



Investigating the medical forensic examination from the perspectives of sexually assaulted women[☆]

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ABSTRACT

Across many jurisdictions, a key institutional response to sexual assault is centred on the collection of medico-legal evidence through a medical forensic examination (MFE). Despite the increased routinization of this practice, such evidence often is not related to positive criminal justice outcomes. As there has been little systematic investigation of the perspectives of victims regarding the MFE, we conducted semi-structured, face-to-face interviews with 19 women aged 17–46 years who had been sexually assaulted and had undergone an MFE in the previous six months at one of four specialized hospital-based sexual assault centres in Ontario, Canada. Extracts from the transcribed interviews were coded into two broad themes, 'Expectations' and 'Experiences', from which a series of lower order constructs were derived. We found that most women went to a centre to have their physical and emotional needs addressed rather than medico-legal evidence collected and were overwhelmingly satisfied with their interactions with specially trained nurse examiners. However, some women were confused about the purpose of the MFE, believing that their access to treatment hinged upon undergoing this process. Moreover, though optional, several indicated that they had been instructed to have an MFE by the police and/or nurse examiner. Most women who chose to have evidence collected did so with the hope that it would hold the assailant accountable and generate social recognition of the harm done to them. While many stated that they were distressed during the MFE, some reported feeling simultaneously empowered by the fact that the experience fostered a "sense of doing something". These findings point to the value of collecting medico-legal evidence in settings staffed with supportive practitioners who also attend to women's health related concerns. Implications with respect to issues of informed consent, revictimization, and empowerment, as well as the relative weight given to the MFE in the post-sexual assault care encounter, are discussed.

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Introduction

Sexual violence has long been a pervasive human rights and health problem, with often devastating impacts on victims worldwide (Jewkes, Sen, & García-Moreno, 2002). For sexually assaulted women seeking to obtain justice, corroborative medico-legal

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evidence (e.g., semen, sperm, anogenital and extragenital injuries) is regularly called for in the law or policy. Protocols tailored to meet these demands are increasingly being implemented and refined across countries (Du Mont & White, 2007; World Health Organization, 2003). These protocols, which often include the use of some form of sexual assault kit, guide the medical forensic examination (MFE) with the instructions and necessary materials for gathering evidence (Du Mont & White, 2007; Kelly & Regan, 2003).

Medical forensic examination

Where protocols are well established, the MFE for female adult victims of sexual assault typically comprises a number of key components (Du Mont & Parnis, 2001; World Health Organization, 2003). Written consent is secured, usually with notification that the woman can halt the examination at any point. A medical history is frequently taken to determine her present state of health and any

physical and psychological needs that may require immediate attention. A history of the sexual assault is also taken for the purpose of guiding the evidentiary examination. Available clothing worn by the victim during the sexual assault, pubic hair combings or cuttings for identification of foreign materials, and samples of urine and blood for drug and alcohol analysis may be collected. Extragenital and anogenital injuries (e.g., abrasions, lacerations, swellings, bite marks, scratches) are documented, the latter using a speculum and, in some jurisdictions, a colposcope, anoscope, and/or staining agent such as toluidine blue dye to enhance findings of microscopic trauma. Samples are commonly taken from the victim's skin and body cavities for the detection of semen and saliva. She also may be further swabbed for DNA evidence at relevant points of contact with the assailant and her emotional state may be observed and recorded as, for instance, crying or depressed, calm, or composed in appearance.

Given the extent to which the MFE has been institutionalized and routinized within many regions, research assessing its impact has been surprisingly limited and focused primarily on the use of medico-legal evidence in criminal justice systems. A recent global review of the MFE in adult sexual assault cases revealed a few dozen studies that have examined the relationship between different types of medico-legal evidence and the progression of cases (Du Mont & White, 2007). In just under half (44%) of those that examined the presence of general physical injury, a significant association with legal outcome such as charge filing and conviction was found. Less than a third of pertinent studies reported that the occurrence of anogenital trauma (29%) or collection of biological and/or nonbiological samples (31%) was related to a positive legal result. None of the relevant research demonstrated a relationship between the identification of sperm or semen and the successful outcome of a case.

