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**Adolescent Sexual Assault Victims' Experiences with  
SANE-SARTs and the Criminal Justice System**

**2007-WG-BX-0012**

**FINAL REPORT**

**November 30, 2010**

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## ABSTRACT

The purpose of this project was to examine adolescent sexual assault survivors' help-seeking experiences with the legal and medical systems in two Midwestern communities that have different models of Sexual Assault Nurse Examiner (SANE) / Sexual Assault Response Team (SART) interventions. This project had two main objectives. First, we conducted qualitative interviews with adolescent sexual assault victims regarding their initial post-assault disclosures and their pathways to seeking help from the medical and legal systems. It is important to understand how and why teen survivors decide to seek help from these programs in the first place. Although SANE-SART interventions have the potential to be useful resources to teen victims, they are only useful insofar as they are utilized by survivors. In Study 1, we conducted in-depth qualitative interviews with N=20 adolescent sexual assault victims 14-17 years old. From these interviews, we identified three distinct patterns of survivors' post-assault disclosures and their pathways to seeking help from SANE programs and the criminal justice system: voluntary (survivors' contact with the legal and medical system was by their choice), involuntary (system contact was not by choice), and situational (circumstances of the assault itself prompted involuntary disclosure). Victims with voluntary disclosures patterns were more likely to remain engaged with the legal system throughout the investigation process. Those in the involuntary disclosure pattern were only sometimes willing to continue to pursue legal prosecution. There were too few situational disclosures to examine the impact of system entry on subsequent system involvement.

The second objective was to conduct a quantitative analysis to determine what factors predict successful prosecution of adolescent sexual assault cases. Once teen victims are "in the system" what factors determine whether a case will be prosecuted? Criminal justice prosecution is a multi-step process, from reporting to referral, arrest, prosecution (which itself has many steps), and final case outcome. Rather than focusing at any one stage, we assessed progress through this system as an ordinal variable in order

to capture incremental change. We examined how differences between the two SANE-SART models—and the evolution of these models over time—predicted prosecution outcomes relative to the predictive utility of victim characteristics, assault characteristics, and medical forensic evidence findings.

In Study 2, we obtained SANE program records, police and prosecutor records, and crime lab findings for a sample of N=392 adolescent sexual assault victims who sought services from the focal SANE programs. The overall rate of guilty plea/trial convictions was 40.3% for sexual assaults committed against adolescents aged 13-17. Using multi-level ordinal logistic regression, we found that cases involving younger victims (13-15) were significantly more likely to progress further through the system than assaults against older victims, and assaults committed against adolescents with documented developmental delays were eight times as likely to move further through the criminal justice system. We found no significant effects for victim race/ethnicity and alcohol use on legal case outcomes. Victim-offender relationship was a significant predictor of case progression, such that non-stranger assaults were more likely to be prosecuted than stranger assaults. The specific kinds of forced penetrations (i.e., vaginal vs. oral vs. anal penetrations) did not affect case outcomes, but the cumulative number of the assaultive acts perpetrated against the victim did increase the likelihood that the case would progress further through the criminal justice system. With respect to medical forensic evidentiary findings, the more delay there was between the assault and when the survivor had the medical forensic exam, the less likely the case would progress through the system. Cases with positive DNA evidence were five times as likely to progress further through the system, but there were no significant effects for specific physical or anogenital injuries. With respect to site differences, there were no significant main effect differences between the two SANE/SART programs studied, suggesting that one model of SANE-SART intervention was no more or less effective than the other with respect to achieving prosecution success.

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## EXECUTIVE SUMMARY

Adolescents are at substantial risk for rape and sexual assault. National estimates indicate that 6-9% percent of teens have been sexually assaulted, and that adolescents 12-17 years old are the largest group of sexual assault victims. Within the past ten years, two community intervention models have emerged to assist this highly vulnerable population. First, Sexual Assault Nurse Examiner (SANE) programs are staffed by specially trained forensic nurses who provide 24-hours-a-day, first response crisis intervention and medical forensic exams for child, adolescent, and adult sexual assault/abuse victims. Second, many SANE programs operate as part of Sexual Assault Response Teams (SART), which are multidisciplinary community efforts that bring together police officers, detectives, prosecutors, doctors, nurses/SANEs, victim advocates, and crisis intervention counselors to coordinate and improve the community-wide response to rape. SANE-SART interventions have tremendous promise for serving the needs of teen victims and for increasing the reporting and prosecution of crimes against adolescents.

The purpose of this project was to examine adolescent sexual assault survivors' help-seeking experiences with the legal and medical systems in two Midwestern communities that have different models of SANE-SART interventions. These communities are comparable in many key characteristics, but differ in how their SANE programs function as part of multidisciplinary SART teams. In one community there is more formalized integration and all key stakeholders meet regularly to address system-wide protocol issues. In the other site, the SANE program sponsors multidisciplinary trainings and concentrates on one-on-one relationship building with other SART members. These differences in programmatic functioning may affect the quality of community relations, which prior research on SANE-SARTs suggests may be a mechanism through which these interventions can influence prosecution.

Specifically, the current project had two main objectives. The first objective was to conduct qualitative interviews with adolescent sexual assault victims regarding their initial post-assault disclosures

and their pathways to seeking help from the medical and legal systems. It is important to understand how and why teen survivors decide to seek help from these programs in the first place. Although SANE-SART interventions have the potential to be useful resources to teen victims, they are only useful insofar as they are utilized by survivors. Adolescents may have unique developmental considerations that affect their help-seeking decisions. In these interviews, we asked adolescent survivors to retrace the steps that led them to these SANE-SART programs. In addition, we explored how their initial contact with the SANE-SART personnel affected their on-going continued participation in the legal system.

In Study 1, we interviewed N=20 adolescent sexual assault victims 14-17 years old who: (1) received a full medical forensic exam (i.e., a patient history was taken and medical forensic evidence was collected) from one of the two focal SANE programs; and (2) were victimized in one of the two focal counties that were the subject of this study. We identified three distinct patterns of survivors' post-assault disclosures and their pathways to seeking help from SANE programs and the criminal justice system. The first pattern was characterized by *voluntary disclosures*: These survivors first told peers (or multiple peers), who encouraged them to then tell an adult (or multiple adults). These adults, in turn, helped connect the victims to the SANE program and/or the police. Throughout this process, the survivors' disclosures at each step were voluntary, within their control, and reflected their choices and preferences for how to proceed. By contrast, the second pattern reflected *involuntary disclosures*: These victims first disclosed voluntarily to a peer, followed by an adult(s), and then to medical and/or legal personnel, but one or more of these subsequent disclosures occurred against the survivors' wishes. Most often, the peers directly disclosed the assault to an adult without the victims' consent, which led to the survivors having unwanted contact with the SANE program and/or police. The third pattern, *situational disclosures*, was far less common. In these two instances, the victims were unconscious during and after the assault, and were found by their peers who sought help from adults on their behalf.

In all three disclosure patterns, adolescent survivors had consistently positive, empowering, and healing experiences with the focal SANE programs. These positive patient care experiences did not affect their subsequent involvement in the criminal justice system. However, disclosure patterns were related to victims' engagement in the legal system. The survivors who had *voluntary disclosures* of the assault *wanted to pursue prosecution* and stayed involved with the system throughout the investigation. By contrast, those who had *involuntary disclosures*, perhaps not surprisingly, had mixed feelings about pursuing prosecution. Although their entry into the system may have been against their wishes, survivors who received validation from the responding officers and their families changed their minds over time and their *interest in pursuing prosecution increased*. But, those with *involuntary disclosures* who did not receive this kind of support remained steadfast that they *did not want to pursue prosecution*.

The second objective was to conduct a quantitative analysis to determine what factors predict successful prosecution of adolescent sexual assault cases. Once teen victims are "in the system" what factors determine whether a case will be prosecuted? Criminal justice prosecution is a multi-step process, from reporting to referral, arrest, prosecution (which itself has many steps), and final case outcome. Rather than focusing at any one stage, we assessed progress through this system as an ordinal variable in order to capture incremental change. We examined how differences between the two SANE-SART models—and the evolution of these models over time—predicted prosecution outcomes relative to the predictive utility of victim characteristics, assault characteristics, and medical forensic evidence findings.

In Study 2, we obtained SANE program records, police and prosecutor records, and crime lab findings for a sample of N=392 adolescent sexual assault victims who sought services from the focal SANE programs. The overall rate of guilty plea/trial convictions was 40.3% for sexual assaults committed against adolescents aged 13-17. These data are regional, not national, and therefore should not be interpreted to reflect the current state of adolescent sexual assault prosecution in the United States. Using multi-level

ordinal logistic regression, we found that cases involving younger victims (13-15) were significantly more likely to progress further through the system than assaults against older victims, and assaults committed against adolescents with documented developmental delays were eight times as likely to move further through the criminal justice system. We found no significant effects for victim race/ethnicity and alcohol use on legal case outcomes. Victim-offender relationship was a significant predictor of case progression, such that non-stranger assaults were more likely to be prosecuted than stranger assaults. The specific kinds of forced penetrations (i.e., vaginal vs. oral vs. anal penetrations) did not affect case outcomes, but the cumulative number of the assaultive acts perpetrated against the victim did increase the likelihood that the case would progress further through the criminal justice system. With respect to medical forensic evidentiary findings, the more delay there was between the assault and when the survivor had the medical forensic exam, the less likely the case would progress through the system. Cases with positive DNA evidence were five times as likely to progress further through the system, but there were no significant effects for specific physical or anogenital injuries. Turning to site differences, there were no significant main effect differences between the two SANE/SART programs studied, suggesting that one model of SANE-SART intervention was no more or less effective than the other with respect to achieving prosecution success. We did find a significant site X time X age effect such that in Site A (which followed a formalized model of SART operation), there was a decrease over time in the likelihood that cases perpetrated against older teens (16-17) would be successfully prosecuted. This result highlights the importance of examining how SANE-SART models evolve over time in their communities—simple, static main effect contrasts may not be able to capture the complexities of how these interventions operate. Pursuing this issue further, we added variables to the model to reflect the timing of specific changes with respect to how these SANE-SART interventions operated in their communities. Site A had undergone far more sweeping changes in their community than Site B with respect to the operation of its Child Advocacy Center. National standards for

CACs require multi-stakeholder coordinating meetings, which meant that the same organizations—and indeed often the very same individuals—in Site A were now called upon to participate in two sets of meetings. Perhaps not surprisingly, the community momentum became stronger for the newer (child-focused) coordinating council, and our quantitative results show that very effect. The interaction of victim age group and the implementation of a child coordinating council in Site A was significantly predictive of case disposition; the addition of this variable to the model rendered the site by time by age group interaction in site effects model nonsignificant, suggesting that age-related differential changes in case referral over time at Site A could be explained by the timing of implementation of the child advocacy coordinating council at that site. In sum, our results suggest that whether a community follows a more formalized or informal model of SANE-SART integration may not be nearly as important as how a community's resources and attentions can be focused—or divided—among the many victims who want justice for the crimes they have suffered.

## I. OVERVIEW

Adolescents are at substantial risk for rape and sexual assault. In the NIJ National Violence Against Women Survey (NVAWS) 6% of the adult women surveyed disclosed that they had been victims of completed or attempted rape as adolescents (Tjaden & Thoennes, 1998, 2006). Similarly, in the NIJ National Survey of Adolescents (NSA), 8% of the teens reported that they had been sexually assaulted (Kilpatrick et al., 2003). In the OJJDP National Survey of Children's Exposure to Violence, 14% of girls 14-17 years old had been victims of completed or attempted rape in their lifetime, and 6% reported that such violence had occurred in the past year (Finkelhor, Turner, Ormrod, & Hamby, 2009). In a nationally representative sample of schools, 12% of girls in 9<sup>th</sup>-12<sup>th</sup> grades reported they had experienced some form of sexual abuse and 8% had been forced into sexual activity by a dating partner (Schoen, Davis, Collins, Greenberg, Des Roches, & Abrams, 1997). In a review of smaller-scale studies, Maxwell et al. (2003) found that on average, 9% of adolescents have been sexually assaulted.

According to the National Juvenile Justice Center, adolescents 12-17 years old are the largest group of sexual assault victims and they are twice as likely to be sexually victimized as adults (Snyder, 2000; Snyder & Sickmond, 2006). Thirty-two percent of the sexual assault victims surveyed in the NVAWS were first assaulted between the ages of 12-17. Current data also indicate that rates of adolescent sexual assault may be increasing. A cohort analysis of the NVAWS revealed that younger women were more likely to report having been raped before the age of 18 than older women: "These findings suggest that the risk of being raped as a child or adolescent has increased steadily for women over the past half century" (Tjaden & Thoennes, 2006, p. 19). In addition, adolescent sexual assault substantially increases the risk for adult victimization (Fargo, 2009). In the NVAWS, women who were sexually assaulted as minors were twice as likely to report being raped as adults. Messman-Moore and Long's (2003) review of social science studies

on revictimization revealed that child/adolescent sexual assault victims are 2-11 times more likely than non-victims to be re-assaulted as adults. An effective community response at the time of first victimization in childhood or adolescence may provide the healing victims need and the deterrence perpetrators require for the prevention of subsequent assaults.

Within the past ten years, two community intervention models have emerged in an effort to increase reporting and prosecution of adolescent sexual assaults. First, Sexual Assault Nurse Examiner (SANE) programs are staffed by specially trained forensic nurses who provide 24-hours-a-day, first response crisis intervention and medical forensic exams for child, adolescent, and adult sexual assault/abuse victims (Department of Justice, 2004; Ledray, 1999). Second, many SANE programs operate as part of Sexual Assault Response Teams (SART), which are multidisciplinary community efforts that bring together police officers, detectives, prosecutors, doctors, nurses/SANEs, victim advocates, and crisis intervention counselors to coordinate and improve the community-wide response to rape (Barkhurst et al., 2002; DOJ, 2004; Hutson, 2002; Littel, 2001). To date, there have been very few studies that have empirically evaluated SANE-SARTs using methodologically rigorous research designs—and this research has focused exclusively on adult sexual assault cases.

Studies of adult survivors' experiences with SANE-SART programs suggest these interventions may contribute to increased prosecution rates (Campbell & Ahrens, 1998; Campbell et al., 2009; Crandall & Helitzer, 2003; but see Nugent-Borakove et al., 2006; Wilson & Klein, 2005 for negative or inconclusive findings). It is likely there are substantial cross-site differences in how SANE-SART programs operate in their communities, and not all interventions may result in positive legal systems change. As such, future research needs to examine the work of SANE-SARTs in a more contextually nuanced way. For instance, how does the SANE-SART function in the community? How has the intervention model changed over time, and what impact have those changes had on prosecution outcomes? SANE-SARTs are proliferating faster

than researchers are generating evaluation data to guide their implementation, so it is important to understand if, how, and under what circumstances SANE-SARTs can increase the reporting and prosecution of adolescent sexual assaults.

*The purpose of this project was to examine adolescent sexual assault survivors' help-seeking experiences with the legal and medical systems in two Midwestern communities that have different models of SANE-SART interventions.* These communities are comparable in many key characteristics, but differ in how their SANE programs function as part of multidisciplinary SART teams. In one community there is more formalized integration and all key stakeholders meet regularly to address system-wide protocol issues. In the other site, the SANE program sponsors multidisciplinary trainings and concentrates on one-on-one relationship building with other SART members. These differences in programmatic functioning may affect the quality of community relations, which prior research on SANE-SARTs suggests may be a mechanism through which these interventions can influence prosecution.

Specifically, the current project had two main objectives. *The first objective was to conduct qualitative interviews with adolescent sexual assault victims regarding their initial post-assault disclosures and their pathways to seeking help from the medical and legal systems.* The story of adolescent victims' experiences with formal social systems does not begin when survivors present at SANE programs or police departments—it is important to “rewind” and understand how and why teen survivors decide to seek help from these programs in the first place. Although SANE-SART interventions have tremendous promise, they are only useful in so far as they are utilized by survivors. Adolescents may have unique developmental considerations that affect their help-seeking decisions. In these interviews, we asked adolescents survivors to retrace the steps that led them to these SANE-SART programs. In addition, we explored how their initial contact with the SANE-SART personnel affected their on-going continued participation in the legal system.

*The second objective was to conduct a quantitative analysis to determine what factors predict successful prosecution of adolescent sexual assault cases.* Once teen victims are “in the system” what factors determine whether a case will be prosecuted? Criminal justice prosecution is a multi-step process, from reporting to referral, arrest, prosecution (which itself has many steps), and final case outcome. Rather than focusing at any one stage, we assessed progress through this system as an ordinal variable in order to capture incremental change. We examined how differences between the two SANE-SART models—and the evolution of these models over time—predicted prosecution outcomes relative to the predictive utility of victim characteristics, assault characteristics, and medical forensic evidence findings.

## II. REVIEW OF RELEVANT LITERATURE

### A. Adolescent Victims' Post-Assault Disclosures

In the NIJ National Survey of Adolescents (NSA), 32% of teen sexual assault victims said they had never disclosed the assault, 40% disclosed within one month, and 29% waited one month or more to disclose (Bromann-Fulks et al., 2007). Most girls (76%) but far fewer boys (48%) eventually disclosed the assault to *someone*, most typically a peer rather than an authority figure (Kogan, 2004; Nofziger & Stein, 2006). Indeed, the vast majority (81%) of first disclosures were to friends and family rather than formal system personnel such as doctors, social workers, teachers, or police (Hanson et al., 2003). Typically, the first disclosure was to a friend (39% of first disclosures) or a mother or step-mother (34% of first disclosures) (Hanson et al. 2003). In a study of women 14-23 years old who sought help from a medical center, 62% first told a girlfriend, and 10% first told a parent (Rickert, Wiemann, & Vaughan, 2005). In a hospital chart review of sexual assault victims 10-14 years old, researchers found that boys were most likely to disclose to mothers but girls to peers (Edinburgh, Saewyc, & Levitt, 2006).

The reasons why adolescent victims are more likely to disclose to informal rather than formal supports have not been well-documented. Stein and Nofziger (2008) argued that teens may be more likely to disclose to friends than parents because adolescents are likely to "have a strong network of peers and to view these relationships as the most available source of emotional support" (pp. 161). Similarly, Finkelhor and colleagues (2001) noted that because adolescence is marked by increased identification with peers and the assertion of autonomy and independence from parents, this developmental process is a contributing factor in adolescents' reluctance to involve adults.

## **B. Adolescent Victims' Pathways into the Legal and Medical Systems**

Despite increasing rates of adolescent sexual assault and revictimization, most adolescent rapes go unreported to the criminal justice system (Finkelhor, Wolak, & Berliner, 2001). In the NSA (2003), 13% of adolescent sexual assaults were reported to police, 6% to child protective services, 5% to school authorities, and 1% to other authorities, but most assaults (86%) went unreported. Only 8% of the women in Casey and Nurius' (2006) state-wide survey who had been assaulted as adolescents reported to law enforcement. These reporting rates for adolescent sexual assaults are lower than those obtained for adults. For example, in the NVAWS, 15% of sexual victimizations were reported to police (Clay-Warner & Burt, 2005). Bachman's (1998) analysis of the National Crime Victimization Survey (NCVS) found that 25% were reported to the police. Other state-level or community-based studies of adult victims find police reporting rates from 18-39% (Campbell et al., 2001; Filipas & Ullman, 2001).

Some adolescent sexual assaults are of course reported to the police, either by the victims themselves or by someone they disclosed to, such as a parent. According to Finkelhor and Wolak (2003), crimes against juveniles are more likely to be reported if the perpetrator was an adult, if their families were encouraged to report, if the adolescent or family had prior experience with police, if the victims and/or their families believed that the report would be taken seriously, and/or if they believed the child was still in danger. Similarly, NSA data showed that victim-perpetrator relationship may impact reporting, as assaults perpetrated by a parent (57%) or a non-parent adult family member (48%) were more frequently reported than assaults committed by a friend (Stein & Nofziger, 2008). Furthermore, initial disclosures to family and friends may influence whether the assault is ultimately reported to the police. Stein and Nofziger's (2008) analysis of the NSA dataset found that adolescent victimizations that were disclosed to a friend were later reported to an official (e.g., police or child protective services, etc.) only 17% of the time, whereas incidents disclosed to a mother were officially reported 55% of the time.

Unfortunately, very few studies have examined legal case outcomes for adolescent sexual victimizations once they have been reported to the criminal justice system. Stein and Nofziger's (2008) analysis of NSA data showed that overall 13% of all sexual assault cases resulted in an arrest. When adolescents had confided in a friend as compared to their mothers, arrest was far less likely (3% compared to 24%). In a logistic regression model, after controlling for victim and case characteristics, confiding in a mother was the only significant factor that increased likelihood of arrest. An arrest was also more common in cases when the offender was a non-parental adult relative (27%). Only 5% of cases perpetrated by a parent or step-parent, 5% of cases perpetrated by a friend, and 3% of cases with a child perpetrator resulted in arrest (Stein & Nofziger, 2008). Beyond the stage of arrest, no studies to date have examined prosecution rates specifically for adolescent victimizations. Research on child sexual abuse prosecution often includes victims between the ages of 12-17, and reviews of this literature suggest that 40-85% of reported cases are successfully prosecuted (see Cross, Walsh, Simone, & Jones, 2003). The specific rates for teens 13-17 are unknown. In addition, factors predicting successful prosecution of adolescent sexual victimizations have not yet been examined.

### **C. SANE-SART Interventions for Adolescent Sexual Assault Victims**

Sexual Assault Nurse Examiner (SANE) Programs and Sexual Assault Response Teams (SARTs) are community interventions that seek to improve the systemic response to sexual assault by providing comprehensive care to victims and coordinating efforts of the legal, medical, mental health, and rape crisis/advocacy systems. SANE programs provide 24-hour-a-day, first response crisis intervention and medical forensic exams for child, adolescent, and adult sexual assault/abuse victims (Department of Justice, 2004; Ledray, 1999). The first SANE programs emerged in the 1970s, and expanded rapidly throughout the 1990s, now numbering over 400 throughout the United States (Ledray, 2005). To become a SANE, nurses typically complete 40 hours of classroom training on evidence collection techniques, use of

specialized equipment, chain-of-evidence requirements, expert testimony, injury detection, pregnancy and STI screening, and crisis intervention. An additional 40-96 hours of clinical training is also needed, and continuing education is often required by local programs (Department of Justice, 2006; Ledray, 1999). Many SANE programs operate as part of multidisciplinary response teams (SARTs) to bring together police officers, detectives, prosecutors, doctors, nurses/SANEs, victim advocates, and crisis intervention counselors to promote coordination and collaboration among stakeholders and improve the overall community response to rape (Barkhurst et al. 2002; Johnston, 2005; Littel, 2001; Zajac, 2006). In practice, SARTs vary in how they are structured and function. Some SARTs follow an institutionalized model of formalized multidisciplinary meetings to promote communication among stakeholders, and identify strategies for improving their community's response to sexual assault (Ledray, 2004). By contrast, some SARTs function primarily through informal networking and communication among stakeholders (Ledray, 2004; Zajac, 2006). Whether they function in a more formalized or informal manner, SARTs engage in a variety of activities, including, but not limited to: multidisciplinary cross-trainings to share expertise and perspectives; protocol and policy development to standardize the desired response to sexual assault; case review to monitor and coordinate the response to individual sexual assault cases; and community education about sexual assault and resources for survivors (DOJ, 2004; Zajac, 2006).

