted that the heavy emphasis on patient-centered care throughout the training served as a helpful reminder of their role. Research suggests that earlier placement of important content helps instructors continually link subsequent modules to the key content (Carliner, 2015). Although sequencing was not explored in the interview, we suggest it may be important to introduce content on patient-centered care and sexual assault dynamics (e.g., survivors' emotional needs and concerns about help-seeking), early in the training. In our observation of the training, the earlier placement of patient-centered care allowed the instructors to connect the evidentiary content back to the importance of patient-centered care. For example, the medical forensic exam modules taught participants how patient-centered care helps sexual assault survivors feel safe, which might help them better tolerate the medical forensic exam. Thus, earlier placement of this content appears to help instructors explain how patient-centered care is important for each component of the SAFE role.

Consistent reminders of patient-centered care also may be especially important given that most of the curriculum focuses on evidentiary-related topics. The focal training's curriculum was consistent with International Association of Forensic Nursing (IAFN) Educational Guidelines, which covers several evidentiary-related topics such as forensic science, evidence collection, photography, documentation, and the justice system. The inclusion of this content is essential to achieve competency because inaccurate and incomplete evidence collection can be common among health care providers without SAFE training (Downing & Mackin, 2012; Sievers, Murphy, & Miller, 2003). However, some participants noted that they became easily absorbed with learning evidentiary skills because the content was primarily new to them.

Thus, the instructors placing emphasis on patient-centered care throughout the training served as a reminder that their role was to continually attend to the patients' needs even while performing medical forensic examinations.

Earlier placement of content related to patient-centered care in the training also might help alleviate some anxiety related to learning a new role. Although the participants have health care experience, learning a new role has been shown to induce feelings of anxiety (Neal-Boylan, 2006). This can be problematic as high levels of anxiety has been shown to reduce learners' efforts and ability to learn (Klein, Noe, & Wang, 2006; Lundberg, 2008). However, a few of the participants noted that they felt less overwhelmed and anxious once they understood the patient-centered care role of a SAFE because they could draw upon their existing skills and experience of providing patient-centered care. Although these participants still needed to learn the skills necessary to perform medical forensic examinations, confidence in their ability to provide patient-centered care made the learning process more manageable. Thus, mitigating the anxiety early in the training may help students learn the new content. It is important to note that the link between patient-centered care and learner confidence was mentioned spontaneously by these participants and was not systematically explored in the interviews. Therefore, future research should continue to explore how patient-centered care content might influence learner's anxiety and confidence.

In addition, a few participants noted that their respect for the SAFE role increased when they learned that a patient-centered approach could have a positive impact on survivors' well-being. As a result, these participants expressed feeling inspired and more motivated to become SAFEs once they realized that SAFEs could have a positive impact. This finding reiterates the significance of introducing content on patient-centered care early in the SAFE training as motivation to learn increases when learners perceive the training as valuable and meaningful (Stolovitch & Keeps, 2011). This is especially important given that most participants entered the training with the aim of improving the care of sexual assault survivors but were not recognizing that a patient-centered orientation would fulfill that aim. Similar to learner confidence, the link between motivation and a patient-centered orientation was not systematically explored in these interviews but instead volunteered by a few participants. Still, the overwhelming majority of participants expressed enthusiasm about being a SAFE during the interviews and mentioned their intent to stay in this role. This is notable given that retention of SAFEs has been cited as a challenge for SAFE programs (Logan et al., 2007; Maier, 2011). It is possible that the patient-centered orientation provided meaningful work that attributed to their continued enthusiasm (Shanafelt, 2009). Future research should examine how a patient-centered orientation

might influence training participants' motivation to become and remain a SAFE once they enter the field.