With respect to evaluating the MFE in relation to those for whom it was designed, some studies have drawn on health care providers' perceptions of the process for women. A recent survey of 110 sexual assault programs in the United States reported that a substantial proportion of nurse examiners believed that victims found the pelvic examination (47%), act of talking about the sexual assault (46%), and plucking hairs (17%) to be the most distressing part of the process (Campbell et al., 2006). A study of 118 sexual assault nurses in Ontario, Canada indicated that 22% of respondents believed the collection of evidence to be akin to a second assault (Du Mont & Parnis, 2003) and almost three-fifths thought it could be both revictimizing and therapeutic. In a related survey of 31 sexual assault physicians, 48% responded that they sometimes omitted components of the MFE because they believed them to be too upsetting for the victim (Du Mont & Parnis, 2004). In-depth interviews and focus groups with a small number of Canadian nurse examiners revealed that, given sexual assault victims often have few or no physical injuries (Du Mont & White, 2007), there was an institutional over-emphasis on documenting evidence of physical trauma to women's bodies that was of concern (White & Du Mont, 2008).

There exists only a small body of literature based on examining the experience of the MFE from the perspectives of victims themselves. Much of this research has been limited in its scope and characterized by conflicting findings, often related to where and by whom the MFE was performed. Reports from sexually assaulted women examined by physicians with limited training in sexual assault in their surgeries, police stations, and hospital emergency departments have been mostly negative (Temkin, 1998). For instance, in an early study of 26 women in the United Kingdom, almost all those who had undergone an MFE by a doctor "described [it] ... as a horrific endurance test and several ... as utterly degrading. One woman even said it was as bad as the rape itself" (Gregory & Lees, 1994, p. 87). Subsequent research in England found that 86% of 14 women examined by a (former) general practitioner

"were wholly, mainly or partly negative about [the experience]" (Temkin, 1996, p. 1). These feelings were tied largely to the sex and manner of the attending physician, although four women found the examination itself traumatic. More recently, interviews with 81 victims who presented to two different urban hospitals in the United States revealed that 69% representing one and 36%, representing the other reported being "treated impersonally or coldly" during the forensic examination by emergency room doctors (Campbell, 2006, p. 38).

In contrast, a few studies have shown that women who are examined by health care providers with specialized instruction in working with sexual assault victims and in specialized sexual assault centres have been generally more favourable about their MFE experience. In New Zealand, where women were cared for by specially trained on-call physicians in the early 1990s, one study found that over 80% of 34 rape victims who had undergone an MFE indicated feeling "very satisfied" or "satisfied" with how they had been treated during the process (Jordan, 2001). Between 2000 and 2002, 66 service users of specialized integrated sexual assault services known as Sexual Assault Referral Centres (SARCs) were surveyed in Manchester, 26% of whom found the MFE "uncomfortable", but only 7% "clinical/cold" (Regan, Lovett, & Kelly, 2004, p. 22). In a larger related study comparing SARCs to nonspecialized services, a survey of 228 victims revealed the highest levels of satisfaction with examiners at the former (Lovett, Regan, & Kelly, 2004).

In an attempt to further our understanding of the MFE from the perspectives of those who have engaged in this process, we conducted a comprehensive, in-depth qualitative study. Specifically, we interviewed women who had been sexually assaulted in the previous six months and who had undergone an MFE by an examiner with specialized training at one of 30 (at the time) designated Sexual Assault and Domestic Violence Treatment Centres (SADVTCs) in the province of Ontario, Canada.