A major question for researchers, practitioners, and policy makers is whether SANE-SARTs can have a positive impact on prosecution rates. There is very limited empirical research on this topic (all with adult cases), and so far findings across studies have been mixed. With respect to research on *SANE programs specifically*, Crandall and Helitzer (2003) compared prosecution rates in a New Mexico jurisdiction before and after the implementation of a SANE program. Victims treated in the SANE program were significantly more likely to report incidents to police, more charges were filed post-SANE compared to pre-SANE, and conviction rates for SANE cases were also significantly higher, resulting in longer average

sentences. A more recent NIJ-funded study by Campbell and colleagues (2009) also found significant increases in prosecution post-SANE compared to pre-SANE rates, and that the underlying mechanisms of the intervention's effectiveness was due to changes in broader systemic relationships among key stakeholders in the community over time.

Studies of *SART-only approaches* have yielded mixed findings. In an NIJ-funded study of a Rhode Island SART, Wilson and Klein (2005) found that SART cases were no more likely to be prosecuted than non-SART cases. By contrast, in Campbell and Ahrens' (1998) national study, victims in communities with SARTs were more likely to have their cases prosecuted than victims in communities without coordinated response teams. However, the Campbell and Ahrens study did not specifically assess the involvement of SANEs in the different SART models, and therefore these data may not reflect SANE-SART interventions in many instances.

As mentioned previously, many SANEs work within the context of SARTs, so it is also important to study the joint impact of the *SANE-SART model*. In their NIJ-funded work, Nugent-Borakove et al. (2006) compared prosecution rates across three jurisdictions—one with a SANE only, one with a SANE-SART, and one having no SANE or SART—and SANE-SART cases were most likely to result in arrest and charges being filed. However, they also found that victim participation was lowest in the SANE-only cases, but their data do not explain the process mechanisms for why that might have occurred.

The current literature on adult SANE-SART interventions suggests they may be quite promising, but there are three unresolved issues that must be examined in future work. First, no published studies exist on the reporting and prosecution of *adolescent* sexual assault cases in SANE, SART, or SANE-SART interventions, and this gap must be addressed because multiple national data sources (e.g., NVAWS, NSA, NJJC) indicate adolescence is a peak risk period for sexual victimization. Most SANE-SART programs serve adolescent victims (DOJ, 2004), and patients aged 13-17 comprise, on average, 40% of SANE

programs' caseloads (Campbell et al., 2005). SANEs can play an important role in adolescents' recovery as Danielson and Holmes (2004) noted: "With the national trend encouraging the use of Sexual Assault Nurse Examiners, nurses are often some of the first individuals to have contact with an adolescent after a sexual assault . . . in this setting, good nursing care can provide a strong safety net for teens" (p. 387).

Second, research must explore adolescent victims' help-seeking within a developmental context. How do teen victims seek formal help at a time in their lives when they are establishing autonomy and independence from adults? SANE-SARTs have the potential to be quite helpful, but that benefit will not be realized if adolescent victims do not find their way into these programs. It is probable that supportive players, such as family and friends, help direct adolescents to seek formal help. From the adolescents who have received SANE-SART care, we need to understand what (and who) led them to these programs.

Third, given the rapid diffusion of SANE-SART programs, it must be assumed there are different kinds of community interventions from which teen victims may seek help, and yet, we know very little about this variability and its implications for the care of adolescent survivors. Previous work has studied SANE programs without accounting for their possible role in SARTs, or has examined SARTs without accounting for unique work of SANEs. Only one study compared SANE-SARTs to SANE-only (Nugent-Borakove et al., 2006), but this project did not capture variations *within* SANE-SART models of operation. No studies have yet examined specific structural and functional variations in SANE-SART interventions in relation to criminal justice system case processing. Is a model of formally integrated coordination more effective than loosely structured collaborations? How do these intervention models change over time as they operate in their communities, and how do those changes affect legal system impact? Research is needed that examines which structural and functional elements are most helpful to criminal justice prosecution.

### III. THE CURRENT PROJECT

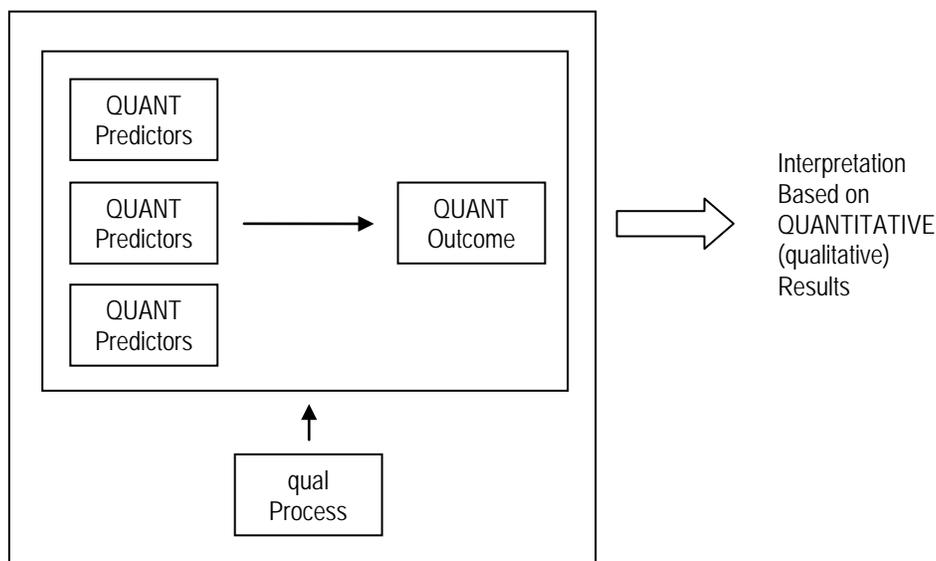
#### A. Research Design

Our first objective was process-focused regarding how teen victims decided to seek help and their pathways into SANE programs and the criminal justice system, but our second objective was outcome-focused regarding prosecution rates and the factors that predict successful case outcomes. As such, a mixed methods design was necessary to address these dual interests. In recent years, the mixed methods literature has developed a comprehensive taxonomy of mixed methods designs (see Creswell & Plano Clark, 2007; Tashakkori & Teddlie, 2003 for reviews). Briefly, mixed methods designs vary by the timing or sequence of different methods and their intended function or purpose. With respect to timing, mixing can occur within the same study (usually termed '*parallel*' or '*simultaneous*'), or across studies within a series (usually termed '*sequential*'). In this project, timing was simultaneous: we collected qualitative interviews from current adolescent sexual assault patients treated in the focal SANE programs, and at the same time, we tracked down legal case outcomes for previously-treated patients. It can take 18 months (and often longer) for cases to filter through the criminal justice system, which necessitated parallel data collection. As to function, researchers must sort out why they need both methods and what they hope to gain from their integration. In some circumstances, *exploration* is the purpose, which is particularly common in new areas of inquiry where there are no guiding frameworks, theories, measures, or instruments. By contrast, both methods may be needed for *explanation*—the findings generated through one method need to be unpacked further using a different method for a more complete understanding of the results. Methods may also be *triangulated* to compare and contrast findings obtained through each method to see if findings converge. As previously noted, adolescent survivors' experiences in the criminal justice system have been under-studied; as such, an exploratory approach was warranted in this project.

Embedded mixed methods designs are an appropriate choice for simultaneous, exploratory data collection. Embedded designs are studies “in which one data set provides a supportive, secondary role in a study based primarily on the other data type. The premises of this design are that a single data set is not sufficient, *that different questions need to be answered, and that each type of question requires different types of data*” (Creswell & Plano Clark, 2007, p. 67, emphases added). Most typically, qualitative work is embedded within a study that is primarily quantitative. There are many variations of embedded designs, but the option most adaptable to the current project is the embedded correlational design (see Figure 1). In this design, the quantitative component focuses on prediction of outcomes and qualitative process data are collected to shed light on hypothesized mechanisms within the quantitative model.

FIGURE 1

Embedded Correlational Design

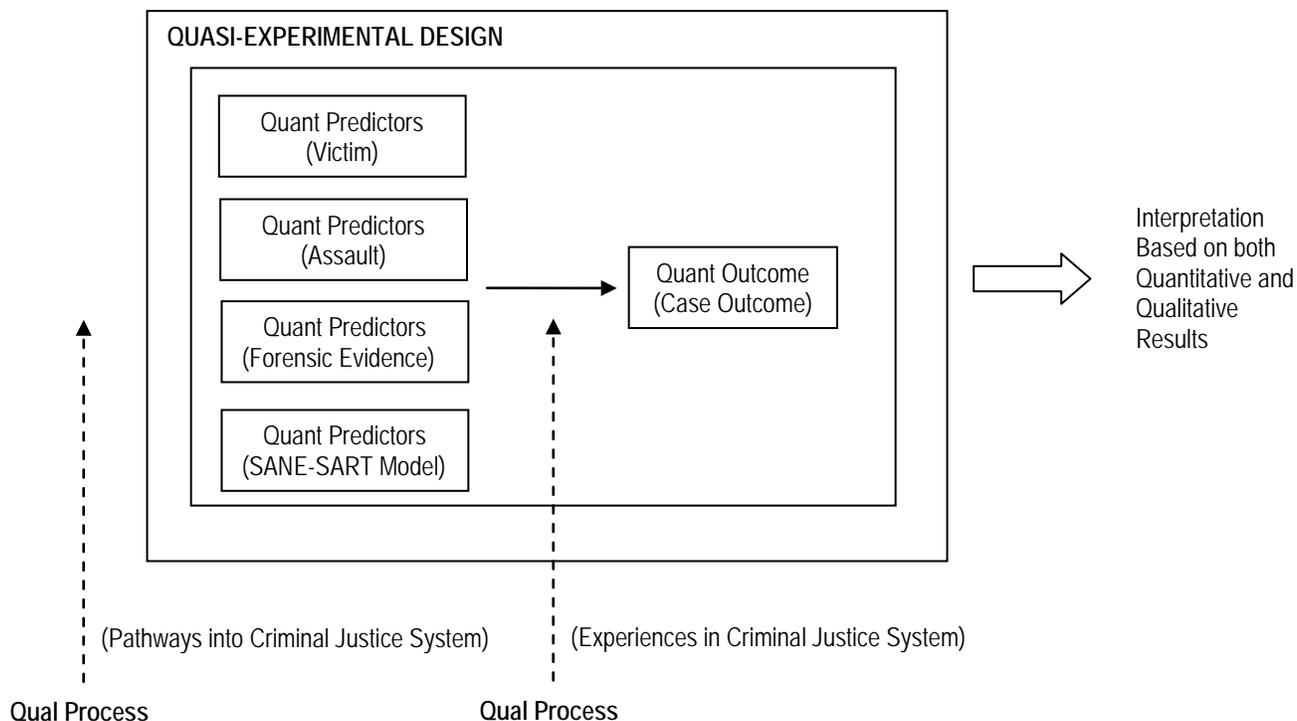


We modified the embedded correlational design for use with quasi-experimental methodology (see Figure 2). Our quantitative component was a quasi-experimental contrast of two Midwestern communities with different models of SANE-SART functioning. The predictive utility of victim, case, and evidentiary characteristics was evaluated relative to SANE-SART features to understand prosecution case progression

through the criminal justice system. As noted previously (and shown in Figure 1 above), the qualitative component of an embedded design provides insight into the *processes* of the hypothesized quantitative model. In this project, we focused on two process elements (shown in dotted lines in Figure 2 below). First, there is no chance of prosecution if adolescent victims do not report to the legal system; in other words, the quantitative model “starts” at the point of system contact, but these data cannot explain the factors that led victims to seek services in the first place. Therefore qualitative work must be embedded in the design to explore how and why teen survivors seek help from the legal and medical systems. Embedded designs are an excellent choice when there are different questions to be answered within the context of a single project, which was certainly applicable in this instance. The second process element we examined was how survivors’ pathways into the criminal justice system affected their continued participation in the system, which undoubtedly affects case outcomes. If victims withdraw from the system or are reluctant participants, it is extremely unlikely that their cases will be successfully prosecuted. Therefore, the embedded qualitative data provide a “behind the scenes” look into one particularly critical process that is quite difficult to model quantitatively, namely, victims’ feelings about the investigation and prosecution process.

FIGURE 2

Adapted Design



**B. Research Settings**

This project was conducted in two counties in the same Midwestern state. According to the 2000 U.S. Census, County A is larger in geographic size and includes more rural areas, while County B is more populated and metropolitan. Despite these differences, these two counties are similar in many respects. First, these counties are reasonably equivalent in demographic and socio-economic characteristics: in both counties, approximately one-quarter of the population is under age 18, the vast majority of residents (over 80%) are Caucasian, and approximately 10% live below the poverty line. Second, according to Uniform Crime Report Data, there are proportionally more rape/sexual offense crimes in County B (as would be expected given overall population differences), typically 250-300 per year (vs. 110-150 per year in County A), but the arrests rates are consistent (17-20% in both counties). Third, both

counties launched their SANE programs about the same time, so the study examines cases processed during nearly identical time-frames (1998/1999 to 2007) within the same state. Fourth, both SANE programs are community-based programs affiliated with long-standing, well-respected rape crisis centers. Fifth, the victims/patients served in these SANE programs are demographically similar. County A's SANE program serves approximately 150 victims/survivors per year, 25% are adolescents between 14-17 years old. The program's clientele is 90% female and 75% Caucasian, 19% African American, and 1% Latina (5% other). County B's SANE program serves approximately 200 victims/survivors per year, 24% are adolescents between 14-17 years old. The program's clientele is 97% female and 73% are Caucasian, 25% African American, and 1% Latina (3% other). Finally, both SANE programs follow training and practice guidelines of the International Association of Forensic Nurses (IAFN), the DOJ (2004) SANE adult-adolescent protocol, as well as appropriate medical organizations (e.g., American College of Emergency Physicians, 1999). Both programs maintain similar policies for exam eligibility, exam documentation/record keeping, and medical forensic evidence collection techniques.

A focal interest in this project was the differences between the SANE-SART models in these two communities. Historically, both counties formed their SANE programs through community-wide task forces that worked over several years to create positive relationships between the legal, medical, mental health, and advocacy/rape crisis center systems. As part of the development of the SANE program, both communities developed county-wide protocols that all sexual assault cases would be referred to SANE for medical forensic exams. Despite these similar beginnings, the two programs diverged over time with respect to how the SANE program works as part of a multidisciplinary SART. Figure 3 depicts the model of SANE-SART operation in Site A. Site A engages in both formal interdisciplinary meetings (represented by solid, bidirectional lines in Figure 3), as well as informal networking among stakeholders. Since the SANE program opened, community stakeholders (including law enforcement, prosecution, the rape crisis center,

and other social service agencies) met for monthly sexual assault coordinating council meetings. These meetings focused primarily on protocol review and team coordination to improve the overall community response to sexual assault, particularly for adult victims. In 2004, attendance began slipping so the coordinating council began meeting quarterly. Shortly thereafter, in 2005 this county's Child Advocacy Center began quarterly coordinating council meetings focused on child victims (ages 12 and under). These new meetings involved the same agencies, and even many of the same individuals who had been part of the adult/adolescent coordinating council. Both committees continued to exist throughout the remainder of this research project, but multiple key informants noted there was a community shift in emphasis to child victims once the child coordinating council meetings were launched.

Figure 4 shows the model of SANE-SART operations in Site B. In this community, the SART team does not have standing meetings, and instead the SANE program director is responsible for maintaining linkages between multidisciplinary groups (represented by dotted lines in Figure 4). The SANE director follows-up with specific members of law enforcement and prosecutors for individual case review. In addition, the SANE program also sponsors annual multidisciplinary trainings for all SART members on a variety of topics related to sexual assault prosecution and victims' services. Table 1 summarizes the key comparisons and contrasts between Site A and Site B.

FIGURE 3

Site A SANE-SART Model

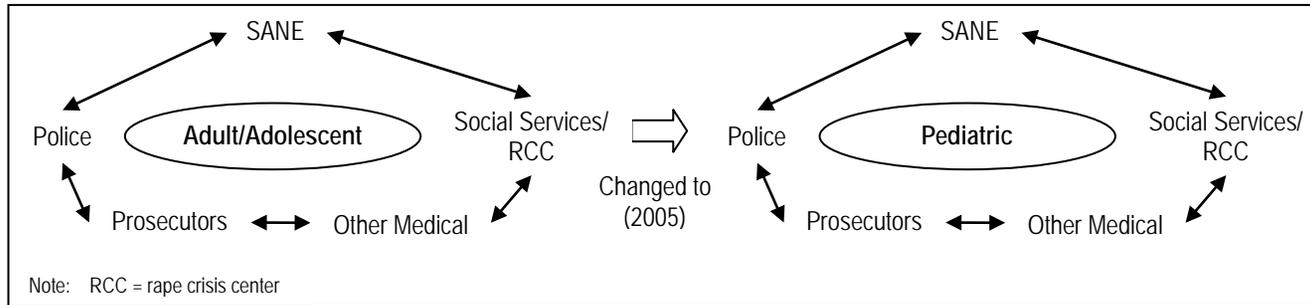


FIGURE 4

Site B SANE-SART Model

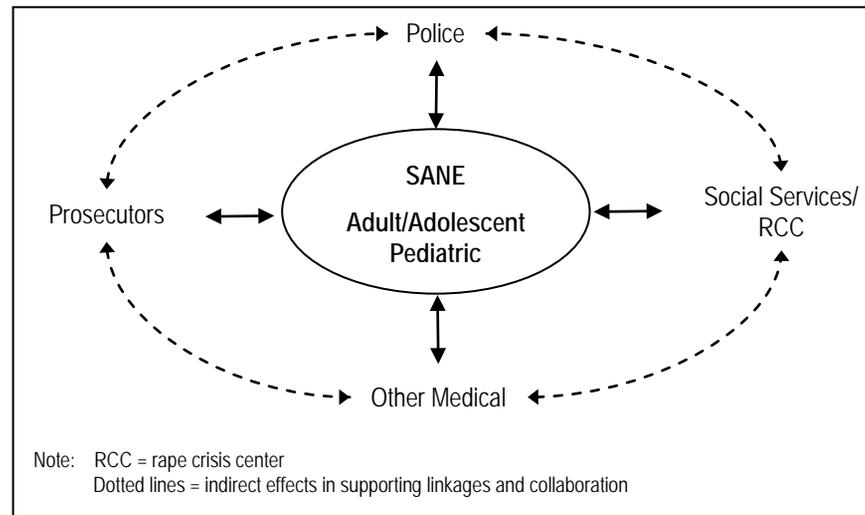


TABLE 1

Summary of Differences between SANE-SART Models in Site A and Site B

Site A	Site B
SANE program director follows up with law enforcement and prosecutors for individual case review	SANE program director follows up with law enforcement and prosecutors for individual case review <i>in addition to case review meetings</i>
No interdisciplinary meetings	Two sets of interdisciplinary meetings for protocol development and case review: 1) adult/adolescent coordinating council; and 2) (since 2005) child sexual abuse case review
Multidisciplinary annual trainings	SANE program director participates in law enforcement and prosecutorial trainings
SANE program director is primarily responsible for maintaining multidisciplinary linkages regarding the community response to sexual assault	Interdisciplinary meetings and SANE program director maintain multidisciplinary linkages regarding the community response to sexual assault

## **IV: STUDY ONE: ADOLESCENTS' DISCLOSURE AND HELP-SEEKING EXPERIENCES WITH SANE PROGRAMS AND THE CRIMINAL JUSTICE SYSTEM**

### **A. Design**

This study utilized qualitative methodology to understand adolescent sexual assault victims' experiences with SANE programs and the criminal justice system. The specific aims of the study were to examine: (1) adolescent survivors' initial disclosure(s) of the assault and their pathways to seeking help from SANEs and the legal system; (2) survivors' experiences with SANE program personnel during their medical forensic exams; and (3) survivors' experiences reporting the assault to the police and their continued involvement in the criminal justice system. Qualitative methods are well-suited for capturing process-focused data, as well as obtaining rich descriptive information in participants' own words.

### **B. Sampling**

The target sample for this study was adolescent sexual assault victims 14-17 years old who: (1) received a full medical forensic exam (i.e., a patient history was taken and medical forensic evidence was collected) from one of the two focal SANE programs; and (2) were victimized in one of the two focal counties that were the subject of this study. The age of our sample was restricted to 14-17 year olds because in the state in which the study was conducted, minors are able to consent to certain services, including mental health and STI treatment, at the age of 14. Therefore, the research team, in collaboration with our community partners and the university IRB, decided to limit the sample to adolescents at least 14 years old so that this study would be in congruence with state laws regarding minors' ability to consent.

### **C. Participant Recruitment**

A prospective sampling strategy was used to recruit adolescent sexual assault victims who sought medical care at the two focal SANE programs. This approach was preferable to retrospective recruitment for two key reasons. First, the research team and both SANE programs agreed it would have been an

unethical violation of patients' confidentiality to use program records to contact former sexual assault victims "out of the blue." Second, it is unlikely that other methods of recruitment (e.g., community-based advertising) would have been successful in reaching an unbiased sample of former patients.

For prospective recruitment, nurses in both programs provided eligible patients with information about the study (see Appendix C-1). Patients were then asked whether they were willing to be contacted at a later date by a member of the research team; if so, patients completed an "Agree to be Contacted Form," which asked them to provide guidance on how and when they could be reached so that their privacy and safety would be protected (see Appendix C-1). This paperwork emphasized that by providing their information, patients were only agreeing to be contacted about the study, but were not committing to participate. Research team members attended both SANE programs' monthly meetings in order to collect completed forms as well as to troubleshoot any challenges in recruitment. At these meetings, the research assistant and the SANE directors also compared the number of patients who received information about the study to the number of patients who were eligible to participate in the study. This allowed the researchers to monitor that the nurses were in fact providing information about the study to all eligible patients. Victims who agreed to be contacted were called by a research assistant approximately three to four weeks after the date they completed the form. Participant recruitment and interviewing continued until the sample size allowed for saturation, whereby the same themes were repeated, with no new themes emerging among participants (Starks & Trinidad, 2007). A sample of N=20 participants is a reasonable size for a qualitative study examining phenomenon in-depth (Creswell, 2007; Sandelowski, 1995).

A total of 119 survivors agreed to be contacted for information about the study: 10% percent were unreachable due to incorrect phone numbers; 39% were never able to be reached (despite numerous attempts); 14% we reached, but we were unable to complete an interview with them (e.g., interviews were scheduled, but the teens did not show up, and they were unreachable afterward); 5% were unavailable to

do an interview (e.g., one had been committed to a residential home); 11% decided not to participate, and 21% (n=25) participated. Five of the girls who participated were later discovered to be ineligible for the project; for instance, in the interview itself, it came out that they had been assaulted in a *different* county (not the focal county, per the sampling criteria). The data from these five interviews were not included in the analyses, resulting in a final sample size of 20 interviews. Because there are no other qualitative studies of sexually assaulted adolescents in the literature (i.e., interviewed *as adolescents*, not as adults in retrospective accounts), we cannot know whether these participation rates are normative for such a population. The literature on research with vulnerable populations certainly suggests that the recruitment challenges we experienced are highly typical (see Liamputtong, 2007 for a review), and that traumatized, stigmatized, or otherwise hard-to-reach adolescent populations may be particularly hesitant to participate in research (Zayas, Hausmann-Stabile, & Pilat, 2009).

All N=20 adolescents were female. The vast majority were white/Caucasian (n=15, 75%), three participants were African-American (15%), one was Asian-American (5%), and one was multiracial (5%). Survivors' ages were fairly evenly distributed. At the time of the assault, 15% were 14 years old, (n=3), 30% were 15 years old (n=6), 30% were 16 years old (n=6), and 25% were 17 years old (n=5). Most survivors were assaulted by one person (n=17, 85%), but three of the participants were victimized by multiple assailants (15%). Most often the assailant was an acquaintance (n=9), dating partner or ex-partner (n=6), or a friend (n=3). One survivor was assaulted by a stranger, one was assaulted by a family member, and two survivors were unsure who had assaulted them. <sup>1</sup> Most survivors stated that physical force was used against them during the assault (n=12, 63%), and a weapon was used in one assault (5%). Half of the sample (n=10, 50%) disclosed that they had been drinking alcohol at the time of the assault.