Limitations

There are several limitations of the study that merit examination. First, the retrospective design of the study relied on participants' memories. It may be possible the participants did not recall other factors that helped them adopt a patient-centered care orientation. However, it stands to reason that SAFEs would remember the factors most salient to them. Second, the sample included SAFEs who attended one blended training, so the findings may not be generalized to other SAFE trainings especially because standardization of sexual assault nurse examiner (SANE)/SAFE curricula does not exist. Although IAFN's educational guidelines indicate the minimum number of required course hours and the targeted core competencies of 12 content areas, it does not outline the specific content required in those 12 areas or the percentage of time allotted to each area. Thus, the frequency and volume of patient-centered care content may vary among trainings. Third, the participants in this study may differ from those who attend other SAFE trainings. The goal of this project was to increase access to SAFE training for those working in lower populated cities and rural areas. Thus, applicants from major metropolitan urban communities were excluded because they have more accessibility to SAFE training in their regions. Therefore, the findings cannot suggest whether this training would be effective in preparing SAFEs to work in major metropolitan urban communities. The culture and service delivery of rural communities differ from urban communities (Johnson, McGrath, & Miller, 2014). For example, rural SAFEs are more likely to know their patients and less likely to have advocates present to address the patients' emotional well-being. Thus, rural SAFEs often have the sole responsibility to address the acute emotional needs of their patients. It is possible that the pressure to fulfill this responsibility contributed to their adoption of a patient-centered care orientation.

Similarly, those individuals who agreed to participate in the qualitative component of the research may be different from the participants who did not. Although there was no statistically significant difference in their demographic background, it is possible that those who were not interviewed would have identified different factors that influenced adoption of a patient-centered care orientation. Finally, this study did not interview the patients of the participants, so we cannot assess whether the participants were practicing patient-centered care for all of their patients. Research has suggested that health care providers are less likely to provide patient-centered care for

marginalized groups such as ethnic minorities (Cooper et al., 2012). It is important for future research to examine whether patient-centered care is provided to all survivors, but especially those from marginalized groups whose first and often only source of professional support is health care (Weist et al., 2007).

In spite of these limitations, the findings of this study suggest several implications for future research. Future research can draw upon these findings by examining the sustainment or abatement of a patient-centered care orientation following a SAFE training. The participants were interviewed approximately 5 months to 1 year following the training, and the overwhelming majority espoused a patient-centered orientation regardless of the time lapse following the training. Understanding what helped them sustain this orientation was beyond the scope of this project. Future research should examine what contributes to maintaining a patient-centered orientation following the training. Prior research suggests that health care professionals' attitudes toward patient care can be influenced by organizational culture (Zomorodi & Lynn, 2010). Thus, it also would be helpful to understand how preceptors, supervisors, colleagues, or their institutions play a role. Future research should also explore whether these contributing factors differ among geographic location. For example, participants from rural communities indicated that they had no or few SAFE-trained preceptors or colleagues in their institutions, which means that these SAFEs may have to practice in geographic isolation. Future research might explore the challenges of maintaining a patient-centered orientation while practicing in geographic isolation.

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Notes

1. For purposes of this article, we will primarily refer to the health care personnel as SAFEs to be inclusive of all health care disciplines such as midwives or physician assistants who are trained to provide specialized care to sexual assault survivors.

2. The pronouns utilized in this report are operationally defined as the following: Most refers to 80% or more; several refers to more than half; some signifies less than half; few refers to 30% or less (Sandelowski, 2001).
3. Because there is limited access to training across the United States, health care clinicians may perform medical forensic exams without the 40-hr SAFE training.

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Author Biographies

Debra Patterson is an associate professor in the School of Social Work at Wayne State University. She holds a PhD in community psychology with a concentration in organizational and social change from Michigan State University. Her research examines sexual assault victims/survivors' barriers to help-seeking; how the legal, medical, and mental systems respond to the needs of survivors; and interventions to improve the response to sexual assault survivors.

Megan Pennefather is a licensed clinical social worker in Detroit, MI. She received an MSW from Wayne State University. Her research and clinical interests include interpersonal trauma, interventions to improve the response to sexual assault survivors, adolescents in foster care, and at-risk youth.

Kathleen Donoghue is a social worker in Detroit, MI. She received an MSW from Wayne State University. Her research and clinical interests include interpersonal trauma, interventions to improve the response to sexual assault survivors, child abuse, and family violence.