Method

Setting

Ontario's SADVTCs provide emergency care 24 hours-a-day, seven days-a-week to those who have been sexually assaulted within the previous 72 h. In addition to the optional collection of medico-legal evidence during an approximately 3-h examination using a Sexual Assault Evidence Kit (Kit), on-call examiners offer: crisis counselling; the assessment and treatment of injuries; counselling, testing, and/or treatment for sexually transmitted infections [STIs]; assessment, treatment, and counselling for pregnancy; blood collection for future HIV testing; longer term counselling; anonymous third party reports to police; and referrals to community-based agencies for services not provided (e.g., support in deciding whether to press charges). SADVTC services are to be delivered based on, among others, the following precept: to provide care in a respectful manner so that clients may reclaim their autonomy (Du Mont & Parnis, 2002).

Recruitment

In spring 2002, we approached the program coordinators of the 30 SADVTCs at their quarterly provincial network meeting with our interest in interviewing sexually assaulted women seen at their sites in the previous six months. This presentation was followed by an e-mail requesting their support in locating qualified interviewers in their region and in recruiting women who had undergone an MFE and whom they believed would be suitable for and amenable to an in-depth interview on that experience. Nine responded to this request. Ethics approval was then secured from each hospital to which a participating program coordinator was attached.

As has been acknowledged in other research centred on sexually assaulted women, recruitment of participants willing to be involved in this study was challenging. According to program coordinators, some women did not wish to revisit such “difficult terrain” (Parnis, Du Mont, & Gombay, 2005, p. 691; see also Gregory & Lees, 1994; Temkin, 1996). Many did not return to the SADVTC after their initial visit and/or moved or changed their phone numbers. Several times a woman agreed to be interviewed but then later changed her mind. Although interviewers did not identify themselves as such when calling prospective participants to arrange an interview time, they occasionally encountered suspicious or hostile people at the other end of the telephone who may not have passed their messages along. Given the sensitive nature of talking to anyone other than the woman herself, interviewers did not attempt to contact these women again. In total, 19 women who had undergone an MFE at one of four SADVTCs were interviewed between September 2002 and July 2004. These particular sites are staffed by sexual assault nurse examiners and serve culturally diverse rural and urban catchment areas that range in population from 100,000 to 1,000,000.

Interviews

Interviews were carried out by three counsellors each with several years of experience working with sexually assaulted women. The project coordinator, posing as a participant, conducted a practice interview with each of the interviewers to evaluate their skills and offer feedback. Interviewers were also given a comprehensive interview guide containing detailed instructions that stressed the need to protect participants’ well-being and to call women a few days after the interview to ensure that they had suffered no ill effects. In the event that they became distressed, interviewers were also given the names of therapists in the area that could provide follow-up counselling free-of-charge. Prior to being interviewed, participants were instructed to read an information sheet explaining the nature of the interview and the purpose and future uses of the research. They were informed that they could refuse to answer questions and stop the interview at any time, noting that any future treatment at an SADVTC would not be compromised.

Semi-structured, face-to-face interviews were then conducted using an interview schedule composed of both closed- and open-ended questions. This schedule was designed to elicit information regarding women’s perceptions of the MFE in the health care context through sequenced questioning. Topics of enquiry included: time of presentation to an SADVTC, reason(s) for coming, health care received, staff–victim relations, reason(s) for undergoing an MFE, prior knowledge of medico-legal evidence collection practices, and feelings about having undergone an MFE. Although some initial questions were centred on a ‘yes/no’ format, interviewers were instructed to follow a woman’s lead if she seemed to have more to say on a subject. Following the interview, women were asked to complete a short Demographic Questionnaire. Interviews were approximately 1–1.5 h in length and were audio-taped and transcribed verbatim. Transcriptions were audited for accuracy.

Data analysis

The first two authors initially read each interview transcript twice. Following this, they constructed a three-column content grid for the distillation of both quantitative and qualitative data. Column one consisted of the pseudonym of the participant and the date and location of the interview and column two contained data collected from the Demographic Questionnaire. The third column was the systematized repository for closed-ended and condensed qualitative responses based on manual extraction and an initial manifest content analysis (Graneheim & Lundman, 2004). Emergent patterns

were identified from this data beginning at the higher order of categorization with two conceptual themes: ‘Expectations’ and ‘Experiences’. Drawing on meaningful commonalities found across responses to questions within each cluster, the authors independently derived a series of lower order constructs, some with sub-categories. These constructs were compared and any differences that emerged resolved through discussion and consensus. Finally, responses identified in each construct were referenced back to the transcripts for context and secondary extraction of relevant quotations for latent content analysis at a deeper level of abstraction (Graneheim & Lundman, 2004).