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<sup>1</sup> Note that these numbers do not add up to the total sample size (n=20) because some survivors were victimized by multiple people with whom she had varying relationships (e.g., one was assaulted by a friend and an acquaintance).

## D. Procedures

Interviews were conducted in-person by three female interviewers (the PI and two research assistants) at the offices of the rape crisis centers affiliated with the focal SANE programs. All three interviewers had extensive prior experience interviewing adult survivors of violence. The PI trained the interviewers on strategies for building rapport and increasing the victims' comfort during the interviews (see Campbell, Adams, Wasco, Ahrens, & Sefl, 2009 for details regarding the interviewer training program). In addition, Co-Investigator Dr. Angie Kennedy and the project consultant, Dr. Debra Patterson, have extensive experience working with victimized adolescents, and they provided additional training on issues specific to establishing trust with adolescents. Interviewer meetings were held regularly to monitor data quality and discuss emergent themes to explore in subsequent interviews.

In research with minors, it is typical to seek parental consent for participation, but in this study we obtained IRB approval for a substitute in loco parentis consent process. An alternative consent mechanism was necessary for two key reasons: (1) adolescents are frequently assaulted by their parents or persons who have close relationships to their parents (e.g., a parent's dating partner), and therefore seeking parental permission could have put them at risk; and (2) many adolescents do not disclose the assault to their parents, and asking parental permission could have seriously deterred their participation in the study, which would have resulted in a substantially biased sample. Therefore, the research team worked together with the IRB, the SANE program directors, and the affiliated rape crisis center directors to construct an appropriate alternative.

During the assent/consent process, a rape crisis center counselor sat in with the interviewer and the participant while the interviewer explained the traditional components of informed consent (e.g., what participation entails, risks, benefits, etc.). Then, the interviewer left the room, allowing the counselor and the adolescent to discuss participation in the project privately. During this time, the counselor assessed

whether the adolescent understood her rights as a research participant. If in the counselor's assessment the adolescent indeed understood all elements of consent and was willing to participate, the counselor signed as a witness to the adolescent's assent signature. The counselor then left and the interview was conducted privately between the participant and the interviewer. Interviews were typically 90 minutes to two hours in duration. With the participant's permission, interviews were tape recorded. Participants received \$30 in compensation for their time and a booklet of resources for sexual assault victims. Interviews were transcribed and transcripts were checked for errors by a research assistant.

### **E. Measures**

The interview was based on the PI's prior study of adult sexual assault survivors' experiences with SANE programs and the criminal justice system (see Appendix C-2). However, the interview was modified to be developmentally appropriate for adolescent participants (e.g., additional introductory get-to-know-you questions to establish rapport, additional questions regarding peers and parents, language changes to ensure a more conversational tone, longer transitions between interview sections to provide more context). The revised interview was reviewed by the SANE program directors and rape crisis center directors for their input and approval. The final semi-structured interview consisted of four main topics: (1) the assault itself; (2) the survivors' initial disclosures; (3) their experiences with the SANE program; and (4) their interactions with the criminal justice system. In addition, each interview concluded by asking the survivors what it was like for them to participate in the study and if they had any suggestions for improving the interview.

### **F. Analytic Plan**

Data analysis proceeded in a two-phase process. First, consistent with Miles and Huberman's (1994) concept of "data reduction," the PI and other two interviewers independently read the transcripts and identified a preliminary list of themes mentioned by participants, and then the transcripts were independently coded by the two interviewers/analysts. 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 (see also Patton, 2002). 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: (1) inadequate amount of evidence; (2) inadequate variety in the kinds of evidence; (3) faulty interpretative status of evidence (i.e., doubts about the accuracy of the data due to social desirability bias); (4) inadequate disconfirming evidence (i.e., no data were collected that could disconfirm a key assertion); and (5) inadequate discrepant case analysis (i.e., no cases exist that are contrary to a key assertion) (Erickson, 1986, p. 140). Assertions are revised or eliminated based on their evidentiary adequacy until a set of well warranted assertions remain. The two analysts and the PI developed assertions based on the phase one open coding, and then one analyst tested the assertions for evidentiary inadequacy. After this process, the team met again to discuss which assertions needed modifications. This process continued until all three analysts were satisfied that the assertions were warranted by the data.

## G. Results

**1. Initial disclosures and pathways into the legal and medical systems.** We identified three distinct patterns of survivors' post-assault disclosures and their pathways to seeking help from SANE programs and the criminal justice system (see Figure 5, page 23; solid arrows denote direct responsibility for disclosure, while dotted arrows denote influencing, but not directly causing disclosure). There were no site differences in these disclosure patterns. In other words, despite varying approaches for coordinating

services for sexual assault survivors, there were no discernable differences in how adolescent sexual assault survivors found their ways into the SANE programs and the criminal justice system.

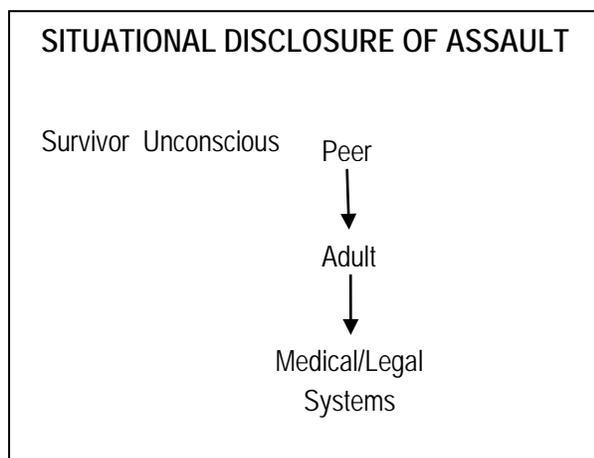
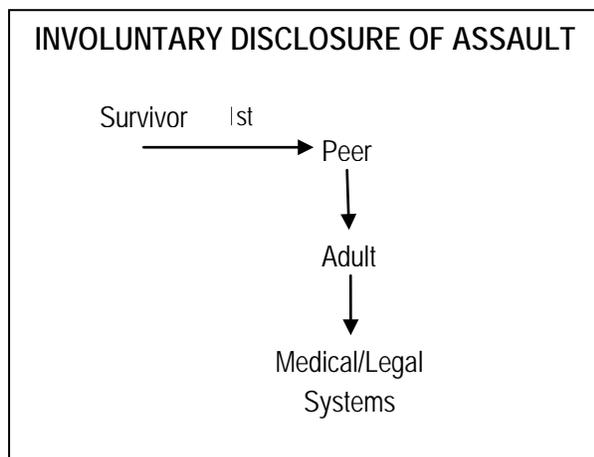
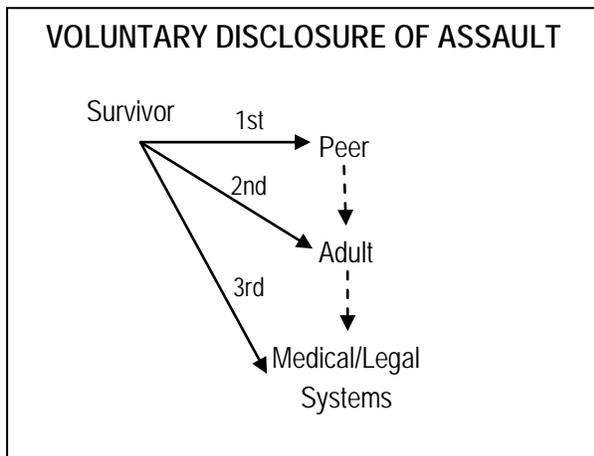
Interestingly, in all three patterns, the initial disclosure of the assault was almost always to a peer (or peers),<sup>2</sup> but it was what happened afterwards that differentiated the survivors' experiences. The first pattern was characterized by *voluntary disclosures*: the survivor first told a peer (or multiple peers), who encouraged the survivor to then tell an adult (or multiple adults). These adults, in turn, helped connect the victim to the SANE program and/or the police. Throughout this process, the survivors' disclosures at each step were voluntary, within their control, and reflected their choices and preferences for how to proceed. By contrast, the second pattern reflected *involuntary disclosures*: the victim first disclosed voluntarily to a peer, followed by an adult(s), and then to medical and/or legal personnel, but one or more of these subsequent disclosures occurred against the survivor's wishes. Most often, the peer directly disclosed the assault to an adult without the victim's consent, which led to the survivor having unwanted contact with the SANE program and/or police. The third pattern, *situational disclosures*, was far less common. In these two instances, the victims were unconscious during and after the assault, and were found by their peers who sought help from adults on their behalf. In other words, the situation was such that the victims were not able to decide the nature of their disclosures.

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<sup>2</sup> Four survivors in this study made initial disclosures to someone other than a peer. Two survivors were assaulted by abusive boyfriends and did not have anyone to give them a ride home. One first disclosed to her mother so that she would come get her, and the other attempted to call her parents, but then called the police when her parents were unable to come get her right away. The third survivor was assaulted by multiple peers at her school. When her mother read suspicious text messages (from the assailants) she confronted the survivor, who then felt forced to disclose the assault. The fourth survivor had a similar experience: when her mother found her crying she felt that she had to disclose. These cases could be appropriately sorted into one of the three disclosure patterns shown in Figure 1 because the rest of their experiences fell into alignment with one of the established patterns.

FIGURE 5

Initial Disclosures and Pathways into the Legal and Medical Systems



In all three patterns, once survivors reached the stage of seeking formal help, they all had contact with both the police and one of the focal SANE programs. If their initial outreach was to the police, law enforcement personnel referred them to the SANE program for a medical forensic exam; if their first contact was with a hospital emergency

department, both sites had county-wide protocols that required hospital personnel to refer victims to the SANE programs for a medical forensic exam. The hospitals and the SANE programs were required to contact the police to let them know a crime had occurred against a minor, but this contact did not require these victims to file a report. As such, victims

in all three groups had similarly intermingled contact between the SANE programs and law enforcement. Each of these patterns will be explored below.

*a) Voluntary disclosure.* Eight survivors comprised the “voluntary disclosure” pattern. Their route to the legal and medical systems was defined

by the fact that their decisions to disclose, and ultimately their decisions to seek formal help were of their own volition. The following quotes illustrate the first step in this voluntary process: the survivors' choices to disclose to peers. Teen victims turned to their peers for a variety of reasons, but often for emotional support. For example, a 17-year old survivor was assaulted by a friend of a friend and then called her best friend:

*After [the rapist] left, I finally like let myself cry and I called my best friend .... even though she lives like an hour and a half away from me, I still called her and she listened to me cry for like a half hour and then once I settled down I told her what happened [101].*

This survivor had been seeking emotional support, but sometimes victims turned to their friends for help trying to fill in the missing pieces about what had happened to them. A 15-year old survivor, who passed out at a party, awoke to find a friend assaulting her, but blacked out again. When she awoke in the morning, she found the same person touching her again, and realized her clothes were missing. She immediately disclosed to a friend:

*And I was all upset, and I told my friend [friend's name], because there's two beds in the room, and she was in the other one. And I told her, and I got a little upset, and we called our friends to come pick us up...*

*Interviewer [I]: Why did you decide to tell [her]?*

*Well, because she was there, and I didn't know if she knew anything, or if she'd seen anything. And I just told her what I remembered, or what happened [102].*

Some survivors purposefully disclosed to peers because they wanted their friends to help them disclose to an adult. For example, a 17 year old survivor who was assaulted by a family member described why she disclosed the assault to her boyfriend:

*I wanted to tell somebody [referring to an adult]...I know that he would have made me do it [tell an adult], so that's why I told him. I just told because I know that he would have been like you need to do it or I'd do it. And that's what I needed. I needed somebody to say that enough is enough, and it is time to do it, you know [103].*

It was not uncommon for survivors to disclose to multiple peers, and frequently one or more of their friends would directly encourage the victims to reach out to an adult, typically tell their parents, and especially their mothers. For example, a 14-year old survivor who was assaulted at a party by her boyfriend first disclosed to a friend, and then to other people who were also at the party. After she left the party, she called her sister, who then encouraged her to tell her parents.

*I told [survivor's sister] what happened...Then she goes, "[survivor name] can I call mom and dad?" At that point I said, "yeah." I didn't really know who else to go to [104].*

Although the survivor's sister actually made the phone call, the survivor made the choice to contact her parents about the assault, with the encouragement of her sister. A 15-year old girl who was in and out of consciousness when she was assaulted at a party, first disclosed to a friend at the party, then disclosed to two more friends. These friends recommended that she tell her parents:

*Me and [name of first friend she disclosed to] left in the morning—we called [two friends] to come pick us up. And [two friends] told me that I should call my mom and tell her. And I was really scared to tell my mom, because I thought she'd be mad that I was drinking. And so I ended up calling my mom and telling her. She picked me up, and we went straight to the police department, and the police department referred us to go to the clinic.*

*I: So, you said that the friends that you called to pick you up, they said to tell you mom?*

*Mm hmm [yes].*

*I: How did you feel about that?*

*I was a little scared. I was just going to leave it, but then they were telling me that, you know...to be reasonable. So, they just told me it was better just to tell them [102].*

This survivor described how initially she was going to “leave it” (meaning not tell her parents), but after hearing her friends’ advice, she choose to disclose to her parents. Another survivor, who was 17 when she was assaulted by an acquaintance, disclosed to multiple friends before telling her mom. One of her friends encouraged her to tell her mom about the assault. She described the influence this had on her:

*I: Okay, do you think that—‘cause one of your friends had encouraged you to tell your mom. Do you think that you would have done it yourself eventually or you think it matter that your friend had said, I think you should tell your mom?*

*Eventually I would have, but I think with her telling me...that I think with her telling me to it was easier [101].*

She made the decision to tell her mom, but her friend’s encouragement made it easier. Although the survivors hesitated about talking to adults, the support of their friends helped allay their concerns.

Some survivors did not need as much coaxing from their friends to reach out to adults, but this was less typical. As illustrated in this next example, these survivors often had prior experiences of abuse or the nature of what happened in the assault was so egregious that they knew they needed the help of an adult. For a 14-year old who was assaulted a party, her first disclosure was to a peer, and as soon as she got home, she disclosed to her guardian:

*I started beating on the door and crying. And [guardian] came to the door, like who is it? I’m like, “just please open the door. Just please open the door.” She like, “what?” I’m like, “I just got raped, open the door, please”.*

*[Later in the interview] I: Why did you decide to tell her?*

*Because...like when I got molested when I was nine, I didn’t say nothing. That was going on for a long time and all that. I felt like if I say something, I can get it off my chest. This won’t be in my conscience, I can, I won’t have to be thinking about this all the time. I won’t be picturing this as much as I do now. I know if I would have like kept it inside, it would have just been in my head all the time and I just would have been messed up. I know I probably would have like seriously, probably tried to kill myself or something like that [105].*

Once survivors had disclosed to an adult, those adults played a significant role in helping the victims access the legal and medical systems. It is important to note that for all of the survivors in this group, the decision to seek formal help was definitively theirs even if it was an adult who made the actual first contact. For example, a 17-year old survivor described the process by which her disclosure to her mother led to her contacting the police:

*My mom's first initial reaction was to go to the police.*

*I: And how did you take that at first? Were you on board with her? Or were you just kind of hesitant at first?*

*I was a little hesitant.*

*I: Why?*

*I was just scared to talk about it, because I knew there was going to be a lot of questions involved, and stuff like that. And I'd have to be completely thorough of what happened.*

*I: So, that night your mom said, "We need to go the police." Did she tell you, "We should do it tonight, or did she kind of—*

*No, she said we can wait 'til the next morning, because you need to calm down....*

*I: Did you feel that overall it was your choice for the police to be called?*

*Yeah. My parents wouldn't have forced me [106].*

Although the survivor initially had some concerns about contacting the police, her mother addressed them, and ultimately, it was the survivor's choice to report the assault.

Several survivors described how they purposefully disclosed to adults, knowing that doing so would push them into contact with the legal and medical systems. In other words, they believed disclosure to an adult was a precursor to formal help-seeking. For example, a 16-year old survivor, who was assaulted by

her boyfriend at a party, disclosed to her sister, who called their parents for the survivor. In the following quote, the survivor discussed why she chose to disclose to her parents:

*My parents, I was kind of nervous about how they would react. So, I guess I wasn't really okay with it, but I knew that's what had to be done.*

*I: Okay. Why was that what had to be done? Can you tell me a little bit more about that?*

*Um, because I knew if I wanted to get anywhere with it, pressing charges, I'd have to tell my parents. [104].*

She believed that in order to take legal action, her parents had to know about the assault. Although adults played a significant role in connecting survivors the legal and medical systems, the distinguishing feature in this sub-group was that these survivors wanted to pursue such help.

**b) Involuntary disclosure.** For ten survivors in this study, their initial disclosures to friends and peers had unexpected outcomes that led to subsequent disclosures and system contact that was involuntary. The same general disclosure sequence—peers first, then adults, then systems—unfolded, but one of more of those disclosures occurred against the preferences of the survivors. Sometimes the disclosure to the adult was voluntary, but then the adults “took over” and necessitated legal and/or medical system contact. For example, a 15-year old was assaulted at a party with older guys:

*My mom was like, oh my god we are calling the police...*

*I: How did you feel when the police got called?*

*Um, I guess I was like, yeah, kind of upset because I don't really want to have like a police file, but um, I guess it is good that they get like caught because I would never want like that to happen to any other girls to where, oh well lets go, Like guys are like 25, and then them be like, okay, like you know, attempted rape, so—*

*I: Yeah, so you don't want it to happen to somebody else.*

*No. So I wanted to like get like, like justice like, you know.*

*I: Did you feel like it was your decision that the police got called?*

*No [107].*

But for most survivors in this group, contact with adults was the first sticking point—one of the peers they disclosed to in turn told an adult about the assault, against the survivors' wishes. Once the adults knew about the assault, they pushed the survivors into contact with the legal and/or medical systems, which again was contrary to the survivors' preferences. For example, a 17 year old survivor was assaulted by multiple acquaintances. She disclosed to her boyfriend, who told his mom about the assault. She described how her boyfriend reacted after she told him about the assault and then went to his house:

*At first he was really upset...I walked in the house and I was standing there and I was crying and he sent me up to his mom. Like he didn't hug me or anything, he was like, go talk to my mom. And I was like, okay...*

*I: So why do you think he told you to go talk to his mom?*

*Because his mom was all upset because she got woken up at like two in the morning to deal with everything that was going on.*

*I: Okay, so do you think he told his mom about what happened before you did?*

*He did tell his mom.*

*I: Okay. How did you feel about that?*

*It actually made me angry because I didn't, I wasn't going to involve the police [108].*

Another survivor, who was 16 when she was assaulted by an ex-dating partner, disclosed the assault to two friends because she was concerned about an injury she sustained during the assault. The second friend told her own mother, who then called the police:

*And then I went upstairs and called another friend of mine...and then she told her mom and that's what got the police involved [109].*

Later in the interview, the survivor described how she was upset that the police were involved in her case, and that she regretted telling her friend about the assault.

One of the survivors in this group was 16 years old when she was assaulted by an acquaintance. She voluntarily told her boyfriend about the assault, but he told his own mother, who then told the survivor's mother—and both of those subsequent disclosures were against the survivor's wishes. The survivor's mom, her friends, and her boyfriend believed that the assault was consensual; they felt that if it was truly an assault, she should be willing to go to the police. As such, the survivor technically "chose" to have contact with the legal and/or medical system, but did so only to try to get her friends and family to believe her. The survivor described why she decided to have contact with the police:

*Um, I just kind of felt a lot of pressure. Like I felt that maybe if I would have been able to go to counseling and stuff, I would have been able to cope with it on my own, but I felt like in order to get my friends and my boyfriend and my family over it, I almost had to.*

*[later in the interview] I hated how much pressure I was under to feel like I needed to prove to everyone that I wasn't lying, so like I went and told [110].*

She agreed to seek formal help, but not because she wanted something from the legal and medical systems; rather, it was because she felt it was something she was pressured into doing, in order to regain the support of her family and friends.

**c) Situational disclosure.** The remaining two survivors experienced what we have termed "situational disclosure:" the survivors did not actually disclose that they were assaulted; rather the situation caused other people to find out about the assault. Both of these young women were passed out when they were assaulted and their peers contacted their parents for help. In both cases, the peers had reason to suspect their friends had been sexually assaulted, and told the survivors' parents about their suspicions. Both survivors did not find out that they may have been sexually assaulted until they were at the hospital.

Unlike the other two disclosure patterns, the survivors in this group never had the opportunity to initiate the disclosure process.

**2. Survivors' experiences with the SANE programs.** Survivors' pathways into seeking help from SANE programs were quite varied as some had purposely chosen to have a medical forensic exam, whereas others were brought in against their wishes—or even their knowledge in the two instances of situational disclosure. It seemed possible that the nature of survivors' experiences with the SANE programs could be quite different given the context in which they came in for help. However, the analyses revealed no difference in how adolescent survivors' characterized their interactions with SANE program staff and the quality of the care they received as a function of their disclosure patterns. All survivors, even those who were brought involuntarily to the SANE program, had positive experiences with both SANE programs. Furthermore, there were no site differences in how survivors characterized the nature of the care. In other words, the particular model of SANE-SART operation in these different counties did not appear to have a direct effect on patient care. The survivors treated in both programs consistently emphasized that they were treated with care and compassion, given choices during the exam process, and were not judged by program staff. The only negatives mentioned were that re-telling the story of the assault was sometimes difficult, and a very few felt that not every aspect of the exam was their choice.

All survivors described their nurses and advocates as caring, nice, and compassionate, which helped them feel more comfortable and safe with telling their story. The following excerpt is from a 15-year old survivor who was assaulted after being drugged with GHB:

*Just that they, like if I cried, they wouldn't make me stop, they didn't have attitudes, they were really sweet and like made sure I was okay, if I needed anything they were there like to get it. Or, if I needed to talk, if I had questions, anything they were there... The nurse. And she was just really there for me. She wasn't there for her money or anything, and just didn't seem like it, you know what I mean?*

*I: What makes you say that?*

*Because like, when somebody's doing their job, they're like, "OK," and they just treat you like a normal person. But like, she wanted to really get to know me, and she wanted to understand me and stuff, and she wanted to be there for me, you know what I mean? And like, same with the advocate, [advocate's name]. She was going on about everything, like the weirdest things, and it was so comforting. Like we were talking about Lifetime movies and stuff, and it was just like, wow, they're not just like, "OK, well, this happened, this happened, are you OK? You're not going to handle it?" It was an actual conversation [111].*

Similarly, a 16-year old survivor who was assaulted by an acquaintance in his car explained how emotionally supportive the nurse was to her:

*They were supportive, and because of the time of night that it was, they asked if I was hungry and thirsty, and if I wanted anything to eat, and stuff like that. And it was just kind of like they wanted to make sure that I was OK before they went through with the exam.*

*I: So they took care of first, you, emotionally, it seemed?*

*Mm hmm.*

*I: OK. And what did you think about that, that they focused on that first? That it felt like comforting and supportive [112].*

Many teens felt that being personable—treating them like people, not patients—was a key component of compassionate care. The nurses and advocates talked to them about things other than the assault (e.g., school, movies, friends), which helped put them at ease. A 17-year old survivor assaulted by her ex-boyfriend described how being treated like a normal person during the exam was helpful:

*Um, before like during the exam, she'd tell me like exactly, exact what she was doing and if I'd feel discomfort or anything in that sort. Um, she was also talking to me like what I'm going to do after high school and what I want to be and stuff. So, she was talking to me and was like a normal person other than just a patient [113].*

Teens also discussed how the nurses were patient with them during the exam and provided them with choices, such as going at their own pace and letting them decide if they want to stop. The following quote from the 15-year old survivor who was drugged with GHB described how her nurse helped buffer the possible traumatizing effects of a rape exam:

*Like, when you're dissecting a frog, you're watching it, and you're just observing what it's doing, and then you go and dissect it, and there's nothing it can do. And that's how like I felt, and it's probably how other people felt, because after it happened to you, you're just like, they're just poking at you, and you're like seeing what happened, and it's just like you're in an experiment and they're seeing the after effects. And it's just really weird, like there's nothing you can do about it... it was just like at first and stuff, it was just awkward and stuff. But the more we went into the process of it and all—she started off very calmly, and she did the hair and stuff, and then she went into the more touchy places and stuff, and I think that helped a lot, because it wasn't like she went right for it. She just slowly got to into it. And she got my confidence and trust and stuff [114].*

Likewise, a 17-year old survivor who was assaulted in her home by an acquaintance describes how being given choices during the exam is helpful:

*I: Okay, yeah. Was it important to you that they also gave the choice to have your mom in the room or not? Like when you had the exam part?*

*Yeah, 'cause I mean like some people, like I mean everybody is different. I mean for me, like I didn't want her in there, but some people would be, you know, terrified you know, in that situation and you know, they would want their parents there or somebody there. But, you know, I'm glad they give you that choice.*

*I: Okay, what did the nurse do, if anything that wasn't so helpful or you wish she wouldn't have done?*

*Nothing like, I was very happy with the way they did things. And like they gave you the choice to like watch like on the monitor what they were doing. And I was just like, that's kind of weird, no thanks. But, I was very, I was satisfied with like what they did [101].*

Teen survivors also discussed that they felt more comfortable when the nurses or advocate explained the exam and other procedures to them. This explanation made them feel comfortable, safe, and prepared for what to expect, as a 17-year old woman who was assaulted by her ex-boyfriend described:

*Um, she told me everything else she was doing, so it was very, it was my first gynecologist exam, so I was, it was very, they were very nice about it and told me exactly what they were doing and that sort. So, it was fine [113].*

Likewise, a 16-year old survivor who was assaulted by a 24-year old co-worker explains why explanation throughout the medical forensic exam is so important:

*She just like making sure that I knew what she was doing and I was like comfortable with it. Making sure that I knew that if it wasn't something that I was comfortable with I didn't have to do it.*

*I: So she explained every bit of the exam. Why is that important to you for her to explain?*

*Um, I guess I just like to know what somebody is doing to me. Like really watching, like just sit there for you know, half an hour or whatever and I have no idea what's going on [110].*

Some teens expressed feelings of self-blame because of what they had been doing at the time of the assault, like using alcohol, being in a place they were not supposed to be, hanging around people they were not supposed to be with, etc. Some survivors were also blamed by close friends and family members for the assault because of these factors. However, when it came to their experiences with SANE, the survivors did not feel such blame. In fact, the nurses emphasized that it was not their fault and believed their story. This next quote is from a 15-year old teen who was blamed by her mother after she had been coerced by adult men to drink and engage in sexual behavior at a hotel party:

*I can't really pick my Mom.*

*I: But at the time, you had this one lady (the nurse) relaying like it is not your fault and you had your Mom yelling at your for like what seems, it feels like forever.*

*And like the other lady (the nurse), (was saying) oh it is not your fault and they are like telling me like why and like I was just kind of like okay maybe it is not my fault, you know . . . (that) like made me feel better [107].*

Because many of the teen survivors we interviewed engaged (and often were pressured) to engage in risky behaviors prior to the assault, they were scared adults would judge them for their experimentation.

However, not a single teen felt that the nurses or advocates treated them differently or judged them because of their story. The following interview excerpt is from a 15-year old survivor who was assaulted by her friend's older brother. Because the assault occurred in the home of her friend and because she knew and trusted the assailant, she wasn't sure if the assault was "serious" and felt that others might judge her:

*I: You said they made you feel like you could tell them about what happened?*

*Yeah, just something about them made me feel like I could tell them and they weren't going to tell anybody and they weren't going to judge me.*

*I: Was there anything in particular that made you feel like they weren't going to judge you or Just that after I told them what happened, their voices didn't change, the way that they looked at me, like they didn't give me dirty looks or just kind of brush me off or nothing [114].*

This next excerpt is from a 15-year old teen survivor who went to party and became intoxicated. Here she discusses how the nurses did not judge her for drinking prior to the assault:

*I: So then, did the nurse and the advocate—how did they treat you in terms of the whole alcohol situation? Did they know about it?*

*They did, but they hardly brought it up . . . But then, [the advocate], and stuff we were talking about, like how all teenagers drink and stuff. And she was all like, yeah, I was the teenager 15 years ago, and I was doing it. So it's not like they were judging me. They were more like on my side and stuff, like, "Everybody does it, it's not your fault" [111].*

Many survivors noted that they did feel judged by family, friends, and law enforcement, so these positive experiences with the nurses and advocates were very meaningful to them and helped them re-evaluate what had happened to them in a different light.

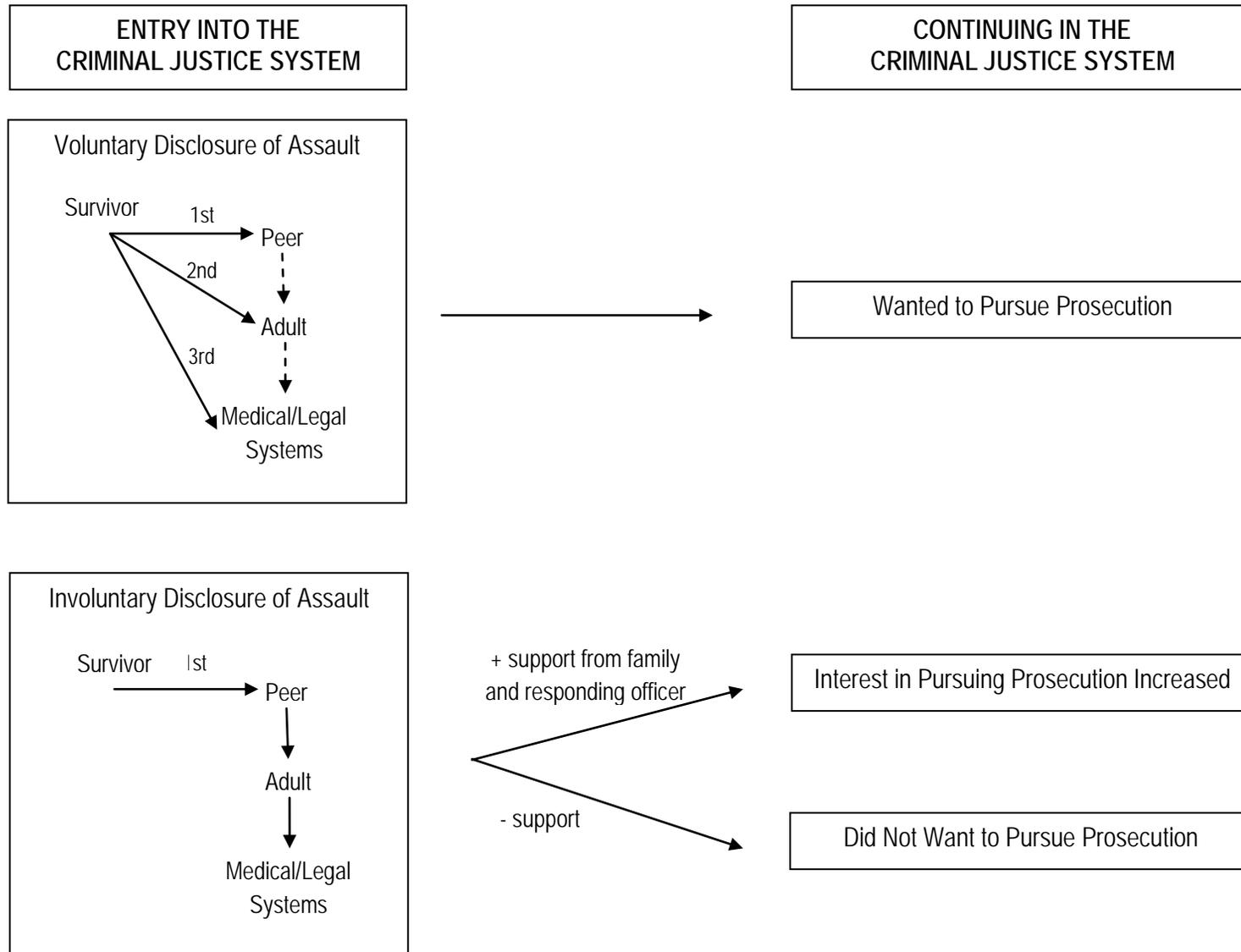
**3. Survivors' experiences with the criminal justice system.** A key aim of this study was to understand not only how adolescent survivors entered into the legal system, but also to examine their continued participation throughout the criminal justice process. Filing an initial police report does not mean that survivors will remain engaged for the next steps of the investigation. A great deal is asked of survivors during this process: in addition to their own follow-up interviews (which can be quite lengthy), detectives may need to remain in contact with them as other evidence is collected, suspects and witnesses may be interviewed, which may necessitate even more follow-up interviews with the survivors. In our sample, only three survivors had had any contact with prosecutors at the time we interviewed them, so our results primarily address their involvement with the criminal justice system from the time of the initial police report through the law enforcement investigation.

We examined whether victims' initial disclosure patterns affected the nature of their continued involvement in the criminal justice system, and found strong associations between these experiences. In other words, how victims came into the criminal justice system directly influenced the degree to which they remain engaged. We also explored whether the nature of victims' experiences in the focal SANE programs influenced their continued participation in the law enforcement investigation. But as noted in the prior section, all survivors had positive encounters with the forensic nurses and advocates. With barely any variability in the nature of SANE program contact, it is impossible to ascertain whether the nature and quality of their patient care affected their criminal justice system participation. Indeed, most survivors stated that they viewed their interactions with the SANE program as completely distinct from their encounters with

law enforcement. Similarly, these qualitative data revealed no site effects. Survivors were no more or less likely to remain engaged in the criminal justice system as a function of how their communities structured coordinated care for victims. Instead, victims' engagement in the law enforcement investigation seemed to have everything to do with how and why they made contact with the police in the first place. Figure 6 depicts the linkages between how survivors entered into the criminal justice system and their experiences of staying in the system throughout the law enforcement investigation.

FIGURE 6

Entry into and Continuing in the Criminal Justice System



The survivors who had *voluntary disclosures* of the assault *wanted to pursue prosecution* and stayed involved with the system throughout the investigation. These survivors had voluntarily disclosed to their peers and to adults in their lives, and chose to seek help from the criminal justice system. From report to investigation, these young women did not waiver in their decision to seek prosecution of the assault. By contrast, those who had *involuntary disclosures*, perhaps not surprisingly, had mixed feelings about pursuing prosecution. Although their entry into the system may have been against their wishes, survivors who received validation from the responding officers and their families changed their minds over time and their *interest in pursuing prosecution increased*.<sup>3</sup> But, those with *involuntary disclosures* who did not receive this kind of validation remained steadfast that they *did not want to pursue prosecution*.

These analyses do not include the two survivors who experienced *situational disclosures*. Because they were unconscious during and after the assault, these survivors were unable to decide whether to report the assault to the police. By the time they had regained consciousness, the legal system was already involved. Therefore, these two cases cannot be included in these analyses, which examine the links between how survivors entered into the criminal justice system and their continued participation.

**a) *Voluntary disclosures* → *Wanted to pursue prosecution*.** The eight survivors who voluntarily disclosed the assault to adults and then to legal and medical system personnel wanted to pursue legal action at the time of the police report, and continued to do so throughout the law enforcement investigation. They wanted to pursue prosecution in order to hold the assailants accountable and prevent them from

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<sup>3</sup> One survivor experienced involuntary disclosure (and did not initially want to pursue her case), but at the time of the interview, she had changed her views and wanted the case to go forward. Her family had supported pursuing the case, but she did not receive the validation from the police officers that the others in this group experienced. Instead, she attributed the change in her feelings to her experiences in counseling, which helped her realize what happened to her wasn't her fault. While the source of support was different, she can reasonably be classified in this group because her increased interest in prosecution was related to the support she received from her family and the professionals with whom she interacted.

assaulting other women and girls. For example, a 15-year old survivor who was assaulted by an acquaintance explained why she wanted the case to go forward:

*But the fact that they have proof, and they have evidence and everything, like hopefully, that he can get in trouble, because I really don't want anything to happen to anybody else. And I feel bad, because they [police] should be out doing other things, but at the same time, you don't know what he's doing, or how many other people he's done this to, or possibly, for all we know, he could have AIDS or something, and he could be doing this to other people, and spreading it. And just like, what else he does, he supposedly sells girls, and he sells drugs and all that stuff, and just that alone, he shouldn't be on the street. And I think that this is the window to get him, and to get other people like him, because if they realize how many people are doing this out there, that they'll like get a whole separate squad or whatever, just to get them off the street, so nobody else has to go through this [111].*

Similarly, a 14-year old survivor who was assaulted by an acquaintance was particularly adamant about continuing on with her case, because she found out that her assailant had orally raped someone else:

*I want [the assailant] to go to jail for the longest time possible...But I want him to get the longest time as possible, because I just want to stop it from happening to another girl. Because from what a boy at my school told me is... [the assailant] forced a girl to have oral sex with him. So I'm like, oh, I'm not the only girl he did something like this to. So, oh yeah, I'm really back to, you know, put my foot down and get really into this to prevent this from happening to any other girl [105].*

All eight of these survivors decided to pursue and endure the police investigation in order to try to have their assailants held accountable for their actions.

**b) Involuntary disclosure + validation → Interest in pursuing prosecution increased.** Six survivors who had involuntary disclosures to adults and the criminal justice system were initially quite hesitant about reporting and pursuing prosecution, but over time, their intentions shifted and they decided they did want their cases to go forward. For instance, a woman who was 17-years old at the time she was assaulted by a dating partner was forced to go to the hospital by her mom, and then the hospital called the police against her will. She didn't want to press charges because she did not want to talk about the assault:

*Because at the time I just wanted to go home. I just wanted to, you know, sort things out in my head. You know, I was tired of telling people the same story over and over and over again [115].*

But as she continued on in the process, her feelings about pursuing legal action changed:

*It made me feel like crap, like every time I said it, it was just like okay this really did happen. You know, we got to do something about it. And then I got more angry as, you know, the day went on and I was like, okay, let's go get him. You know, let's go do something about it, I'm getting really pissed [115].*

The critical factor that changed this woman's mind as well the other survivors in this group was the validation they received from their families, and perhaps even more importantly, from their responding officers.<sup>4</sup> These adults, through what they said and did, affirmed that what happened did constitute an assault, and that taking legal action was the right thing to do. For example, a 16-year old victim of acquaintance rape, who had feared that the police would not believe her, was validated by the responding officer's reaction:

*I: OK, so tell me how [the responding officer] reacted to you. Like how did that whole experience go?*

*He acted like he believed me, and he wanted justice for me, and stuff [101].*

By acting like he wanted justice for her, the officer confirmed that the case deserved legal action. Similarly, another survivor who was 15 when she was assaulted by a friend described how her mom's commitment

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<sup>4</sup> One survivor experienced involuntary disclosure (and did not initially want to pursue her case), but at the time of the interview, she had changed her views and wanted the case to go forward. Her family had supported pursuing the case, but she did not receive the validation from the police officers that the others in this group experienced. Instead, she attributed the change in her feelings to her experiences in counseling, which helped her realize what happened to her wasn't her fault. While the source of support was different, she can reasonably be classified in this group because her increased interest in prosecution was related to the support she received from her family and the professionals with whom she interacted.

made her change her mind about pursuing prosecution. The survivor had had mixed feelings about calling the police, and her mom made the decision to call them.

*I: ...so did you feel that it was your choice that the police got called or*

*No.*

*I: But you still were glad*

*I'm glad*

*I: ...Did she talk to you about her decision or was she just like, "I'm going to do this"?*

*She did after like we came home [from the police department] and she talked to me about how this are going to get better and like and not alone or whatever. And she told me why. She told me that she wants to help me and that she doesn't want this to happen again and she thinks that I'm going to need a little bit help getting over it or like coping with it [114].*

Through this discussion the survivor's mother validated that this was a traumatic experience, and also reiterated the importance of criminal justice action in order to prevent the assailant from committing the same crime again.

Although family members and legal system personnel were validating, these survivors noted that there was sometimes a fine line between validation and pressure. For instance, a survivor who was assaulted by an ex-boyfriend at the age of 17 felt pressured into going forward because of her mother's and the responding officer's desires to see charges pressed.

*Just like her attitude was like she is like, well I'm about to leave if you are not going to do anything about it. She needed to do something about it.*

*I: How did that feel to you?*

*I was scared, I was okay I'll do it? (laughs)*

*I: Okay.*

*You know.*

*I: Did you feel like you had to?*

*Yeah, my mom was like breathing down my neck, you know, saying that I have to do it [115].*

Although initially she felt pressured and frightened into reporting the assault, later the responding officer's reaction to her case influenced how she felt about pressing charges:

*I think [the responding officer] was more angry about the situation like she just wanted to go out and get him. And I really liked that, like she did want him to get caught.*

*I: Okay, why did that make a difference to you?*

*Because...I was just like yeah, I really need to do something about it...[115].*

Other survivors in this group also felt some pressure from family and friends to continue participating, but ultimately, they chose to go forward because they, the victims, wanted to and they had been validated by critical adults.

**c) Involuntary disclosure without validation → Did not want to pursue prosecution.** The other four survivors who had involuntary disclosures to adults and the criminal justice system did not receive validation from their families and from the police, and as a result, they remained steadfast in their resistance to pursue prosecution. However, despite those preferences, many of these survivors were still, in their words, forced to go forward with the investigation. Most often, these girls' families and friends did not believe they were assaulted or blamed them for the assault, and they felt pressured to continue participating in the legal system to prove to them that they were raped. A 16-year old survivor, who was raped by a co-worker, described how the fact that her mother and her boyfriend believed the assault was consensual drove her to pursue legal action:

*Well, I guess [victim's mom] was kind of looking for the same thing my boyfriend was. She was looking for answers. She didn't believe me at first. She didn't believe that, you know, I was manipulated or whatever. She really thought that it was something that I wanted to do.*

*I: How did that make you feel?*

*It just, like I really felt really alone. Because like I kind of, you know, that kind of pushed me more to tell [the police]... And I really considered not telling the police, but at the same time I felt like everyone that didn't believe me or was having a really hard time believing me, definitely wouldn't, if I just refused to tell, so, yeah, I kind of felt like I had to prove myself [110].*

Later in the interview she stated:

*I hated how much pressure I was under to feel like I needed to prove to everyone that I wasn't lying, so like I went and told [the police; 110].*

This survivor did not want to pursue prosecution and only went forward to prove she wasn't lying. Unlike the few survivors who felt pressured in the "involuntary with validation group," these survivors did not receive messages that validated that they were assaulted and that the assault deserved criminal action. Rather, the pressure they felt came from that the fact that their family and friends blamed and/or did not believe they were assaulted, and wanted the survivors to prove their trustworthiness by participating in the criminal justice system. While survivors in the "involuntary with validation" group ultimately went forward because they, the victims, wanted to, the survivors in this group only went forward in an attempt to placate their family and friends.

Being dragged into the criminal justice system did not help these survivors feel comfortable about participating in the investigation process. They were there against their wishes and lacked validation from the police and their families (which might have helped change their minds about prosecution, as was the case for the survivors in the second group), so when the investigation demanded their full disclosure and participation, they balked. All four survivors in this group withheld information or evidence from legal system

personnel. For example, a survivor was 17-years old when she was assaulted by multiple acquaintances at a party. The prosecutor wanted to use evidence from the survivor's phone in order to determine whether or not to prosecute the case. The survivor refused to give up her phone:

*And I told the detective, I'm like I can't, you know, I can't live without a phone, I'm 18 and I still live at home with my mom. I'm never home, but I have to be to get a hold of her, so to tell her where I'm going. It was like, I need my phone. And plus I pay my phone bill every month. Why am I going to hand you my phone? And I was like, can't you just take his phone and they are like, no, they were refusing to take his phone. They want my phone, because I'm the one pressing charges. So, it is like, you know, they want to get text messages and stuff, and not only that, but I'm scared that they are going to take like anything else in my phone and like, you know, use it against me. Because there is...my personal stuff. I'm 18 years old, I have personal stuff on my phone [108].*

She was supposed to call the prosecutor so they could make arrangements for taking her phone, and she never did because she was afraid that it would be used against her.

Another survivor withheld information by lying and saying that she was not assaulted. She was 16-years old when she was assaulted by an ex-boyfriend. A friend's mother who had found out about the assault called the police and told them about the assault, and gave them the survivor's address. The survivor described what happened when the police first arrived at her house:

*I went downstairs and answered the door and it was [the police] and they said someone here was raped. And I said, no.... So, I just lied and said, nothing happened [109]*

Although the assault had already been reported against her will, she tried to avoid going through the legal system by saying that she had not actually been assaulted. However, the police returned later with an ambulance crew and forced her to participate in the legal process. While at her house, the police and ambulance personnel were trying to get the survivor to give up her clothes, and asking her if she wanted to press charges. Ultimately, she said yes; however, it was not because she actually wanted the case to go forward.

*I: Okay. So when you said that they asked you if you wanted to press charges, did you feel like it was your choice to continue with that or*

*I felt like it was being pressured.*

*I: Okay.*

*I felt like if I didn't do it everybody would be mad at me. I didn't know what to do.*

*I: Okay. Mad at you how?*

*Because I didn't do what they said to do, they're trying to force it saying it is the right thing to do and everything else. But, I didn't feel it was right [109].*

A 14-year old survivor of gang rape was forced by her father to report the assault to the police. She described how she deliberately left out information during interactions with legal personnel, specifically, she down-played or omitted details about the extent to which she was coerced by the rapists:

*But in [interview with police] I didn't really put like how I was like pressured that much, 'cause at that point I mostly thought it was my fault [116].*

She withheld this information because she thought that what happened was her fault, and without support from others to re-frame what had happened to her, she was not willing to participate fully in the investigation process. All of the survivors who did not want to pursue prosecution did not participate fully in the investigation, which suggests that forcing adolescents through the system may not benefit the case in the long run.

## **V: STUDY TWO: FACTORS PREDICTING PROSECUTION IN REPORTED INCIDENTS OF SEXUAL ASSAULTS AGAINST ADOLESCENT VICTIMS**

### **A. Design**

The purpose of this study was to examine what factors predicted the prosecution of reported incidents of sexual assault against adolescent victims. The two focal counties varied with respect to how their SANE-SART programs functioned over time. These site differences were examined as possible predictors of prosecution outcomes, relative to the effects of victim characteristics, assault characteristics, and medical forensic evidence findings. This study employed a quasi-experimental, non-equivalent comparison group design to compare prosecution outcomes for adolescent sexual assault cases treated in the two focal counties. A quasi-experimental design was necessary because it was not feasible to randomly assign victims to different SANE-SART models. Once the SANE programs were created in these counties, all hospitals in both communities referred their cases to these programs (which also precluded collecting a concurrent comparison sample). It is also not possible to randomly assign counties to use different SANE-SART models. Interventions develop indigenously over time, and studying naturally occurring group variations enhanced the external validity of this project (Kelly, 2006). Shadish et al. (2002) noted this quasi-experimental design can effectively address issues of internal validity, provided that the two groups compared are as equivalent as possible. County-level data and program-patient characteristics are reasonably equivalent, while differing in key areas of substantive interest (e.g., SANE-SART model). In addition, sampling criteria were selected to further maximize the similarities between the comparison sites.