Results

Description of the sample, assaults, and the care received

The 19 women interviewed ranged in age from 17 to 46 years. Approximately half ($n = 10$) were single. Almost four-fifths ($n = 15$) were born in Canada, one of whom identified as French and two as Aboriginal Canadian. Those who were born abroad came from Hong Kong, Brunei Darussalam, and Brazil. Over two-fifths ($n = 8$) of women identified as visible minorities. Less than half ($n = 8$) had some post-secondary education and one-third were employed ($n = 6$). A substantial minority reported having a disability ($n = 4$) and household income under 15,000 Canadian dollars ($n = 5$). Four women were living alone, 11 with family, three with nonrelatives, and one in an alcohol and drug rehabilitation centre. All women had been sexually assaulted by a single male assailant, only one of whom was a complete stranger. Other assailants included: acquaintances (almost all known <24 h), friends, dates, and current and previous boyfriends.

Over four-fifths ($n = 16$) of women presented to an SADVTC within 72 h of being sexually assaulted. Approximately two-thirds ($n = 12$) were instructed to do so by police, who had been notified of these assaults in 13 instances. Thirteen women had sustained an injury. Most stated that they received crisis counselling ($n = 12$) and were offered and accepted prophylactic treatment for possible pregnancy ($n = 11$) and STIs ($n = 15$). Of the latter, 10 had either stored blood for future HIV testing specifically and/or were given HIV post-exposure prophylaxis.

Expectations

Determination to hold the assailant accountable

For many women who chose to undergo an MFE, the reasons they offered for having done so were, in large part, consistent with the original intent behind the establishment of this protocol, which was to systematize the collection of medico-legal evidence to aid in prosecuting sexual assault cases (Provincial Secretariat for Justice, 1979). Over three-quarters ($n = 15$) stated that they hoped the evidence collected would assist in obtaining justice. Taken together, their comments suggested that having an MFE would:

- get evidence or proof of the assault;
- force the assailant to take responsibility for what he did;
- help identify the assailant;
- prove the assailant’s guilt;
- prevent the assailant from re-offending or hurting other women; and
- increase their feelings of safety and protect loved ones from the assailant.

Desire for social recognition of the harm done

Almost half ($n = 9$) the women interviewed indicated that they had consented to an MFE because they were seeking some kind of

“objective proof” of what had happened to them, not for the courts, but for family, friends, partners, etc. A 20-year-old student from the northern part of the province explained that she did not want “people to look at her differently, [to be perceived as the] girl [falsely] crying rape” (Interviewee 11). In a similar vein, a 19-year-old Canadian born woman of South Asian descent who felt she needed evidence to confirm what had happened to her stated, “my friends at first they were very shocked and asked ‘are you sure that’s what happened? Are you positive about the details?’” (Interviewee 17).

Experiences

Importance of health care

A clear pattern that emerged from the interviews was the significance of the health care dimension of the SADVTC experience for women. Fewer than half ($n=8$) went to a centre with the intention of undergoing an MFE, the possibility of which was generally raised with them by the police or nurse examiner. Most women were seeking medical attention and/or counselling. Four were looking to “talk to someone”, to get “help [to] get through it”, and to deal with “how [they were] feeling, and what [their] fears were”, including “nightmares” they were experiencing post-sexual assault (Interviewees 1, 9, 12, 16) and nine had come specifically to be assessed and treated for STIs. Comments made by a 46-year-old divorced woman are illustrative, “I just thought I should get checked because I was starting to think about diseases and everything and that’s what scared me the most. ... I’d get everything checked ... for my own well being” (Interviewee 5). A 19-year-old student living with her boyfriend was also motivated by her concerns about becoming pregnant, “[i]t’s the best thing, really. That way you know you’re not gonna’ catch anything or ... get anything you don’t want, because somebody 14 years old doesn’t want a kid. Even at 18 years old, I didn’t want a kid” (Interviewee 6). When women were questioned about the relative weight they placed on different aspects of their experiences at a centre, the collection of evidence was considered less important than the provision of health care by many ($n=10$).