### **B. Sampling**

Adolescent sexual assault cases were sampled from the patient files of the two focal SANE programs from the dates the programs opened through 11/31/2007 (Program A opened in February, 1998

and Program B in September, 1999). Cases were included in the sample if they met the following criteria: (1) sexual contact occurred or was suspected; <sup>5</sup> (2) the patient was 13 to 17 years old at the time of the exam; (3) the assault occurred in the respective focal county and was reported to law enforcement; and (4) the patient received a full forensic exam, including a patient history and medical forensic evidence collection. <sup>6</sup> Two additional criteria were used to exclude cases from the sample. At Program A, as part of their routine patient paperwork, survivors were asked whether they would consent to having information from their files used for research and evaluation purposes; patients who declined such consent were not included in the sample. Also, one of the police departments in County B did not retain case records from this time period. All cases handled by this department were excluded because it would have been impossible to obtain final outcome data. These sampling criteria yielded N=395 cases (see Figure 7). This study examined predictors of two types of criminal justice system outcomes: police referral of cases for prosecution, and *final* case disposition (1 = not referred, 2 = referred, not warranted/authorized, 3 = authorized but later dismissed or acquitted at trial; 4 = guilty plea or convicted at trial). Referral data was available for all cases in the sample; however, final case outcome data could not be determined for three cases, yielding a final sample size of N=392 for the analyses predicting final case disposition.

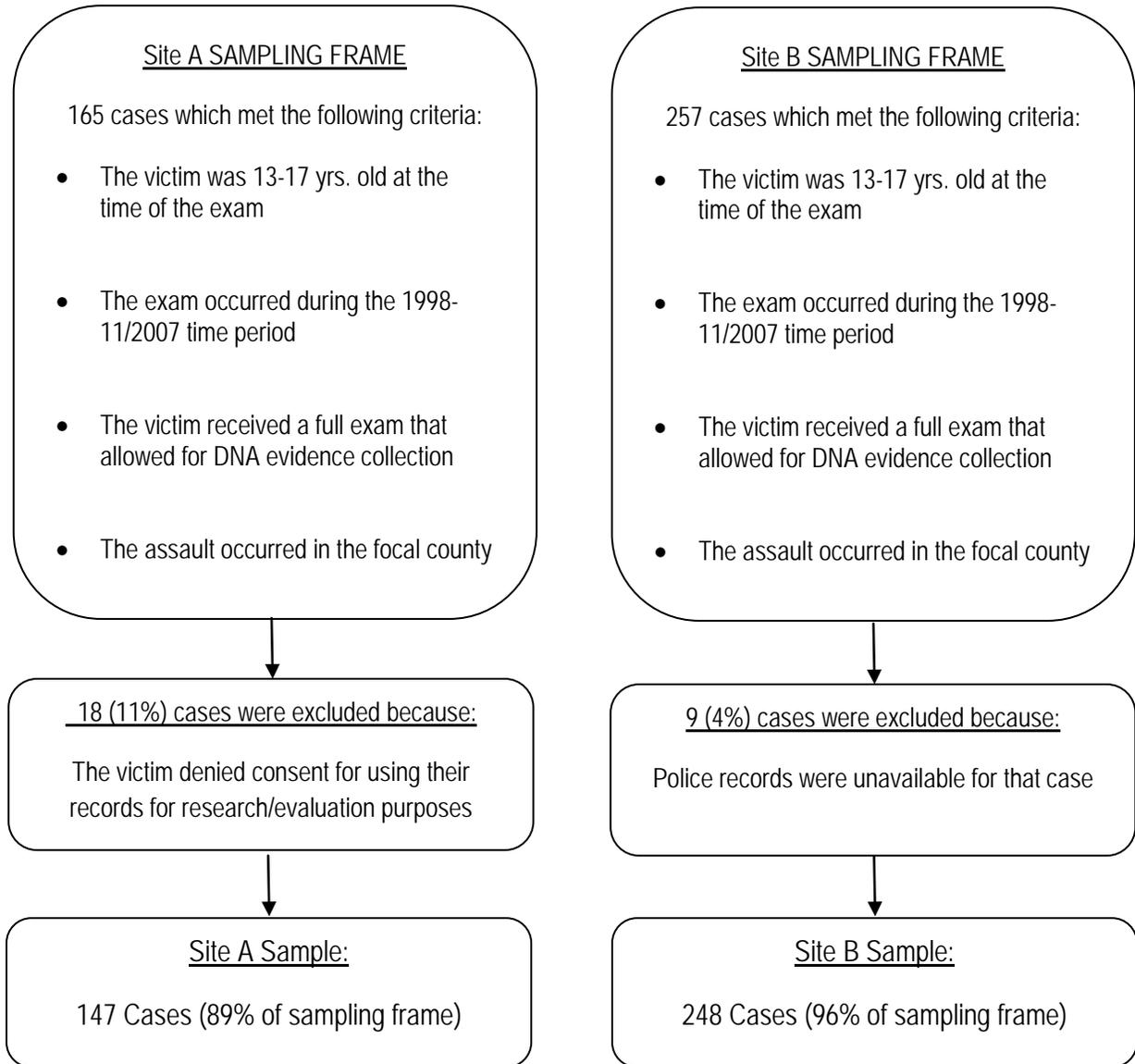
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<sup>5</sup> No-contact sexual abuse, and physical, non-sexual abuse cases were excluded. In addition, several adolescents denied that any sexual contact occurred, but were seen at the SANE program because an adult suspected that sexual activity occurred and therefore brought them to the SANE program (consistent with the DOJ [2004] Protocol, only adolescents who consented to an exam received one). If there was additional evidence to suggest that sexual contact did occur (e.g., in the form of a witness or anogenital injury), the case was retained in the sample. There were also several cases where a patient had been unconscious and upon regaining consciousness suspected an assault occurred. If there was evidence of an assault (e.g., a witness, injuries, or missing clothing), the case was retained in the sample.

<sup>6</sup> "Forensic evidence collection" was based on whether the patient received forensic evidence collection at the site of the assault (i.e., an anogenital examination if there was anogenital contact or an oral examination if there was oral contact.)

FIGURE 7

Study 2 Sampling Process



**C. Data Collection and Coding Procedures**

1. **SANE program records.** Two research assistants coded SANE program records for victim characteristics, assault characteristics, and medical forensic evidence findings. The coding framework was developed based on the PI's prior study on the predictors of adult sexual assault prosecution. In addition,

the directors of both SANE programs were consulted to ensure that the coding framework included variables relevant to adolescent cases. Thirty percent of cases were coded by both research assistants to assess inter-rater reliability. Coding was monitored throughout in order to maintain reliability of kappa  $>.80$ . Final kappa across all variables = .98.

**2. Criminal justice system records.** Police and prosecutor records were collected to document case progression through the criminal justice system. Cases were matched from the SANE records to the criminal justice system records by victim name, police complaint number, and date of the assault. A research assistant searched the county prosecutor's database in order to determine whether the case was authorized by the prosecutor's office, and if so, the ultimate disposition of the case: dismissal, plea bargain, acquittal, or conviction at trial. If a case was not authorized by the prosecutor's office, police records were requested under the Freedom of Information Act. These records were necessary to determine whether law enforcement personnel had referred the case for prosecution and the prosecutor's office denied the warrant (i.e., the case was not authorized) or if the police closed the case without referring it on for prosecution.

**3. Crime lab records.** The list of victim names, complaint numbers, and assault dates were also submitted to the state crime lab. For each case, crime lab staff indicated whether a rape kit had been submitted, and if so, provided the DNA analysis results (i.e., inconclusive, negative, positive for DNA).

#### D. Measures

**1. Dependent variable.** The dependent variable was assessed as a four-level ordinal variable in order to reflect case progression throughout the criminal justice system: 1 = case reported, but not referred to prosecutor's office by police; 2 = referred to prosecutor's office but not warranted; 3 = warranted, but dismissed and/or acquitted at trial; 4 = pled guilty and/or convicted at trial. Follow-up analyses were conducted to hone in on the predictors of law enforcement case referral: 0 = case reported but not referred, 1 = referred to the prosecutor's office for prosecution.

**2. Independent variables.** The two focal counties varied with respect to how their SANE-SART programs functioned over time. To develop reliable indicators of intervention changes, two research assistants examined all available archival records from both sites regarding SANE program development and SANE-SART functioning. In addition, the SANE program directors and the rape crisis center directors affiliated with these SANE programs provided information about changes in leadership within the SANE programs over time. Also, archival records were used to obtain data on changes in the elected prosecutor over the 1998/1999-2007 time period. For the final analyses, cases were grouped by month in which the assault occurred and each month was coded to reflect the following variables: SANE director (changed in Site B only); elected prosecutor (changed in both sites); frequency of adolescent/adult sexual assault coordinating council meetings (changed from monthly to quarterly meetings); and multidisciplinary Child Advocacy Center coordinating council meetings (initiated in Site A only). In addition to these site-effect variables, independent variables related to victim characteristics, assault characteristics, and medical forensic evidence findings were also coded by the SANE program records (see Appendix C-3 for the coding sheet of the independent variables; and Section E. below on Analyses).

## **E. Analyses**

The quantitative analysis focused on identifying predictors of the extent to which reported cases of sexual assault against adolescents progressed through the criminal justice system. Cases were investigated by 23 police departments in two sites – 8 police departments investigated cases examined by the Program A and 15 police departments investigated cases examined by Program B. Each police department investigated from 1 to 36 cases. Due to common personnel, policies, and procedures, cases investigated by the same police department were likely to be more similar than cases handled by different departments, although the amount of variance shared within police departments was modest. For the ordinal case disposition variable, the intraclass correlation (ICC) across police departments = .029,

indicating that slightly less than 3% of the variance could be explained by differences among police departments. However, the ICC for the dichotomous variable reflecting the first decision point in the process -- referral for prosecution -- was greater, with the ICC across police departments = .080. This indicates that 8% of the variance in the referral for prosecution could be explained by differences among police departments. Because a non-negligible amount of variance in case processing was attributable to differences among police departments, all analyses incorporated the influence of police department as a random effect.

The cases in these analyses occurred over nearly 10 years beginning in April 1998. Cases handled near the same time were assumed to share similarities due to common historical, political, and policy influences. For the ordinal case disposition variable, the ICC across months = .043, indicating that approximately 4% of the variance could be explained by month-to-month fluctuations. For referral to the prosecutor, ICC across months = .053, indicating that 5% of the variance in the dichotomous variables (referred/not referred) was explained by month-to-month fluctuations. To reflect the influence of case timing, cases were grouped by month, which allowed examination of the data for time trends, seasonal effects, and influences of identified historical events and programming shifts. To facilitate interpretation and improve the stability of estimation of interaction terms, the time variable was centered at the mean of all observations (month 66), effectively setting this point as the intercept.

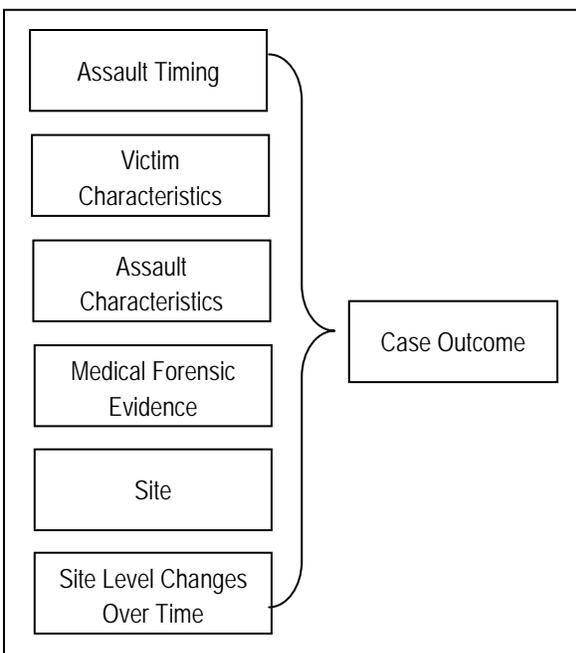
To reflect both the grouping of cases by police department and by month and the ordinal nature of the dependent variable, multilevel ordinal regression was used to analyze the impact of case characteristics and other influences on case progression through the justice system (see Hedeker & Gibbons, 1994; Raudenbush & Bryk, 2002). Ordinal regression analyzes the cumulative probability that a case will exceed a particular level on the ordinal outcome variable, as a function of the predictor variables included in the analysis. Multilevel ordinal regression is an extension that incorporates the shared influence of predictor

variables that affect groups of cases, along with variables that exert independent effects on individual cases. Multilevel analyses produce standard errors that are appropriate for testing the influence of group-level variables, reflecting the lack of independence of their effects on individual cases.

For multilevel analysis, cases were grouped by both police department and month of assault. Individual cases were modeled at Level 1, nested within the 23 police departments at Level 2. A random intercepts model was specified, with average effects estimated across police departments. Month of assault was specified as a fixed effect at Level 1; linear and nonlinear effects of time were tested, as were possible seasonal effects. Site (Site A vs. Site B) was specified as a Level 2 covariate. All other predictors were modeled as fixed effects at Level 1. Predictor variables were examined in six ordered blocks (see Figure 8).

**FIGURE 8**

**Predictors of Criminal Justice Case Progression**



The first block contained the effect of case timing, or the month in which the assault occurred, numbered sequentially from the initial month, April, 1998. Graphical methods were used to assess patterns of change in case progression toward prosecution over time, and linear and quadratic terms were tested to assess the trajectory over time. Graphical and statistical methods were used to test for possible recurrent seasonal patterns in case progression.

The second block contained victim characteristics

that may have affected case outcome, including the victim's age (dichotomized at the age of consent, with 60.5% age 13 to 15 and 39.5% age 16 to 17); victim's gender (96.5% female); victim's race (80.3% Caucasian vs. 19.7% minority, most of whom were African American); a proxy variable for victim's

household income <sup>7</sup> ( $M = \$47,625$ ,  $SD = \$10,594$ ; whether the victim was identified as having a developmental delay (2.4%) or any type of disability (including both physical and mental; 12.2%), and whether the victim had consumed alcohol or drugs prior to the assault (38.5% had done so).

The third block contained assault characteristics, including the relationship of the perpetrator to the victim (64.8% acquaintance, 12.4% gang assault, 9.6% stranger, 6.8% family member, 5.6% intimate partner); whether the assault included vaginal penetration (94.0%), oral contact (33.2%), or anal penetration (14.9%); and the number of types of sexually assaultive acts involved in each case (1-5 possible;  $M = 1.45$ ,  $SD = 0.79$ ). This block also contained tactics used in the assault, including physical force (48.4%) and use of a weapon (3.3%). Also included in this block were additional contextual features of the assault, such as whether there were victim assertions that no sexual contact occurred (1.4%), that the contact was consensual (17.1%), or that s(he) was unsure if sexual contact had occurred (10.4%).

The fourth block contained medical forensic evidence findings, including DNA findings (15.7% positive; 43.8% negative; 40.5% kit not submitted); findings of genital injury (49.9%), hymen injury (20.0%), and non-anogenital physical injury (48.9%). This block also included a continuous variable characterizing the amount of time elapsed between the assault and the medical examination ( $M = 0.99$  days,  $SD = 1.16$ ).

The fifth block contained site variables as both a main effect explaining differences between the two sites in level of progression toward prosecution, and in interaction with time, explaining site differences in the trajectory of change in the proportion of cases reaching different stages in the prosecution process. In addition, this block contained site interactions with variables examined in previous blocks, testing for site differences in the effect of victim, assault, and medical forensic variables on case progression.

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<sup>7</sup> Data on victim's household income were not available. We used the average income for households in the zip code where the victim lived (through census data) as a proxy for victim income.

The sixth block contained variables reflecting the timing of identified programmatic changes at the two sites, including implementation of community coordinating councils, changes in coordinating council meeting frequency, and changes in SANE directors and prosecutors at each site.

The multilevel ordinal regression was performed in a hierarchical manner, entering each block sequentially in order to control for the effects of variables in earlier blocks when examining the effect of variables in later blocks. To reduce model complexity and optimize interpretability, variables showing no significant relationship to the dependent variable when entered were trimmed from the model (as recommended by Hosmer & Lemeshow, 2000). Analyses were conducted with HLM 6.08 software (Raudenbush, Bryk, & Congdon, 2004), using the hierarchical generalized linear model with a logit link function to characterize an ordinal dependent variable. Full maximum likelihood was used for estimation. To reduce the influence of non-normal distributions on the outcome variable, robust standard errors were used to compute confidence intervals; however, results were virtually identical using robust or non-robust estimation. Missing observations on predictor variables (5.8% of the data matrix of individual case-level variables) were estimated using expectation maximization (EM) based on all available data, an approach shown to introduce less bias than other methods of handling missing data, such as listwise deletion of cases with missing observations (Schafer & Graham, 2002).

## **F. Results**

### **1. Descriptive findings regarding case progression through the criminal justice system.**

Prosecution was measured as a four-level ordinal variable to capture case progression through the criminal justice system. Table 2 summarizes case outcomes overall and by site. As noted previously, no studies to date have examined prosecution rates specifically for adolescent victimizations. In adult samples, on average 17-29% of reported assaults are successfully prosecuted (i.e., guilty plea or trial conviction); in

child samples (which often combine adolescents with youth under 12), on average 40-85% of reported cases are successfully prosecuted. In this study, the overall rate of guilty pleas/trial conviction was 40.3%.

**TABLE 2**

**Descriptive Results: Case Progression Outcomes**

Outcome	Overall	Site A	Site B
Not referred by police for prosecution	34.4%	32.7%	35.5%
Referred to prosecutor, but not warranted for prosecution	16.8%	15.6%	17.6%
Warranted by prosecutor, but dropped or trial acquit	8.4%	15.0%	4.5%
Guilty plea or trial conviction	40.3%	36.7%	42.4%

**2. Multilevel ordinal regression predicting case progression.** Results of the ordinal regression are summarized in Table 3. The “ordinal effects” block describes the expected cumulative probabilities of case outcomes at the three thresholds of the ordinal dependent variable, with all other variables in the model held constant at zero. In the Time model, these effects were at the intercept of time, which was centered at month 66. At this point in time, the log odds of conviction/guilty plea vs. other dispositions (i.e., warranted/acquitted or dropped, referred but not warranted, and not referred) was -0.308. This translates to a cumulative odds ratio (OR) of 0.74, which indicates that an assault reported in month 66 was 74% as likely to attain a conviction/plea as to receive a lesser disposition (i.e., acquittal/dropped, referred but not warranted, or not referred for prosecution). The log odds that a case reported in month 66 would be warranted vs. not warranted was 0.35. This translates to a cumulative OR of 1.42, which indicates that a case was 42% more likely to be warranted (and either convicted or acquitted/dropped) than not warranted.

Finally, the log odds that an assault reported in month 66 would be referred for prosecution vs. not referred was 1.06. This translates to a cumulative OR of 2.89, which indicates that a case was nearly three times as likely to be referred for prosecution as not referred.

Block 1 in Table 3 shows the marginally significant influence of the linear effect of time (OR = .994,  $p = .059$ ). Across the 10 year span, the odds that a case would reach a higher level of disposition declined slightly, at a rate of less than .01 per month. This effect was essentially linear over time; quadratic effects added no explanatory power and were not retained in the model. No seasonal effects were identified.

Block 2 of Table 3 shows the influence of victim characteristics. Cases involving victims aged 16 or 17 were only about one fourth as likely to reach a higher level disposition than those involving victims age 13 to 15 (OR = .27). Identification of the victim as developmentally delayed had a positive effect on case progression, with these cases eight times as likely to progress further through the system than other cases (OR = 8.03). Other victim characteristics – gender, race, household income, or whether the victim had consumed alcohol or used drugs prior to the assault – made no contribution to the prediction of case progression.

Block 3 of Table 3 adds to the model the influence of assault characteristics on case progression. Higher levels of case progression were associated with assault by a family member (OR = 9.80), an intimate partner (OR = 6.00), or an acquaintance (OR = 4.99), relative to assaults perpetrated by a stranger; cases involving gang assault were no more likely to progress further than those perpetrated by a single stranger. Although disposition was not related to specific types of assaultive acts, it was positively associated with the total number of types of acts perpetrated during the assault (OR = 1.84); each additional act nearly doubled the odds of a case progressing further. Case outcome was not associated with tactics used in the perpetration of the assault (e.g., physical force or weapon) or with the victim's

assertions that no sexual contact had occurred or that s(he) had desired the contact or was uncertain about what had happened.<sup>8</sup>

Block 4 of Table 3 adds the contribution of medical forensic evidence findings to the prediction of case progression, controlling for the effects in previous blocks. Time between the assault and the medical forensic examination was not significantly related to case progression but was retained in the model to control for possible timing effects on the viability of forensic evidence. Controlling for time between the assault and the exam, DNA evidence was positively related to case progression. In comparison with cases in which rape kits were not submitted to the crime lab, cases with positive DNA evidence were more than 5 times as likely to progress further in the system (OR = 5.63); cases with negative DNA evidence were more than 3 times as likely to progress further (OR = 3.14). Other types of medical forensic evidence (e.g., genital, hymen, or other physical injuries) were not associated with case progression.

Block 5 of Table 3 adds site differences to the model. The main effect for site was not significant, indicating that case progression did not differ between the two sites at the intercept of time (month 66), holding the effects of predictors in earlier blocks constant at zero. However, there was a significant site by time interaction (OR = .99), indicating that the trajectory of change in the odds of higher case progression differed between the two sites. This effect is illustrated in Figure 9. At Site A, the odds that a case would reach a higher level of disposition declined over time at a rate of .01 month, while there was no change at Site B. The site by age group interaction was marginally significant (OR = 1.77,  $p = .09$ ), suggesting that, although cases with older victims did not progress as far in the system as those with younger victims at

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<sup>8</sup> Cases in which the victim denied any sexual assault occurred were only kept in the study if there was other evidence in the SANE record (typically a witness) that an assault occurred.

both sites, there was less difference at Site A than at Site B, after controlling for the Site by time interaction. No other site interactions approached significance.

Block 6 of Table 3 adds dichotomous variables designating the timing of specific community and/or policy changes at one of the sites, including changes in SANE directors, implementation or change in site community coordinating councils, and prosecutor elections and changes. Only one of these – implementation of the child advocacy coordinating council at Site A – was significantly predictive of case disposition; the OR of .21 indicated that higher levels of case progression were only one fifth as likely for assaults reported at Site A after implementation of the child advocacy coordinating council compared with assaults reported before implementation. Furthermore, addition of this variable to the model rendered the site by time interaction in Block 5 non-significant, suggesting that differential changes in case progression over time in the two sites could be explained by implementation of the child advocacy coordinating council at Site A. The effects are shaded in Table 3.

In summary, cases progressed further through the criminal justice system if the victims were under the age of 16; the victims had developmental delays; the rape kit was positive or negative for DNA (as compared to no rape kit submitted); the assailants were an acquaintance, family member, or intimate partner (as compared to a stranger); and the victims endured a higher number of sexually assaultive acts. Implementation of the CAC at Program A accounted for a difference between sites in prosecution rates over time. See Figure 10 for a visual summary of significant predictors of the ordinal case outcome.

The model was checked for the influence of problematic collinearity, suppression, and overfitting by examining the effects of variables in the final model with other predictors removed. Discrepant findings (e.g., effects reaching significance only when other variables were in the model) might identify suppression or other multi-variable effects that are too complex to be supported by the limited sample size. However,

the coefficients for all predictors remained essentially consistent regardless of the presence or absence of other variables, suggesting that model effects are robust and adequately supported by the sample size.

TABLE 3

**Ordinal Regression Predicting Case Progression throughout the Criminal Justice System**

	Time Model			Victim Characteristics Model			Assault Characteristics Model			Medical Forensic Evidence Model			Site Effects Model			Community Level Changes Model		
	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>
Ordinal effects																		
Threshold 1i	-0.308	0.735	0.018	0.174	1.190	0.252	-2.273	0.103	0.000	-3.136	0.043	0.000	-3.052	0.047	0.000	-3.147	0.043	0.000
Threshold 2j	0.351	1.420	0.000	0.398	1.490	0.000	0.430	1.536	0.000	0.473	1.605	0.000	0.478	1.613	0.000	0.487	1.627	0.000
Threshold 3k	1.063	2.894	0.000	1.193	3.295	0.000	1.319	3.741	0.000	1.466	4.333	0.000	1.477	4.378	0.000	1.505	4.503	0.000
Block 1: Time effects																		
Month in which assault occurred	-0.006	0.994	0.059	-0.005	0.995	0.143	-0.006	0.994	0.029	-0.005	0.995	0.112	0.001	1.001	0.740	0.001	1.001	0.718
Block 2: Victim characteristics and time effects																		
Age group (0 = 13-15; 1 = 16-17)				-1.322	0.267	0.000	-1.225	0.294	0.000	-1.116	0.327	0.000	-1.341	0.262	0.000	-1.359	0.257	0.000
Developmental Delay				2.083	8.028	0.004	2.130	8.418	0.001	2.056	7.815	0.024	1.909	6.744	0.017	2.049	7.763	0.011
Block 3: Assault characteristics																		
Relationship to assailant-Acquaintance							1.606	4.985	0.002	1.770	5.870	0.000	1.803	6.066	0.000	1.768	5.859	0.000
Relationship to assailant-Gang							0.416	1.516	0.348	0.594	1.811	0.208	0.697	2.007	0.056	0.607	1.834	0.084
Relationship to assailant-Familial							2.282	9.799	0.001	2.416	8.184	0.000	2.473	11.853	0.001	2.426	11.313	0.001
Relationship to assailant-Intimate							1.792	6.001	0.033	2.102	8.184	0.001	2.179	8.839	0.009	2.123	8.353	0.008

<sup>a</sup> (Convicted/plead) vs. (Warranted & Dropped/acquitted, Referred, or Not referred)

<sup>b</sup> (Convicted/plead or Warranted & Dropped/acquitted) vs. (Not warranted)

<sup>c</sup> (Convicted/plead or Warranted & Dropped/acquitted or Referred) vs. (Not referred)

	Time Model			Victim Characteristics Model			Assault Characteristics Model			Medical Forensic Evidence Model			Site Effects Model			Community Level Changes Model		
	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>
Relationship to assailant-Stranger (reference category)																		
Number of types of sexual assault							0.612	1.844	0.000	0.492	1.635	0.001	0.477	1.611	0.001	0.541	1.717	0.000
Block 4: Forensic evidence																		
Days between assault and exam										-0.116	0.891	0.201	-0.105	0.901	0.159	-0.087	0.917	0.259
DNA-Positive										1.727	5.626	0.000	1.818	6.162	0.000	1.903	6.709	0.000
DNA-Negative										1.143	3.136	0.000	1.186	3.274	0.000	1.257	3.513	0.000
DNA-No kit submitted (reference category)																		
Block 5: Site Effects																		
Site (0 = Program B; 1 = Program A)													-0.407	0.665	0.140	0.198	1.219	0.558
Site X Time (month in which assault occurred)													-0.014	0.986	0.014	0.005	1.005	0.486
Site X Age group													0.569	1.766	0.088	0.518	1.679	0.084
Block 6: Agency/Community level changes																		
Child advocacy coordinating council at Program A (0 = before; 1 = after)																-1.585	0.205	0.001
Variance of random intercepts across police departments	0.087			0.127			0.045			0.057			0.045			0.065		

FIGURE 9

Change Over Time in Probability of Higher Case Progression, by Site

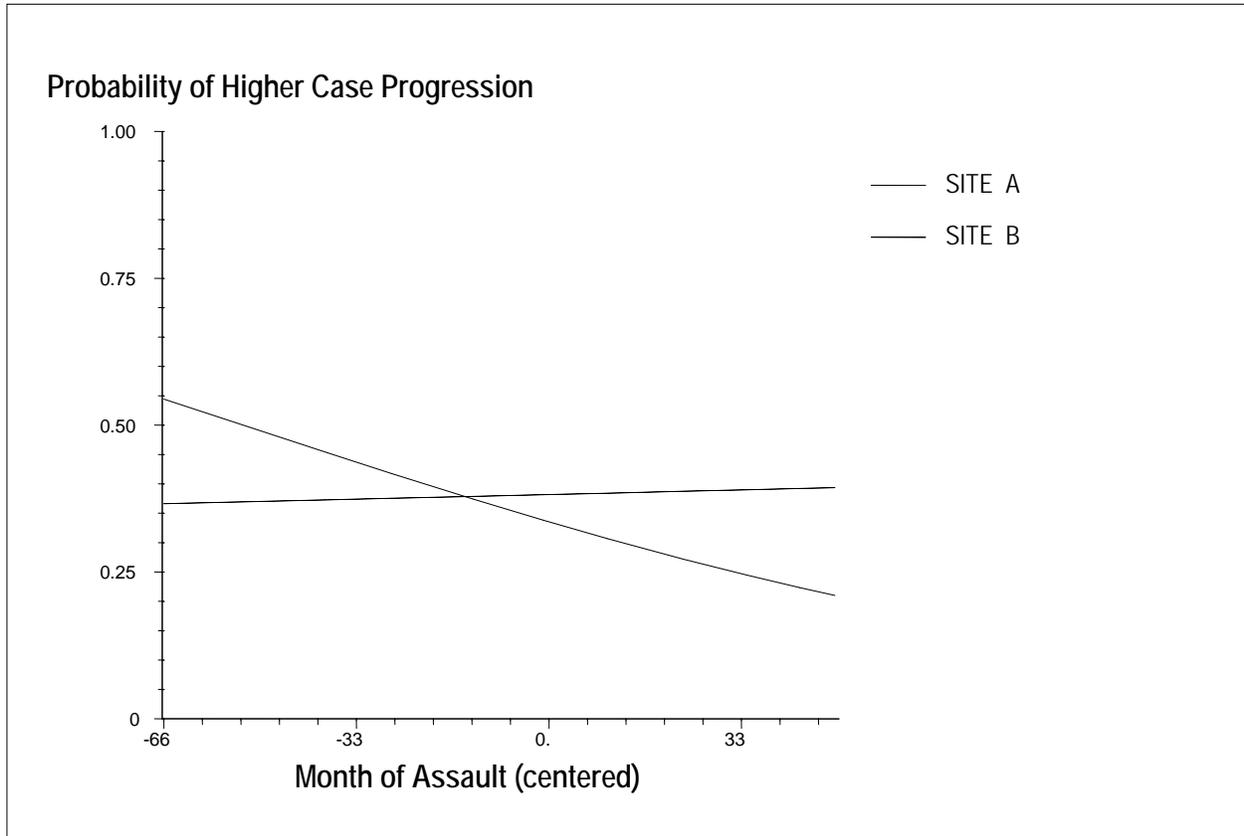
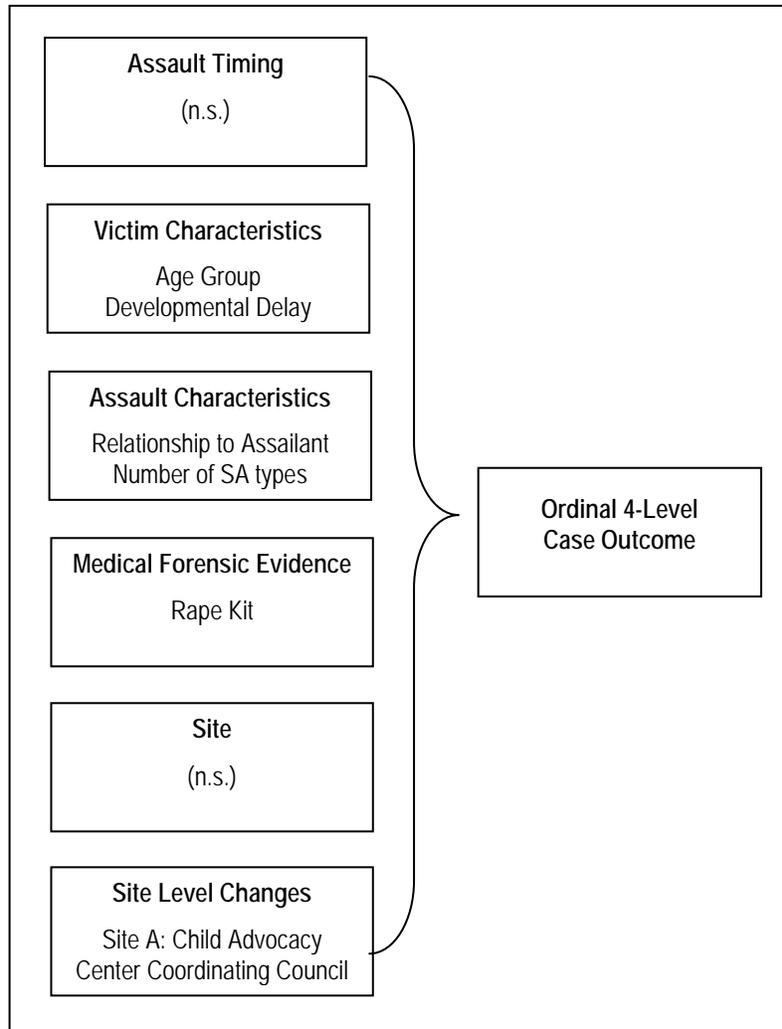


FIGURE 10

Results Summary: Multilevel Ordinal Regression Analyses Predicting Case Progression



**3. Multilevel logistic regression predicting referral to prosecutor.** In an effort to more fully understand the influence of case characteristics and site-specific policy and programming changes on the progress of cases through the criminal justice, a separate analysis focused specifically on the police decision to refer a case to the prosecutor. This analysis used multilevel logistic regression to model predictors of the dichotomous outcome (referred/not referred) and was conducted in a parallel manner to the previous analysis of the ordinal case disposition variable. Results are summarized in Table 4.

The intercept in the time model of Table 4 (OR = 2.38) indicates that an assault referred at the intercept of time (centered at month 66) was nearly 2.5 times as likely to be referred to the prosecutor as not. The effect of time was nonsignificant, indicating no overall change in the odds of referral over time. No nonlinear or recurrent seasonal patterns in referral were found.

Block 2 of Table 4 adds victim characteristics to the model. The significant effect of age group (OR = .35) indicates that cases with victims above the age of consent (age 16 to 17) were only one third as likely to be referred as cases with younger victims. This likelihood did not change over time. No other victim characteristics were significantly related to the police decision to refer a case to the prosecutor, including developmental delay, which was significantly predictive of ordinal case outcome.

Block 3 of Table 4 adds assault characteristics to the model. Similar to the model of ordinal case outcome, assaults by acquaintances (OR = 4.91) or family members (OR = 50.22) were significantly more likely to be referred for prosecution than assaults by strangers. In contrast to the prediction of ordinal case disposition, assaults by intimate partners were no more likely to be referred for prosecution than assaults by strangers. Gang assaults were also no more likely to result in referral. Similar to the previous analysis, the number of types of sexual acts perpetrated by the assailant was predictive of referral (OR = 2.04); each additional act doubled the odds of referral for prosecution. As with the ordinal case outcome, referral was not associated with tactics used in the perpetration of the assault (e.g., physical force or weapon) or with

the victim's assertions that no sexual contact had occurred or that s(he) had desired the contact or was uncertain about what had happened.

Block 4 of Table 4 adds the contribution of medical forensic evidence to prediction of case referral, controlling for the effects in previous blocks. Only DNA evidence was predictive of referral. In comparison to cases in which rape kits were not submitted to the crime lab, cases with positive DNA evidence were more than 8 times as likely to be referred (OR = 8.49), and cases with negative DNA evidence were 4 times as likely to be referred (OR = 4.06). Other types of medical forensic evidence (e.g., genital, hymen, or other physical injuries) were not associated with case referral. In contrast to the prediction of ordinal case outcome, the time elapsed between the assault and the medical forensic exam was not related to referral for prosecution.

Block 5 of Table 4 adds site differences to the model. Neither the main effect for site nor the interaction between site and time (month in which the assault occurred) was significant, indicating that case referral did not differ between the two sites at the intercept of time (month 66) nor over time, on average. However, there was a significant 3-way interaction between site, time, and age group (OR = .96). The probability of case referral did not change over time for either age group at Site B. At Site A, while the probability of case referral did not change for younger victims, for cases involving victims over the age of consent (ages 16 and 17), the probability of referral declined significantly over time. The age difference in changing referral probabilities at Site A is shown in Figure 11.

Block 6 of Table 4 adds dichotomous variables designating the timing of specific community and/or policy changes at one or both sites, including changes in SANE directors, implementation or changes in community coordinating councils, and prosecutor elections and changes. Only one of these variables – the interaction of victim age group and the implementation of a child advocacy coordinating council at Site A (month 15 of the centered distribution of time) – was significantly predictive of case disposition; the OR of

.06 indicated that, for victims above the age of consent at Site A, referral was only 6% as likely for assaults reported after implementation of the child advocacy coordinating council compared with assaults reported before implementation, after accounting for the effects of other variables in the model. Pre- and post-implementation probabilities of referral for cases involving older and younger victims are illustrated in Figure 12. The addition of this variable to the model rendered the site by time by age group interaction in Block 5 nonsignificant, suggesting that age-related differential changes in case referral over time at Site A could be explained by the timing of implementation of the child advocacy coordinating council at that site. The coefficients related to this explanatory effect are shaded in Table 4.

In summary, cases were more likely to be referred to the prosecutor's office if the victims were under the age of 16; the rape kit was positive or negative for DNA (as compared to no rape kit submitted); the assailants were an acquaintance, family member, or intimate partners (as compared to stranger); and the victims endured a higher number of sexually assaultive acts. At Site A, cases involving 16-17 year old victims, prior to the implementation of the Child Advocacy Center coordinating council, progressed further through the system than 16-17 year old cases at Site A post-council implementation. See Figure 13 for a visual summary of significant predictors of case referral to the prosecutor's office.

TABLE 4

Logistic Regression Predicting Case Referral to the Prosecutor's Office

	Time Model			Victim Characteristics Model			Assault Characteristics Model			Medical Forensic Evidence Model			Site Effects Model			Community Level Changes Model		
	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>
Intercept	0.867	2.379	0.230	1.329	3.775	0.000	-1.073	0.342	0.060	-2.181	0.113	0.000	-2.299	0.100	0.002	-2.338	0.097	0.002
Block 1: Time effects																		
Month in which assault occurred	-0.003	0.997	0.456	-0.005	0.995	0.283	-0.006	0.994	0.277	-0.005	0.995	0.418	-0.008	0.992	0.342	-0.008	0.992	0.350
Block 2: Victim Characteristics and time effects																		
Age group (0 = 13-15; 1 = 16-17)				-1.040	0.353	0.000	-0.950	0.387	0.000	-0.832	0.435	0.000	-1.092	0.336	0.000	-1.099	0.333	0.000
Age X Time				0.004	1.004	0.518	0.006	1.006	0.369	0.007	1.007	0.441	0.024	1.024	0.050	0.024	1.024	0.053
Block 3: Assault characteristics																		
Relationship to assailant-Acquaintance							1.591	4.909	0.005	1.941	6.967	0.000	2.011	7.472	0.000	1.939	6.953	0.000
Relationship to assailant-Gang							0.280	1.323	0.559	0.611	1.842	0.128	0.800	2.225	0.086	0.651	1.917	0.151
Relationship to assailant-Familial							3.916	50.215	0.001	4.294	73.252	0.000	4.452	85.765	0.000	4.301	73.744	0.000
Relationship to assailant-Intimate							1.653	5.225	0.161	2.081	8.016	0.067	2.216	9.166	0.066	2.144	8.537	0.071
Relationship to assailant-Stranger (reference category)																		
Number of types of sexual assault							0.710	2.035	0.000	0.662	1.938	0.000	0.682	1.978	0.000	0.763	2.144	0.000
Block 4: Forensic evidence																		
DNA-Positive										2.139	8.487	0.000	2.268	9.656	0.000	2.369	10.684	0.000
DNA-Negative										1.401	4.061	0.000	1.502	4.491	0.000	1.531	4.621	0.000

	Time Model			Victim Characteristics Model			Assault Characteristics Model			Medical Forensic Evidence Model			Site Effects Model			Community Level Changes Model		
	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>	Log Odds	Odds Ratio	<i>p</i>
DNA-No kit submitted (reference category)																		
Block 5: Site Effects																		
Site (0 = Program B; 1 = Program A)													0.030	0.970	0.942	0.248	1.281	0.733
Site X Time (month in which assault occurred)													0.007	1.007	0.513	0.015	1.016	0.472
Site X Age group													0.519	1.680	0.070	1.333	3.793	0.073
Site X Time X Age group													-0.041	0.960	0.009	-0.016	0.984	0.598
Block 6: Agency/Community level changes																		
Child advocacy coordinating council at Program A (0 = before; 1 = after)																-0.742	0.476	0.569
Child advocacy coordinating council X Age group																-2.882	0.056	0.003
Variance of random intercepts across police departments	0.211			0.234			0.203			0.333			0.338			0.380		
Model deviance	1226.10			1203.27			1142.59			1101.40			1091.74			1087.37		
Number of parameters	3			5			10			12			16			18		
LR chi square (2-tailed) compared with previous model	-----			0.00001			0.00001			0.00001			0.047			0.112		

FIGURE 11

Change over Time in Probability of Referral to Prosecutor (Site A)

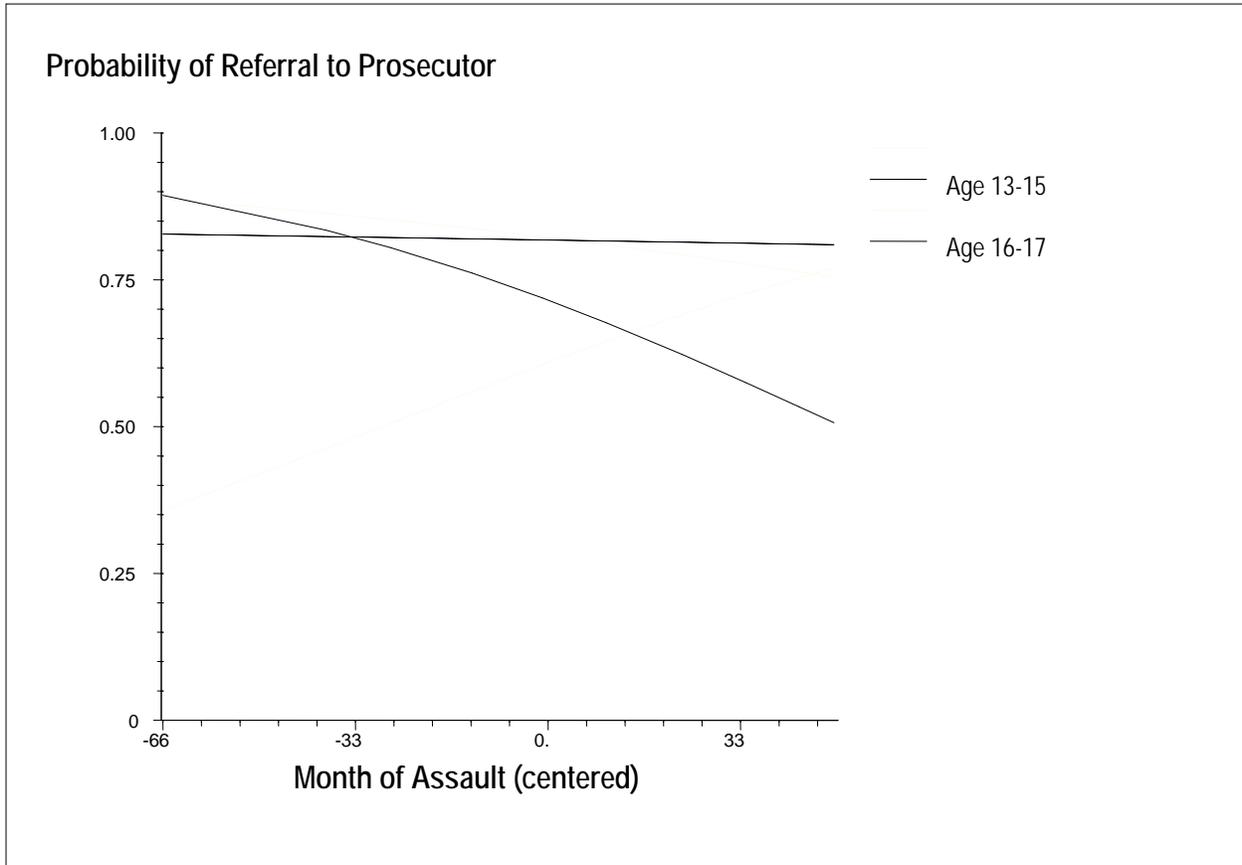


FIGURE 12

Probability of Referral to Prosecutor Before and After Implementation of Child Advocacy

Coordinating Council, by Age (Site A)