Positive impact of supportive staff

Women were almost unanimous in their claims regarding the positive role that staff played in their SADVTC experience. Most found nurse examiners to be “very understanding” ($n=17$) and were “very satisfied” ($n=15$) with their interactions with them. As reflected in the following quotes, women felt they were not being judged and were provided the time and attention warranted by their circumstances:

“[T]he nurse was amazing. ... She was very comforting ... the first thing I was told when I walked in the door [was] it’s not your fault, you may think it is, people may tell you [it is], but it’s not ... that reassured me.” (Interviewee 10)

“She [the nurse examiner] was ... really friendly. ... She really cared. ... She listened really well. ... It made me feel good about myself.” (Interviewee 5)

“I can actually say I’ve probably never been treated with more compassion ... ever in my life. I was probably treated better at that time than I had been in a very, very long time.” (Interviewee 16)

“They were very, very caring, very patient. ... [T]hey’re wonderful people.” (Interviewee 7)

Misunderstandings and misrepresentations

Confusion about the purpose. Some women were confused with respect to the purpose of the MFE. Although SADVTCs are mandated

to provide health care irrespective of whether evidence is collected, five women stated that their primary reason for undergoing a forensic examination was to make sure that their health was not jeopardized. Two high school students, one assaulted by a previous and the other by a current boyfriend, explained:

“It was to protect me and my boyfriend, to protect myself mostly. By getting it done, I wouldn’t get something I didn’t want. You know, just so I was safe ... like I didn’t want a kid or nothin’.” (Interviewee 6)

“I was just hoping that everything was okay, that I wasn’t pregnant or I didn’t have any diseases or anything.” (Interviewee 2)

A 33-year-old French Canadian woman similarly commented, “I didn’t think [the Kit] would prove anything. ... [T]he reason it was done was to ensure that I didn’t have herpes or any other STD” (Interviewee 8).

A second and perhaps more disconcerting misconception of the MFE was held by one 35-year-old woman who perceived it as a form of lie detection intended to measure her veracity rather than that of the assailant. Assaulted by a drug dealer she had known for many years, she stated:

“[A] Kit [was done] so they could find out if you were lying. I thought it was like a proof kit so that ... the police had proof that the woman was actually telling the truth. ... I never thought it was for evidence ... against the perpetrator ... against the person that’s done the crime.” (Interviewee 16)

Less than half ($n=9$) of the women had heard of a Kit prior to presenting to a hospital and sources of information included television (both from news broadcasts and programs profiling unsolved or cold cases), friends (only some of whom had themselves been raped), and high schools.

Sense of a lack of choice. Several women conveyed having felt that they had no choice but to undergo an MFE. More than one in five stated that they had been told to do so by the police ($n=4$) and/or a nurse examiner ($n=2$). A 40-year-old Asian born woman accompanied by law enforcement officers to hospital explained, “[t]hey told me I take it. ... May be I am wrong, but I think on that night ... I had to take the Kit test. I don’t know I have a choice” (Interviewee 14). In a similar vein, an 18-year-old university student sexually assaulted by an acquaintance stated:

“[T]he nurses told me I was going to get the Kit and the evidence done. ... [T]he Kit at no point was an option for me. I had to do it.” (Interviewee 15)