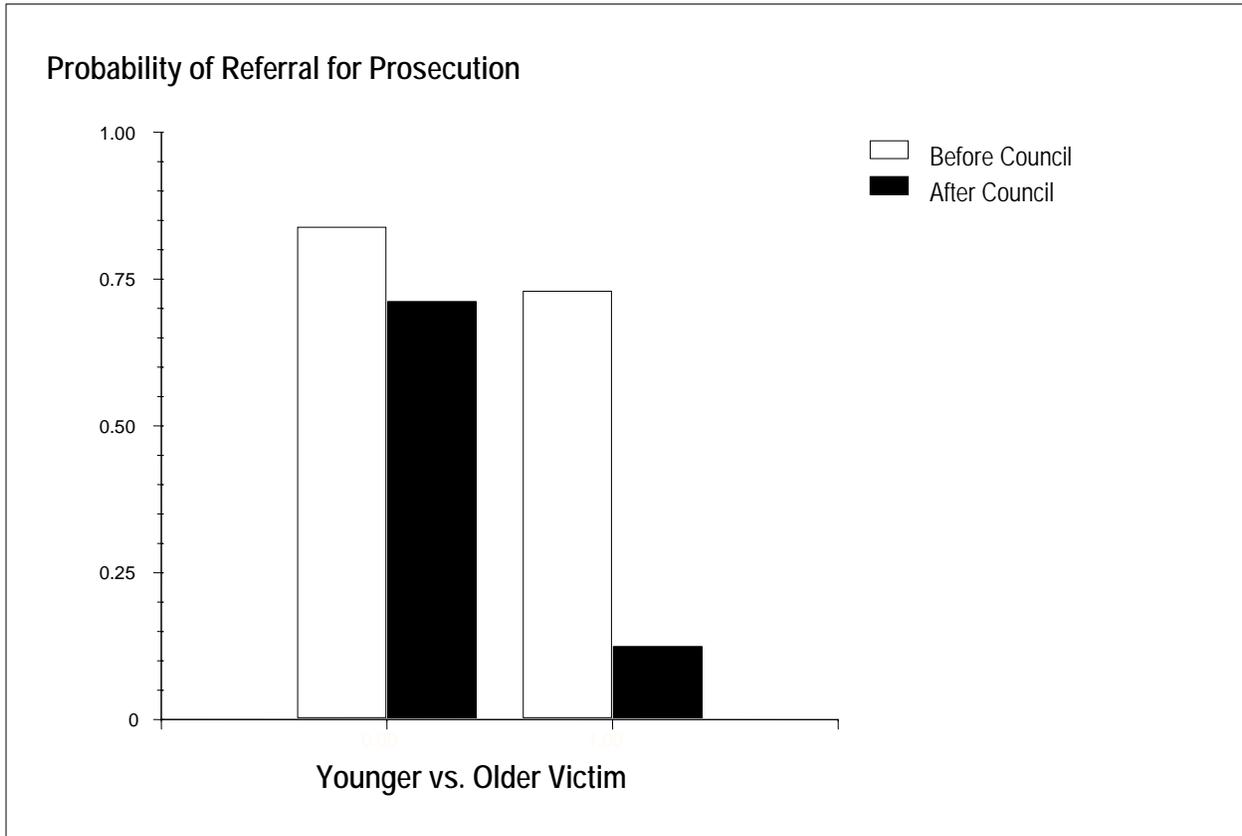
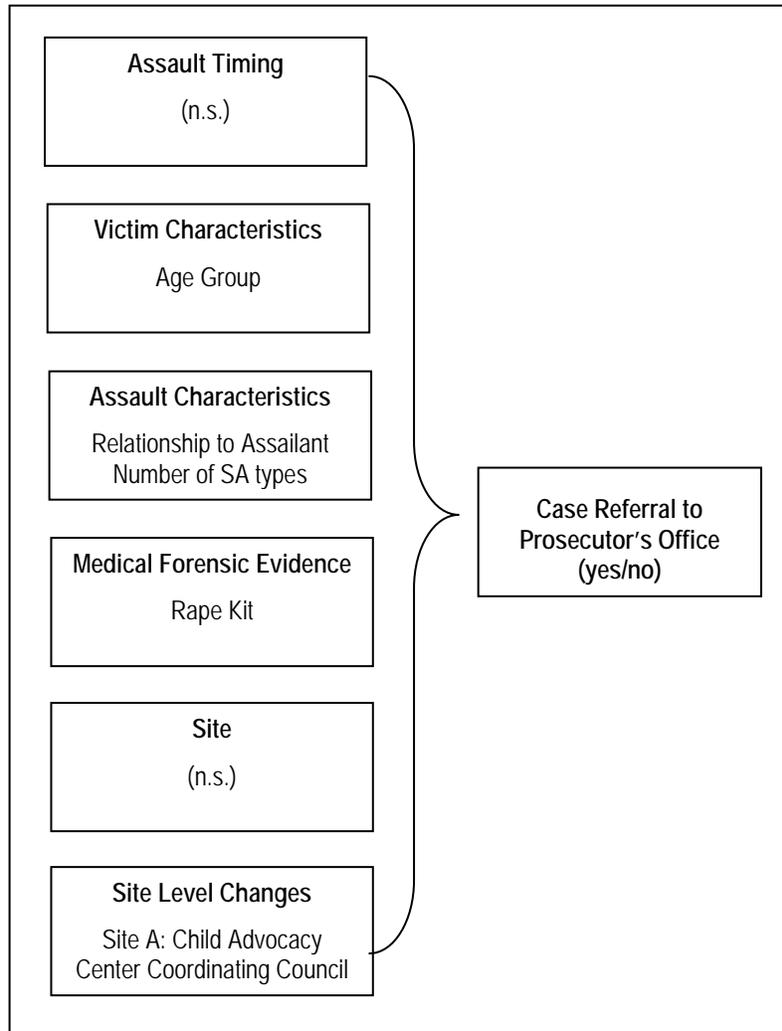


FIGURE 13

**Results Summary: Multilevel Logistic Regression Analyses Predicting Case Referral**



Further analyses were conducted to examine the possibility that other factors, such as changes in case mix (i.e., changes in the characteristics of cases that were reported to the police), might explain the declining probability of referral of cases with older victims at Site A. A series of interactions between victim age and other victim and assault characteristics were added to the model to explore possible alternative explanations. Of particular interest were variables that could indicate expansion in the cases being considered for investigation and prosecution, such as possible increases in the proportion of cases in which the victim could not recall what had happened or cases in which the victim had used drugs or alcohol. Despite an extensive search, no variables were identified that showed significant change in case mix over time and were predictive of referral to the prosecutor.

## VI. DISCUSSION OF FINDINGS

### A. Summary of Findings

**1. Findings from Study 1: Qualitative investigation of pathways into the system.** The NIJ NSA project found that 40% of adolescent sexual assault survivors disclosed within the first month of the assault, and in this study we were able to connect with an informative subsample of that population: those who disclosed within a month *and* had sought formal help from the medical and legal systems. These teens are undoubtedly unusual with respect to the broader population of adolescent sexual assault survivors, but they are *the* source for information regarding how young victims can connect to social systems. Trickett (1997) argued for the utility of “seeking out samples of inconvenience”—those that are ‘unusual’ vis-à-vis a field’s ‘typical’ samples for “purposefully sampling ecologically different settings as well as groups within those settings” (p. 203). Interviewing adolescent survivors who had connected to formal systems provides a rare opportunity to understand teens’ help-seeking processes, which can help inform efforts to link more survivors to community service programs.

Prior national-scale research as well as smaller-scale studies consistently indicate that adolescent victims are most likely to disclose to informal sources of support, mostly notably friends and family. Our qualitative results replicate those findings as nearly every teen survivor in this study first disclosed to a friend. Why? Their peers are physically and emotionally close, and are often privy to or directly involved in the events that preceded the assault, such as experimenting with alcohol, going to parties, or spending time with older men. Moreover, some survivors had fragmented memories and wanted help reconstructing what had happened to them, and their friends often knew the details. Sometimes teen victims wished they could forget, and turned to their friends for help with the emotional pain of what they did remember and what they

did know happened to them. Adolescents turn to their peers for so many other matters, big and small, and so it followed that their friends would be the first ones to hear about the assault.

Once the survivors had told a friend, or multiple friends, the story often unfolded to others very rapidly. Analysis of the NSA dataset revealed that mothers are the key to formal system contact: adolescent victims are far more likely to report to law enforcement if they first disclosed to their mothers rather than to friends. In this study, adults, most typically mothers, were indeed the last step in the disclosure chain before the incident came to the attention of the legal and medical systems. This study builds on these prior findings by uncovering the process by which this happens. On the surface, the sequence was clear and nearly uniform: first to friend(s), then to adults (often mothers), and then to the system. A critical advantage of using qualitative methods is that such approaches can reveal underlying context, and indeed context was everything. We identified three unique pathways from initial disclosure to contact with the legal and medical systems, which were distinguishable by the survivors' agency and the extent to which they were able to maintain control over the disclosure process. Perhaps not surprisingly, in a developmental period characterized by struggles for autonomy and independence, the extent to which survivors could shape the course of events that eventually led them to formal help was incredibly impactful and carried through to color their experiences with the criminal justice system.

For two young women in this study, the choice to disclose was never theirs—these “situational disclosures” involved assaults whereby the survivors were unconscious, but their friends reached out to adults immediately to seek help. All other survivors in this study were able to choose how and when they made their *first* disclosure. One group of victims experienced what we termed “voluntary disclosures”—at each step in the process, these teens were able to decide for themselves who to tell and what should happen next. They often received encouragement from their friends to reach out to an adult, and with that support, they did. Many of these young women understood that if “something was going to happen,”

meaning police involvement and prosecution, then they would need the help of an adult. When these adults learned of the assault, they did not “take over” and force the survivors to report or seek medical help, which is not to say that they didn’t have strong feelings and even stronger preferences in the matter—the teens said there was little doubt in their minds what their trusted adults wanted them to do. Nevertheless, these survivors were given time and space to make their own choices. As might be expected, having the opportunity truly to decide whether to participate in the legal system strongly affected these teens’ experiences with criminal justice system personnel once engaged in the prosecution process. It can be quite grueling to report a sexual assault and stay involved throughout the investigation and prepare for prosecution. The young women in this group did not waver in their desire and commitment to prosecute.

The disclosure experiences for the second group of survivors started off much the same—a voluntary disclosure to a friend—but after that, subsequent disclosures were involuntary and often quite hurtful. Upon learning of the assault, their friends turned to adults—their own parents or the survivors’ parents—without the consent, permission, or involvement of the survivor. The survivors’ wishes were not considered and their control was violated. Why? We only have data from the survivors themselves, but when asked about the possible motives of their friends, some noted that they thought their friends were just scared and wanted to help; but others indicated that their friends didn’t believe them and turned to adults in an attempt to force the truth. The sting of their friends’ actions had not yet faded before adults were brought into the picture, and in turn, those adults did not allow the survivors to make their own decisions about seeking help from the medical and legal systems. In the end, these survivors were brought into the system against their wishes.

However, these difficult beginnings did not necessarily mean the survivors in the involuntary disclosure group continued to have difficulties with the criminal justice system. Some survivors who had involuntary disclosures were met with validation from their responding police officers, and when bolstered

with additional validation from their family and friends, they changed their minds and their engagement with the criminal justice system steadily increased. In other words, validation from within the system and from outside could overcome painful beginnings and help these teens re-evaluate their decisions regarding participation in the criminal justice system. The importance of such assistance was clearly evident by what happened to the survivors who experienced involuntary disclosures but did *not* have internal and external validation. Without help from both the police and their families, these survivors did not want to pursue prosecution. The necessity of providing support and encouragement to adolescent victims as they enter the bewildering world of the legal and medical systems cannot be understated.

Across all three disclosure patterns, we found a remarkably consistent effect with regard to the survivors' experiences with the focal SANE programs. It did not matter whether their initial contact was of their volition, against their will, or even outside of their consciousness—their interactions with the nurses and advocates were consistently positive, empowering, and healing. The survivors were often frightened of the exam, were still struggling to make sense of what had happened to them, and the nurses and advocates provided information and choices to help reinstate their sense of control. There was no evidence to suggest that the nature of patient care affected their later involvement with the criminal justice system. For the survivors who had voluntary disclosures, their decision for continued involvement with the investigation process remained steadfast. For the survivors with involuntary disclosures, the critical presence or absence of later validation from police, family, and friends shaped their commitment. This does not mean that excellent patient care was not impactful—indeed, every indication from the survivors was that it was powerfully healing experience. Both SANE programs maintain strong emphasis on patient care as the first and foremost responsibility of forensic nursing and whereas SANEs may collaborate with the legal system as part of their SARTs, this does not shape how they care for their patients.

Taken together, these findings suggest there are relatively easier and more difficult pathways to seeking formal help, which begs the question of why survivors have such markedly different disclosure experiences. Was there something about the survivors themselves or what happened in the assault itself that made voluntary or involuntary disclosures more probable? Unfortunately, we did not find any evidence to suggest that certain kinds of survivors—by age, by socioeconomic factors, or by family environment (such that it was disclosed in the interview)—were more or less likely to have voluntary or involuntary disclosures. Similarly, the nature of the assault—alcohol use, victim-offender relationship, offender age relative to the survivor—was also not linked to disclosure pathways. We suspect the reason why we cannot answer this question is because our sole data source was the *survivors* and it was their *friends* who were so influential in determining what happened next in the disclosure process. The survivors' *first* disclosures were always voluntary (the situational disclosures notwithstanding), but it was how their friends reacted and what they did with the information that shaped what happened next. Research with adult sexual assault survivors has found that negative social reactions from friends and family are remarkably strong determinants of survivors' short-term and long-term well-being (see Ullman, 2010 for a review). This is not say that the survivors' own agency and behaviors are unimportant, but rather highlights both the risks and benefits of the incredible salience of the peer group in this developmental period.

**2. Findings from Study 2: Quantitative prediction of prosecution outcomes.** As noted previously, no studies to date have examined prosecution rates specifically for adolescent victimizations. In adult samples, on average 17-29% of reported assaults are successfully prosecuted (i.e., guilty plea or trial conviction); in child samples (which often combine adolescents with youth under 12) on average 40-85% of reported cases are prosecuted (Campbell, Greeson, & Cabral, 2009). In this study, the overall rate of guilty plea/trial convictions was 40.3% for sexual assaults committed against adolescents aged 13-17. These data are regional, not national, and therefore should not be interpreted to reflect the current state of

adolescent sexual assault prosecution in the United States. However, our findings suggest a possible developmental trend in the legal system's response to sexual violence crimes that should be examined further in larger-scale studies. For younger victims, who are stereotypically presumed to be less culpable or not at all culpable for the assault, prosecution rates are substantially higher than for adult women, who bear the brunt of societal rape myths regarding their responsibility for the assault (Ullman, 2010). Adolescents are developmentally in-between and so too were their prosecution rates: substantially higher than results for adult women, but at the lower end for childhood sexual abuse survivors.

Additional evidence of this possible developmental effect emerged in the multi-level ordinal logistic regression model predicting case progression through the criminal justices system. In the *victim characteristics block*, age was a significant predictor such that cases involving younger victims (13-15) were significantly more likely to progress further through the system than assaults against older victims. Also consistent with the notion that system response is linked to perceived culpability, sexual assaults committed against adolescents with documented developmental delays were eight times as likely to move further through the criminal justice system. Prior studies with adult samples have yielded mixed results whether the victims' race/ethnicity predicts case outcome (no effect: Campbell et al., 2009; Frazier & Haney, 1996; Kerstetter, 1990; Spears & Spohn, 1997; Spohn & Spears, 1996; racial effect such that white victims were more likely to have their cases prosecuted: Campbell et al., 2001; Chandler & Torney, 1981; Spohn, Beichner, & Davis-Frenzel, 2001). In this study, we did not find a significant effect for victim race/ethnicity, but our sample was predominately white, consistent with the racial composition of the focal counties, and there may not have been sufficient variability to detect to an effect—if there was one to be found. One of the most robust findings in the adult literature is that victim alcohol use at the time of the assault decreases the likelihood a case will be successfully prosecuted (Campbell, 1998; Campbell et al., 2009; Chandler & Torney, 1981; Frohmann, 1997; Spears & Spohn, 1996); however, in this sample of

adolescents, alcohol use had no effect on case progression. Perhaps because teen drinking is often viewed as normal experimentation and/or because teens who were assaulted while drinking may be perceived as having been taken advantage of, legal system personnel did not weigh such factors heavily as compared to adult women who are developmentally presumed to “know better by now.” These findings require quantitative replication and would also benefit from follow-up qualitative work with legal system personnel to understand why alcohol use does or does not affect their decision making in different populations of survivors.

In the *assault characteristics block*, victim-offender relationship was a significant predictor of case progression. In Stein & Nofziger’s (2008) analysis of the NSA dataset, arrest was more common in adolescent sexual assault cases when the offender was a non-parental adult relative, and our results show a similar, but more generalized effect that any non-stranger assaults were more likely to be prosecuted than stranger assaults. These findings are consistent with recent studies of adult sexual assault victims (e.g., Campbell et al., 2009). The specific kinds of forced penetrations (e.g., vaginal vs. oral vs. anal penetrations) did not affect case outcomes, but the cumulative number of the assaultive acts perpetrated against the victim did increase the likelihood that the case would progress further through the criminal justice system.

In the *medical forensic evidence block*, after accounting for significant victim and assault characteristics, medical forensic evidence could still predict significant variance in case outcomes. In other words, what determined case progression through the system was not solely based on features of the victim and/or the assault. Cases with positive DNA evidence were five times as likely to progress further through the system when compared to cases in which no rape kit was submitted to the crime lab; however, there were no significant effects for specific physical or anogenital injuries. This does not mean that SANE documentation of injuries is unimportant, but it is not clear whether their specific injury findings are directly

influencing police and prosecutor decision making. It may be a complex combination of the number, type, and location of injuries, and the extent to which those findings match victims' accounts of the assault that is influential for case progression, but we simply did not have sufficient statistical power to detect such effects. Alternatively, as Campbell and colleagues (2009) noted in their study of adult SANE-treated survivors, most victims do not sustain injuries, and therefore multidisciplinary SANE-SART trainings often de-emphasize the role of injury as "proof" of assault. As such, these non-significant findings may reflect some success of these training efforts to educate members of the legal community about the dangers of over-emphasis on injury.

In the *site effects model*, there were no significant main effect differences between Site A and Site B, suggesting that one model of SANE-SART intervention was no more or less effective than the other with respect to achieving prosecution success.<sup>12</sup> We did find a significant site X time X age effect such that in Site A (which followed a formalized model of SART operation), there was a decrease over time in the likelihood that cases perpetrated against older teens (16-17) would be successful prosecuted. This result highlights the importance of examining how SANE-SART models evolve over time in their communities—simple, static main effect contrasts may not be able to capture the complexities of how these interventions operate. Therefore, in the *community-level changes model* we added variables to reflect the timing of specific changes with respect to how these SANE-SART interventions operated in their communities. Site A had undergone far more sweeping changes in their community than Site B with respect to the operation of its Child Advocacy Center. National standards for CACs require multi-stakeholder coordinating meetings (National Children's Alliance, n.d.), which meant that the same organizations—and indeed often the very

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<sup>12</sup> Due to the non-experimental nature of this study, the sites differed on other variables besides SANE-SART model (e.g., one site (partially) served an urban population whereas the other site served more rural areas). Such site differences could have obscured an effect of SANE-SART model on prosecution rates.

same individuals—in Site A were now called upon to participate in two sets of meetings. Perhaps not surprisingly, the community momentum became stronger for the newer (child-focused) coordinating council, and key informants in the community indicated that interest in adult/adolescent cases began to wane. Indeed, our quantitative results show that very effect. The interaction of victim age group and the implementation of a child coordinating council in Site A was significantly predictive of case disposition; the addition of this variable to the model rendered the site by time by age group interaction in site effects model nonsignificant, suggesting that age-related differential changes in case referral over time at Site A could be explained by the timing of implementation of the child advocacy coordinating council at that site. These findings provide yet more support of a possible developmental effect in the legal system's response to sexual violence crimes. In sum, our results suggest that whether a community follows a more formalized or informal model of SANE-SART integration may not be nearly as important as how a community's resources and attentions can be focused—or divided—among the many victims who want justice for the crimes they have suffered.

In our final set of analyses, we tested this model with a simplified dependent variable: the binary outcome of whether the case was referred by the police to the prosecutor. These analyses are useful in determining whether the factors that influence law enforcement decision making are substantially different than the more integrative model of police and prosecutorial actions reflected in the four-level ordinal dependent variable (which captures all steps and stages). Although there were some minor variations with respect to which specific variables were statistically significant (e.g., developmental delay was not significant; no differences between stranger and intimate partner-perpetrated assaults were documented; and delay from assault to exam was not influential), the overall model was remarkably similar, particularly so in the site effects and community-level changes blocks. The site by time by age effect in Site A that was

associated with the implementation of the child advocacy center coordinating council was evident in the model predicting law enforcement decisions as well.

## **B. Project Strengths, Limitations, and Implications for Future Research**

The qualitative interviews in Study 1 revealed not only the process of adolescent sexual assault victims' disclosures and the sequences of disclosures that ultimately lead to social system contact, but also the context of these interactions and their far-reaching effects on victims' engagement in the legal system. Our results indicated that how friends and adults respond to victims' initial disclosures has long-term implications for survivors' engagement with the criminal justice system. Unfortunately, it was beyond the scope of this study to collect companion data from parents and peers to ascertain their perspective on the disclosure process. Though it would be undoubtedly difficult to collect, paired data would be the ideal source of information for understanding teen victims' pathways to the legal and medical systems. Another key contribution of this qualitative study is that we were able to understand the *process* of help-seeking. These findings could be extended in the future by examining how community outreach and educational programs offered by SANE programs and rape crisis centers affect adolescents' help-seeking behaviors.

One of the long-standing challenges of research in the criminal justice system is that cases process at rate more slowly than most study timelines can reasonably wait-out. As such, our qualitative interviews with the adolescent survivors captured only the early stages of criminal justice system processing (i.e., through investigation), which is certainly important, but unfortunately leaves a remaining gap in the literature regarding adolescents' experiences with prosecution. Our quantitative data provide some insight into what factors predict successful prosecution, but the stories behind it these latter-stage events remain unknown.

A unique contribution of this study is that we were able to reach a hard-to-reach population—adolescent sexual assault survivors—to learn about their experiences of disclosure and accessing

community services. Whereas this is a first step in understanding adolescent help-seeking, this study is limited in that it only captures the experiences of the adolescents who ultimately sought help. We are unable to speak to the experiences of adolescents who did not eventually connect with these systems. Future research could examine how the assault, disclosure, and reactions to disclosure differ among adolescent survivors who do and do not have formal systems contact.

Another key limitation of Study 1 was its small sample size, but even with N=20 interviews, we were still able to achieve saturation on key themes. Perhaps with a larger sample size we may have been able to ascertain whether some victim- and assault-related factors were related to voluntary or involuntary disclosure pathways. Our recruitment efforts to reach adolescent sexual assault patients were exhaustive and we even obtained a waiver of parental consent in effort to remove that barrier to study participation (should it be one for some individuals). Nevertheless, this was an extraordinarily difficult population to recruit into research. The adult sexual assault literature suggests that immediately post-assault survivors may not want to discuss the assault any further and for their own long-term well-being, they must focus on other aspects of their lives (Campbell, Dworkin, & Cabral, 2009). Although this issue has not been explicitly studied in the adolescent literature, our data shed some light on why adolescents may be particularly difficult to recruit for interview studies. The teen survivors we did reach consistently told us that once they made their first disclosure, the story was passed along quickly—and not always by their choice. In that context, it makes sense that adolescent survivors may be reluctant to talk with researchers in the immediate aftermath of the assault. Developmentally, their capacity and interest to sustain continued disclosure and processing may be limited. This suggests that interview research with teens should have modest expectations, or that perhaps other data collection technologies, such as audio computer-assisted self-interviews (administered by iPods perhaps) or web-based surveys, may be worth exploring (Galvez, Mankowski, Braun, & Glass, 2009).

With respect to the quantitative modeling in Study 2, this project provides the first examination in the literature of variations between and within SANE-SART models. Although we found no site differences, it would be premature to conclude that formalized vs. informal models of SANE-SART integration has no bearing on legal system outcomes. Instead, our findings emphasize that how intervention models change over time is particularly important, and therefore, there is a pressing need for further research on heterogeneity in SANE-SART operation. Furthermore, it is reasonable to expect that there are many variations of “informal” and “formal” SANE-SART integration, and a national-scale mapping of SART structure and function—and the impact of different SART models on prosecution rates—is warranted. This study also found that how a community responds to the needs of one population (in this case, children) can have unanticipated effects on the outcomes for another population (in this instance, adolescents. Future studies that map the impact of SART structure and function could also examine different strategies that SARTs have for addressing the needs of different groups of survivors.

Several limitations of these quantitative analyses should be acknowledged and considered in interpreting the findings. First, the variables designating the timing of community-level changes such as council implementation are crude measures of complex phenomena; it is unlikely that the date on which a change was initiated reflects the date that the change actually exerted a measurable impact on prosecution of cases involving adolescent victims. Second, community-level changes were not independent and likely had combined effects that cannot be accurately reflected in a limited statistical model. For example, the date the child advocacy coordinating council was first implemented at Site A occurred 21 months after a decision was made to reduce the meeting frequency for another coordinating council in the same community. It is likely that these two events are related and that both may have affected case progression, but it is not possible to definitively untangle the influences of the two events due to their proximity and the low number of cases handled in the interim. The child advocacy coordinating council implementation was

more strongly related to case disposition, although the reduction in meeting frequency of the other coordinating council was marginally related and may have contributed to the effect. Another limitation is the relatively small number of cases handled within a particular time interval, especially those involving older victims (age 16-17) at one site. For example, only 17 cases involving older victims were investigated by the police at Site A following the implementation of the child advocacy coordinating council (compared with 28 in this age group investigated prior to this policy shift at this site). In light of these sample size issues, results involving community-level policy changes should be interpreted with caution. Finally, another limitation of the study is that there are other differences between the two sites beyond their SANE-SART models. After accounting for the implementation of the CAC coordinating council at Site A, there were no site differences. Other differences between these sites (e.g., relative outreach to urban vs. rural populations) may mask further effects of SANE-SART model on prosecution rates.