Contradictory effects on well-being

Occurrence of physical and emotional difficulties. Despite most women being “very satisfied” ($n=14$) or “satisfied” ($n=2$) with the way the Kit was administered, many ($n=12$) revealed that undergoing an MFE was very difficult. They described feeling “scared”, “upset”, “stressed”, “nervous”, “embarrassed”, “angry”, “very exposed, very vulnerable, [and] ... uncomfortable” (Interviewees 2, 5, 6, 7, 8, 9, 10, 14, 18). A young college student said, “it was horrible ... just awful” (Interviewee 1) and two women born overseas described it explicitly as “traumatizing” (Interviewee 15, 9). Five women found procedures such as the drawing of blood, swabbing internally for semen, particularly in the anus, and the photographing of injuries so potentially distressing that they “refused” to have them done. Additionally, four women commented that in hindsight they wished that they had refused to undergo certain components of the Kit. For some of those women, it was “needles” and the internal examination that were particularly upsetting:

"I got too much blood taken ... that's why I passed out. ... [They] had all my blood, they had to take my underwear, and I had this water thing done. It was really gross, I didn't like it all." (Interviewee 2)

"She tried about three times [to insert a speculum], and I really didn't want to do that at the time, 'cause I think I was ... reliving the whole experience and just wanted to put my clothes on after awhile." (Interviewee 1)

Several women framed the experience as a revictimization, a "bad experience [that] ... reminds you of the thing that happened" (Interviewee 14; also 3). A 17-year-old student living with her mother elaborated:

"You ... feel like a piece of crap. ... I felt violated. ... [S]itting naked on a table with your legs spread, and someone in between your legs, and you're just like 'what the hell ... this isn't right' ... it was hell. I didn't deserve to be put through that. And ... the last thing I wanted is to be violated, sitting in a room half-naked having blood-work done and being touched." (Interviewee 2)

Creation of a feeling of empowerment. While many women felt distressed during the administration of the Kit, most ($n = 14$) stated that they would recommend the MFE "in a heartbeat", "right away" (Interviewees 8, 19). For 14 women, undergoing an MFE was perceived, at least in part, as empowering. Their comments, in this regard, centred on feeling "more in control", "more ... powerful", and actively "doing something" (Interviewee 3, 5, 6, 10, 16, 19). One stated it was "something [she] had to do for [herself]" (Interviewee 10). A 35-year-old woman living in a drug and alcohol rehabilitation centre stated that the benefit was an increased sense of well-being:

"It kind of made me feel like ... it was all about me ... It wasn't about ... prosecuting somebody in the future, may be it did have something to do with that, but I just felt good about doing something. ... [D]oing [the Kit] gave me more clarity ... it helped ... tak[e] back my power [and] ease the emotions I was feeling." (Interviewee 16)

Certain of these women also implied that having a forensic examination was empowering with respect to the desire to see an assailant brought to justice. A 36-year-old unemployed woman explained, "I was gonna' do whatever it takes to get evidence to get a conviction and to identify the assailant" (Interviewee 12).

Discussion

Findings from this study raise some important points for further consideration regarding women's expectations and experiences of undergoing an MFE. Our results suggest that there may be a disjuncture between what some victims believe a forensic examination can achieve and what in reality it may deliver. Most women had a stated expectation that it would help them obtain justice for the violation they had experienced. This is notable in light of research indicating that medico-legal evidence is often not related to the legal resolution of sexual assault cases (Du Mont & White, 2007). The strongest predictor of a positive legal outcome has been documented general physical injury (Du Mont & White, 2007), with moderate-to-severe injury most highly associated with charging and conviction (McGregor, Du Mont, & Myhr, 2002; McGregor, Le, Marion, & Wiebe, 1999). However, in the present study, as in earlier research, some women were not physically injured (White & Du Mont, 2008). Where injuries had been sustained, they were described most commonly as "mild bruising" (e.g., Du Mont & Parnis, 2000; Rambow, Adkinson, Frost, & Peterson, 1992; Stermac, Du Mont, & Dunn, 1998; Tjaden & Thoennes, 2006; White & McLean, 2006). Given this, it may be advisable to

provide women with the information necessary to make a fully informed decision to undergo an MFE. Just as sexually assaulted women in some jurisdictions are provided with statistics on their probability of acquiring HIV, they could be similarly apprised of the likelihood of a conviction with or without collected medico-legal evidence.

Some women also believed that the evidence collected from the MFE would serve as objective proof for family and friends that they had been sexually assaulted. This need to prove to others that a sexual violation has occurred may not be surprising in view of the disbelief rape victims often face in our society. The pervasiveness of rape myths centred largely on the mistrust of women and focussed unduly on their character and behaviour prior to, and during a sexual assault has been well established (Du Mont & Parnis, 1999; Filipas & Ullman, 2001; Gavey, 2005; Idisis, Ben-David, & Ben-Nachum, 2007; Jordan, 2004; Sivagnanam, Bairy, & D'Souza, 2005). These myths may influence women's quest for evidence that might lend credence to their experience of having been sexually assaulted. In this regard, it is important that we continue to develop, refine, and deliver educational initiatives aimed at eradicating negative beliefs about rape and raped women.

Findings from this study that underscored sexually assaulted women's primary concerns with their health may reinforce the value of collecting medico-legal evidence in specialized settings where medical care is also offered (Du Mont & Parnis, 2002; Kelly, 2004). The desire of most women to have their physical and emotional needs addressed reflects findings from earlier research (Christofides, Muirhead, Jewkes, Penn-Kekana, & Conco, 2006; Martin, Young, Billings, & Bross, 2007; Monroe et al., 2005). Campbell, Wasco, Ahrens, Sefl, and Barnes (2001) note the positive impact that such care can have on women's post-assault well-being. The fact that medico-legal evidence is not often effective legally, and health considerations appeared to matter most to women who were interviewed may suggest a need to reflect on the relative weight given the MFE in the post-sexual assault care encounter—especially in an era of expanded medico-legal evidence collection through new DNA technologies and tools such as med-scopes. It may also support the importance of the right to access health related sexual assault services, whether a victim agrees to undergo an MFE or to report to police (Monroe et al., 2005; Resnick et al., 2000).

Some women expressed a specific desire (and believed themselves) to be assessed and treated for potential STIs. Other research has also documented that women often experience anxiety over the possibility of contracting STIs, including HIV, post-rape (Regan et al., 2004; Resnick et al., 2000). Despite such concern, however, prioritization of this particular health issue in this context has been inconsistent. Campbell et al.'s (2006) survey of American SANE programs revealed that victims were often not tested for STIs, and sometimes not offered prophylaxis as a routine part of the service (see also Campbell, 2006; Campbell et al., 2001; Christofides et al., 2005, 2006; Ciancone, Wilson, Collette, & Gerson, 2000; Monroe et al., 2005; Stermac, Dunlap, & Bainbridge, 2005). Given that sexual assault victims may be at increased risk for contracting such infections (e.g., Jenny et al., 1990), it could be argued that prophylactic medications should be made universally available to them.

Sexual assault examiners need to be attuned to any potential misunderstandings that could arise regarding the intent of the MFE. In our study, almost half the women had never heard of a sexual assault kit. For those who had, sources of information included popular television dramas, which may not have accurately portrayed its purpose. Some women mistakenly underwent a forensic examination assuming it necessary in order to have their physical concerns addressed. This confusion presents a problem concerning informed consent. It is possible that in some instances nurse examiners may not have adequately explained the purpose of the

forensic examination in relation to the provision of health care. Even when a thorough explanation is given, however, it is important to realize that women who have been recently traumatized may be unable to fully absorb the information (Lovett et al., 2004). In jurisdictions for which an MFE is optional, it may be advisable to clarify several times for victims that they may undergo a non-forensic physical examination and receive medical treatment without having medico-legal evidence collected.

One disquieting finding was that some women felt the MFE had been misrepresented as mandatory by the police and/or a nurse examiner. Post-rape trauma may influence a woman's ability to consciously and independently choose whether or not to undergo an MFE, thereby providing an opportunity for law enforcement and health professionals to give input to clarify the process. However, at a time in which a woman's life may feel remarkably out of control, being able to choose what procedures to undergo can be of great importance (Ericksen et al., 2002). Exercising personal choice in the aftermath of sexual assault has been identified as a "primary curative step for her to take ... [in] resuming personal authority over her own life" (Koss & Harvey, 1987, p. 82). Where the decision to have an MFE is to be made of the victim's free will, it may be important to make clear(er) the voluntary nature of this activity. Emphasis might be placed on enhanced training of examiners to reconfirm the terms of consent and/or on the potential role of victim advocates in the MFE process. As well, it might be of value to have more information made available to the public about sexual assault and the medico-legal responses to it through community awareness campaigns.

As our knowledge from victims grows, sexual assault services should be reviewed and fine-tuned. Many women in this study were distressed by the MFE. This may not be surprising given that, at an already difficult time, there are several potentially intrusive and hard to complete components in a sexual assault kit (Du Mont & Parnis, 2001; Feldberg, 1997; Regan et al., 2004). Certain tests and procedures, such as the drawing of blood and the vaginal examination, were perceived as traumatic for some. Findings such as these may point to the importance of reevaluating various components of the protocols—such as the routine testing for alcohol and drug levels in the absence of any history suggestive of drug-facilitated sexual assault; and the use of colposcopes, which add length and a further level of intrusiveness to the internal examination—without clear evidence of benefit (Du Mont & White, 2007; Rogers, McIntyre, Rossman, Bacon-Baguley, & Jones, 2008; White & Du Mont, 2008; World Health Organization, 2003).

Affirming some of what has been speculated and reported on in the literature—that an MFE can feel like a "second rape" (Campbell et al., 2006; Kelly & Regan, 2003; Temkin, 1996; US Department of Justice, 2004)—some women in our study felt revictimized by the experience. Though earlier accounts of forensic examinations as retraumatizing were often linked to insensitive professionals (e.g., Temkin, 1996), we, like Regan et al. (2004), and others (Jordan, 2001), found that most women felt overwhelmingly positive about their interactions with examiners, strengthening the case for approaches to care that are founded on sensitive victim-centred practices, and intensively trained medico-legal staff (Campbell, Patterson, & Lichty, 2005; Sievers, Murphy, & Miller, 2003; Stermac & Stirpe, 2002). As Regan and colleagues (2004) have noted experiencing an MFE "as similar to an assault may be inevitable for some survivors" given the invasive nature of the process (p. 23).

Finally, our study revealed that although many women felt distressed while the sexual assault kit was being administered, most simultaneously reported a sense of "doing something" positive for themselves. This fact suggests that for some, the act of undergoing an MFE is in and of itself important in helping to regain a sense of self-efficacy. Some of these women also suggested that being forensically examined was empowering with respect to

potentially holding an assailant legally responsible. However, at the time of the interviews, no case had yet moved into the courts. If and when cases do, these women may have a different perception of the value of having undergone an MFE, given the low conviction rates for sexual assault across jurisdictions (Du Mont & White, 2007). While these findings contribute to the understanding of women's perceptions of the MFE and the role it may play in creating a feeling of empowerment, they may also highlight the need to explore additional ways in which to facilitate their sense of agency following sexual assault.

This study is one of the first comprehensive explorations of women's perceptions of the MFE. However, like most qualitative research, it has limitations with respect to the generalizability of findings and points to the need for further research. Although the women interviewed came from diverse backgrounds and presented to four sites with the same mandate as other SADVTCS, they represent only a small number of the approximately 2000 victims seen per year across the province, and their experiences may have been different from those seen at centres not represented in this study. The process of undergoing an MFE needs to be explored in a larger sample of women and across other types of settings and jurisdictions. Future qualitative studies should account for the impact the variety of attitudes and behaviours of examiners has on women. As well, it would be important to interview women who have been administered a sexual assault kit after their cases have moved (or not) through a criminal justice system. Finally, to get a fuller understanding of what matters to the broader constituency of sexually assaulted women, it would be of value to interview those who chose not to access medico-legal services.

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