### **C. Implications for Policy and Practice**

The adolescent sexual assault survivors interviewed in Study 1 had consistently positive experiences with both focal SANE programs, suggesting that good patient care can occur under different types of SANE-SART intervention models. We also found that there was no “carry over” effect from the teens’ positive experiences with the SANE programs to their willingness to engage with the criminal justice system to pursue prosecution. In this study there was so little variability in the teens’ experiences with the SANE programs (i.e., all were very positive), but hypothetically, if some teens had supportive SANE experiences and others did not, then we might have been able to detect an association with criminal justice system participation, if such a relationship exists. For some constituents within a SART, this non-association could be viewed as a negative finding, reflecting lack of coordination. Our data do not suggest there were problems in communication or collaboration between legal and medical system personnel in either community, but rather that both SANE programs did not view their role as trying to influence their

patients' decisions to report and prosecute. Role boundaries have been a challenging issue in SARTs (Cole & Logan, 2008; Hatmaker, Pinholster, & Saye, 2002), but emerging evidence suggests separation of roles can be beneficial to service providers in preventing burnout and to survivors for promoting their emotional well-being (Campbell, Greeson, & Patterson, 2010; Patterson, Campbell, & Townsend, 2006; Townsend & Campbell, 2009). As such, it is important for SARTs to address this issue proactively to resolve any conflicts about role delineation in their community.

The qualitative interviews also highlighted the critical significance of social support for teen survivors. Our data indicate that peers are the true "first responders"—not the nurses, the police, or any other SART member. Friends are the beginning steps in the pathway to social services, but do peers really know what to say or what to do to help survivors? The adult sexual assault literature suggests that friends are often confused and torn about what to say and do when they hear that someone close to them has been raped (Ahrens & Campbell, 2000). Over the past 20 years, there have been substantial national efforts to increase rape awareness education and rape prevention programming for youth (Centers for Disease Control [CDC], 2004). Our findings suggest that rape awareness programs must provide specific instruction on how to manage sexual assault disclosures: what is "good support, what is "bad support," what should friends say, what should they not say; what can friends do to be helpful. Educating teens about SANE-SARTs is important so they can provide information and options for their friends.

Once adolescent victims are in contact with SANE-SARTs, our results show that continued social support is critical. Teen victims are often very scared of legal system personnel, but when they received validation from their responding officers and detectives--and their families--survivors were more willing to pursue prosecution. These findings emphasize that it is the responsibility of all SART members to provide support to victims, not just advocates and nurses, who are traditionally viewed as the "appropriate" disciplines for emotional and psychological issues. It is also important to note that the nature of the support

provided by responding officers and detectives which the teens found so helpful was quite straight-forward: validating that what happened to them was wrong, and that it deserved criminal justice system action. It seems unlikely that these simple expressions of support would create difficult role conflicts or boundary issues for law enforcement. Adolescent survivors' participation in the criminal justice system is also strongly shaped by the validation (or lack thereof) they are receiving from their families, so SART protocols must include strategies for reaching out to victims' families. A recent national-scale review of online training resources on sexual assault for SART team members revealed that most curricula do not conceptualize adolescent survivors as a designated special population (SARA Project, 2009). Our findings challenge that practice and suggest that specific instruction on working with teens—and their families—is warranted.

The results of our quantitative modeling in Study 2 indicate that whether a community follows formalized or informal models of SANE-SART integration may not be nearly as important as how a community's resources and attentions can be focused—or divided—among the many victims who want justice for the crimes they have suffered. Adolescent sexual assault prosecution began to drop-off in Site A when key stakeholders' time and attention was redirected to new child advocacy coordinating council meetings. It is to be expected that the same organizations and often the same people will be tapped for multiple community-wide initiatives, and our results suggest that SART teams must pay particular attention to how they will prevent possible over commitment, burnout, or exhaustion from divided attentions. Consistent with Kelly's (1966, 1968) ecological principle of cycling resources, communities would be well-advised to consider how limited resources can be leveraged more effectively as new programs emerge so that existing interventions can be sustained.

Embedded in these community-level contextual factors are the specific cases—the individual victims and the nature of the assaults committed against them. Historically, a substantial body of research has demonstrated that whether a sexual assault case is prosecuted will depend a lot more on who the

victim is as a person rather than the nature of the crime or its supporting evidence (Feild, 1978; Feild & Bienen, 1980; LaFree, 1989; Reskin & Visher, 1986; Spears & Spohn, 1997). Consistent with that long-standing norm, we also found that factors related to perceived culpability, such as age, disability, and degree of intimacy between the victim and offender affected legal case outcomes. Such findings emphasize the importance of continued rape myth education for all SART members. Case review, whether formal or informal, may be a particularly useful strategy to ensure that all cases are fully investigated and considered.

That said, it appears that SANE-SART interventions may be effective in shifting more emphasis to the evidentiary quality of a case. A recent study of adult sexual assault SANE cases found that although victim and assault characteristics were clearly influential, the evidentiary merits of a case were also significant elements in case outcomes (Campbell, Patterson, Bybee, & Dworkin, 2009). In this study we also found that positive DNA evidence was associated with successful prosecution (above and beyond victim and assault characteristics), but interestingly, whether the rape kit was submitted to the crime lab was also predictive of positive case progression--regardless of its findings. In other words, a kit that was submitted to the crime but, but turned out to be negative for DNA was still instrumental in securing guilty plea/trial convictions. Perhaps as one key informant told us, "having the kit in play puts defendants in a different position, and a plea may start looking pretty good." The findings of this study support the growing public outcry about the problem of rape kit backlog (Human Rights Watch, 2009), and highlights how kit submission and analysis--in itself--can be instrumental in the prosecution of sexual assault.

## VII. REFERENCES

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## APPENDIX A: PROJECT STAFF

Project staff for NIJ 2007-WG-BX-0012 (in alphabetical order):

Deborah Bybee, Ph.D., Co-Investigator/Principal Statistician

Rebecca Campbell, Ph.D., Principal Investigator

Giannina Fehler-Cabral, M.A., Interviewer/Analyst

Megan Greeson, M.A., Project Director

Angie Kennedy, Ph.D., Co-Investigator

Katie Parker, B.A., Research Assistant

Debra Patterson, Ph.D., Consultant

Elyse Watkins, B.A., Research Assistant

## APPENDIX B: DISSEMINATION

(As of 11/30/2010)

### Pending Student Theses/Dissertations:

Fehler-Cabral, G. (in progress). Adolescent sexual assault survivors' pathways into the legal and medical systems. Doctoral Dissertation, Department of Psychology, Michigan State University, East Lansing, MI.

Shaw, J. (in progress). Crime lab analysis of sexual assault medical forensic exam kits: Why are some kits unanalyzed? Master's Thesis, Department of Psychology, Michigan State University, East Lansing, MI.

### Conference Presentations and Invited Talks:

Greeson, M.R, Campbell, R., Fehler-Cabral, G., Diegel, R., & Van-Order, P. (2010, October). Adolescent sexual assault victims: Disclosure, help-seeking, and legal and medical system experiences. Presented at the International Association of Forensic Nurses, Scientific Assembly, Pittsburgh, PA.

Fehler-Cabral, G., Campbell, R., & Greeson, M.R. (2010, October). Adolescent sexual assault: How teen survivors disclose and seek help. Presented at the 15th International Conference on Violence, Abuse and Trauma, San Diego, CA.

Campbell, R., Greeson, M., & Fehler-Cabral, G. (2010, June). Invited Talk: Improving criminal justice outcomes by focusing on victims. National Institute of Justice Research Conference, Washington, DC.

Campbell, R., Greeson, M., & Cabral, G. (2009, June). Adolescent sexual assault victims' experiences with the criminal justice system. National Institute of Justice Research Conference, Washington, DC.

## APPENDIX C: DATA COLLECTION INSTRUMENTS

APPENDIX C-1: Recruitment Flyer/Agree to Be Contacted Form

APPENDIX C-2: Interview Protocol

APPENDIX C-3: Study 2 Coding Sheet

**APPENDIX C-1:**

**Recruitment Flyer/Agree to Be Contacted Form**

# We want to know what YOU have to say

## Your voice matters

An all-women research team from Michigan State University is doing a study to find out ways to better help teens who have been sexually assaulted.

We want to interview you to learn about your experiences and who you told about the assault like what was helpful to you and what made things worse.

*If you fill out the blue form, we will call you in two weeks with more information. Remember, filling out the form doesn't mean you have decided you want to do an interview, it just means we can call and tell you a little more about our project.*

## WE CARE ABOUT TEEN SURVIVORS

- ◆ We keep everything you say private.
- ◆ We will give you \$30 for participating.
- ◆ You don't need you parent's permission to talk to an interviewer.
- ◆ We will use the information from this study to teach nurses and police officers how to work with teens.
- ◆ We aren't looking for any right or wrong answers. We just want to hear what you think.

## If you wanted to talk with us:

- ◆ A trained female interviewer would meet up with you at [name of agency] for a one-on-one interview.
- ◆ You wouldn't have to talk about anything you don't want to talk about.
- ◆ She would ask you questions about who you told, what they did, what it was like to have the medical/forensic exam, and what it was like if the police got involved.
- ◆ If you feel uncomfortable you could stop at any time.
- ◆ She won't judge or blame you for anything you tell her.
- ◆ She won't tell anyone that you were in the study.
- ◆ She won't tell anyone what you specifically said.
- ◆ It usually takes about 2 hours, maybe more, maybe less to finish an interview.

*TEENS TALK*

*We Listen*

## Questions?

For more information,  
call Megan at 1-800-787-8916.

You don't have to decide now whether you want to participate. If you would like some more information about the project, fill out this form and place it in the lock box. [Name of agency] will have no way of knowing whether you filled out the form.

By signing below, I agree to have the research team call me to provide more information about their study. I understand that I am under no obligation to participate in an interview.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Today's Date

**IMPORTANT-Please Provide the Following Contact Information**

Fill out this portion so that we can contact you and protect your privacy.

*IT'S OK FOR THE RESEARCH TEAM TO CONTACT ME AT THESE NUMBER(S):*

(\_\_\_\_) \_\_\_\_\_ Does anyone else answer this phone? \_\_\_ No \_\_\_ Yes  
your own cell phone

(\_\_\_\_) \_\_\_\_\_  
your home phone

(\_\_\_\_) \_\_\_\_\_ What type of number is this? \_\_\_\_\_  
other (like a friend's cell or work)

Is it ok for us to leave a message with someone else or on your voice mail if you don't answer? The message we would leave is:

"I am part of a research team from Michigan State University and I am calling for \_\_\_\_ (your name) about a study we are doing on teenager's experiences. Please have \_\_\_\_ (your name) call Megan back at 1-800-787-8916." Can we leave this message? \_\_\_ No \_\_\_ Yes

Which number(s) is best to reach you at? \_\_\_\_\_

When are good days/times to call? \_\_\_\_\_

When should we NOT call you? \_\_\_\_\_

Anything else you want us to do/not do or say/not say? \_\_\_\_\_

## **APPENDIX C-2:**

### **Interview Protocol**

## Qualitative Survivor/Victim Interview Protocol

Participant ID Number \_\_\_\_\_

Interviewer ID Number \_\_\_\_\_

Date Interview Conducted \_\_\_\_\_

Length of Interview \_\_\_\_\_

### INTRODUCTION AND OVERVIEW

Thank you so much for coming in today, I know that what you have/are gone/going through is not easy and I understand that it may be difficult to talk about it. But please know that we will go at your pace during this interview and there are no right or wrong answers- we are simply interested in your personal experience.

Before we start, I want to tell you exactly *why* we are doing these interviews. We want to get a better understanding of teenage girls' experiences with the sexual assault nurse examiner program and the criminal justice system (such as police, prosecutors, etc.). Your personal experiences are *very* important to help us understand what was helpful and not so helpful with these systems/programs. We will then combine all the feedback and experiences from other teenage girls we interviewed in an effort to improve these programs for future teenage sexual assault survivors.

However, there is one very important thing to remember- *everything* we talk about today will be kept **confidential**. This means that everything you say will be kept **private**. Your parents, teachers, friends, people from [name of agency], police, etc. will not be told about anything we talk about today. Your name will not be connected to anything you say. I will not write your name on the interview itself.

This interview will take approximately 2 hours to complete. As we're going through the interview, if you need to take a break or stop, just let me know. If there are any questions that you don't want to answer, just say so, and I will move on to the next section. Feel free to change the topic if you feel uncomfortable and you can let me know if you want to get back to it later. Also feel free to ask me questions throughout the interview if you are not sure about something. It is completely up to you how much or how little you tell me. Keep in mind that I'm not looking for any particular response- there's no right or wrong answers. I am interested in hearing what *you* have to say.

If it's ok with you, I would like to tape record this interview. The only reason I would like to do this is because it is hard for me to get everything down on paper, so the tape can help me fill in anything I might have missed later. The only other person who will listen to this tape will be the supervisor of this project. I will not use your name throughout the interview and your name will not be written on the tape. When the project is done, the tape will be destroyed. May I tape record our discussion?

Before we get started I need to get your consent/permission to be interviewed (go through procedures step by step to obtain informed consent). Do you have any questions before we start?

## SECTION ONE: INVOLVEMENT IN THE INTERVIEW

I'd like to start off by talking a little about how you decided to participate in the interview.

Q1. Why did you decide to participate in the interview?

What made you want to talk with me today?

Q2. When you learned about the study, what did you think about being part of it?

Q3. Were there specific things that made you feel unsure about participating in the study and being interviewed?

a. If so, what were those things?

b. What can I do to make you feel more comfortable during the interview?

*Note to Interviewer: use her language- how does she refer to "sexual assault", what does she call the assailant, SANE, prosecutor, etc.?*

## SECTION TWO: BACKGROUND ON THE ASSAULT

Before we start, I want to tell you the main sections of the interview so that you know what to expect.

First, we will talk about what happened the day/night of the assault. Second we will talk about what happened afterwards- like who you told, and what that was like for you. Third we will talk about your experiences with the nurse and advocate at SANE. Finally we will talk about any experiences you might have had with the police or anyone else from the criminal justice system (detectives, attorney, etc.). So if it's ok with you I would like to go ahead and begin by asking you about the assault itself.

Q4. Could you tell me happened?

Could you tell me about the assault?

Please feel free to tell me as little or as much as you want about that day- whatever you feel comfortable with.

Thank you for sharing your experience with me. If it's ok, I'd like to ask you a few specific questions about the assault so that I can understand a little better about what happened.

*PROBES:*

a. How long ago did the assault happen?

Do you remember the date?

b. How old were you at the time of the assault?

c. Type of assault (*Do not ask this out loud. If you cannot get this from her story, then you may get it from probe D below*)

1 = STRANGER RAPE

2 = ACQUAINTANCE RAPE

3 = DATE RAPE

4 = LONG-TERM DATING PARTNER

5 = MARITAL RAPE

6 = GANG RAPE/ STRANGER

7 = GANG RAPE/ ACQUAINTANCE

8 = Gang Rape/ stranger AND acquaintance

9 = Relative

10 =OTHER (Specify\_\_\_\_\_)

d. What was your relationship with assailant(s) before the assault  
Specify\_\_\_\_\_)

1 = NONE, WERE STRANGERS

2 = KNEW EACH OTHER BY SIGHT

3 = FRIENDS, CASUAL

4 = FRIENDS, CLOSE

5 = DATE

6 = BOYFRIEND/GIRLFRIEND

7 = EXBOYFRIEND/GIRLFRIEND

8 = FAMILY

9 = OTHER (\_\_\_\_\_)

10 = DON'T REMEMBER

*Ask only if she was the victim of non-stranger rape*

e. Were you living together at the time?

1 = YES

2 = NO

ee. Was this the first and only time he/she assaulted you? Or was he/she

hurtful to you in the past?

1 = SINGLE SEXUAL ASSAULT

*(Probe: so, just to clarify, was he emotionally, physically, or sexually abusive/hurtful outside of the incident you described?)*

*(CIRCLE ALL THAT APPLY)*

2 = **MULTIPLE SEXUAL ASSAULTS** (e.g., sexually assaulted you before)

3 = **EMOTIONALLY ABUSIVE** (e.g., acted jealous, controlled who you hang out with and/or and told you hurtful things repeatedly ) can

4 = **NON-SEXUAL PHYSICAL VIOLENCE** (e.g., hit, slapped, punched, pushed)

f. Race/ethnicity of the assailant

1 = WHITE

2 = AFRICAN-AMERICAN/BLACK

3 = LATINO/HISPANIC

4 = NATIVE AMERICAN INDIAN

5 = ASIAN AMERICAN

6 = ARABIC-AMERICAN

7 = BIRACIAL-MULTIRACIAL

8 = OTHER (Specify \_\_\_\_\_)

9 = DON'T KNOW

g. In addition to the injury of rape itself, were there any other physical injuries you got from the assault?

1 = YES (Specify \_\_\_\_\_)

0 = NO

2 = DON'T KNOW

h. Was a weapon used in the assault?

1 = YES (Specify \_\_\_\_\_)

0 = NO

2 = DON'T KNOW

i. Was the assailant using alcohol at the time of the assault?

1 = YES

0 = NO

2 = DON'T KNOW

j. Was the assailant using drugs at the time of the assault?

1 = YES (*GO TO QUESTION jj*)

0 = NO (*GO TO QUESTION k*)

2 = DON'T KNOW

jj. Assailant was using

MARIJUANA 1 = YES 2 = NO

TRANQUILIZERS 1 = YES 2 = NO

AMPHETAMINES 1 = YES 2 = NO

COCAINE/CRACK 1 = YES 2 = NO

HEROIN 1 = YES 2 = NO

HALLUCINOGENIC 1 = YES 2 = NO

OTHER (SPECIFY \_\_\_\_\_)

8 = DON'T REMEMBER

### SECTION THREE: EXPERIENCE AFTER THE ASSAULT/ INITIAL DISCLOSURES

Thank you for sharing that with me. Now I would like to discuss how your feelings after the assault and who you talked to right after the assault.

Q5. Can you describe your initial reactions after the assault? Can you describe your feelings for me?

Q6. Who did you tell? Who found out first? (*Probes: How/What did you tell them? How did they find out if it wasn't from you?*)

Q7. Why did you tell them?

Q8. How did they respond to you? (*Probes: What did they say or do? What was good or bad about how they acted or treated you?*)

Q9. What happened right after you told \_\_\_\_? Where did you go first?

*Jump to section on experiences with SANE or police depending on her answer.*

## SECTION FOUR: EXPERIENCE WITH SANE

Now I would like to talk to you about your experiences with the SANE program

Q10. How did you end up going to the SANE program?

*Probes:*

- a. Why did you go to the SANE program?
- b. Was it your choice to go to the SANE program? Why / Why not?
- c. Who did you talk to about whether or not you should go to SANE? What did you discuss? How did this influence your decision/what you wanted to do?

Q11. Before you got there, what did you expect from the SANE program? (*Probes:* what did you know about the program / what was going to happen?)

Q12. What were your thoughts about having a sexual assault exam/rape kit done? (Probe: Did you have any concerns? First Pelvic exam?)

Q13. Could you tell me about your experience with the SANE program?

What happened once you got there?

### ***NURSE TOPIC PROBES***

- a. Was the nurse supportive? Was the nurse helpful? What did the nurse do that was good?
- b. What was not so good during your experience with the nurse? What did she do/say that you wish she wouldn't have? What do you wish had been different?
- c. What did you need from the nurse that you didn't get?

### **ADVOCATE TOPIC PROBES**

- a. Was the advocate supportive/helpful/good?
- b. What was not so good/ hurtful during your experience with the advocate? What did she do/say that you wish she wouldn't have? What do you wish had been different?
- c. What did you need from the advocate that you didn't get?
- d. **If survivor did NOT have an advocate available:** Would you have liked someone else besides the nurse to be there for you? Why?

Q14. Did anyone go with you to the SANE program?

*Probes:*

- a. Who?
- b. What was it like having them there?
- c. What was good about having them there?
- d. What was not so good about having them there?

**Ask only IF SHE HAD PARENT/GUARDIAN/OTHER ADULT THERE WITH HER:**

Q15. Do you feel the nurse paid attention to what *you* wanted/what *you* said/what *you* thought? (or was she paying more attention to your mother/guardian?) How did that make you feel?

Q16. Do you feel the advocate paid attention to what *you* wanted/what *you* said/what *you* thought? (or was she paying more attention to your mother/guardian?) How did that make you feel?

Q17. What should nurses know about working with teens? What should advocates know about working with teens? (What can they do better when working with teens?)

Q18. Did anyone tell you if you had injuries from the assault? Did anyone tell you if they found DNA from the rape kit? Who told you? Was this helpful information?

*[Ask only if relevant]*

*PROBES:*

What were the findings of your forensic exam?

DNA

0 = Negative

1 = Positive

2 = Inconclusive

8 = Don't Know

INJURIES

0 = Negative

1 = Positive

2 = Inconclusive

8 = Don't know

Q19. Was having a medical forensic exam important to you? Why?

Q20. Looking back at your experiences with SANE, what would have been good to know before going there?

Q21. Looking back, are you glad that you went to the SANE program? Why or why not?

## SECTION FIVE: CONTACTING THE POLICE

*[Ask only if relevant]* Great, thank you for sharing your experiences and views about SANE, they were very helpful. If it's alright, now I'd like to ask you some questions about your thoughts on contacting the police about the assault.

Q21. Who decided to contact or not contact the police?

*(Probe: Did you want the police to be called? Was it your choice?)*

Q22. Who did you talk to about whether you should call the police?

*(Probe: What did you discuss? How did this influence your decision?)*

Q23. How did you feel when the police were/weren't contacted?

Q24. What were your thoughts about contacting the police? *(Probe: any concerns?)*

Q25. What did you expect from the police? What did you think the police would do if they were called? If they were called, what did you want them to do?

## SECTION SIX: EXPERIENCES WITH POLICE/DETECTIVES

Q26. What was your experience with the police like?

*(Probe: What happened when you had your first contact with the police?)*

*[Ask only if relevant]*

*TOPIC PROBES:*

- a. What happened during the time you talked with the police? *(Find out if she made a police report and if she participated in the continued investigation).*
- b. Why/How did you decide to make a police report? Why/How did you decide to continue the investigation?
- c. What did the police do that was good?
- d. What did the police do that was not so good?
- e. What do you wish had been different with the police? What did you need from the police that you didn't get?

Q27. Was anyone with you when you talked to the police? Who? How was it having \_\_\_ with you?

### **ASK ONLY IF SOMEONE WAS THERE WITH HER**

Q28. Do you feel the police officers paid attention to what *you* wanted/what *you* said/what *you* thought? (or were they paying more attention to your parents, guardian?) How did that make you feel?

Q29. What was your experience with the detective like?

*(Probe: What happened when you had your first contact with the detective?)*

*[Ask only if relevant]*

*TOPIC PROBES:*

- a. What happened during the time you talked with the detective?
- b. Why/How did you decide to continue the investigation and prosecute?

c. What did the detective do that was good? not so good?

d. What do you wish had been different with the detective? What did you need from the detective that you didn't get?

Q30. Was anyone with you when you talked to the detective? Who? How was it having \_\_\_\_\_ with you?

**ASK ONLY IF SOMEONE WAS THERE WITH HER**

Q31. Do you feel the detective paid attention to what *you* wanted/what *you* said/what *you* thought? (or were they paying more attention to your parents, guardian?) How did that make you feel?

Q32. What should police officers/detectives know about working with teens? (What can police officers/detectives do better when working with teens?)

Q33. Looking back at your experience with the police/detectives, what would have been good for you to know before contacting them?

Q34. Looking back, are you glad the police were called? Why /why not?

## SECTION SEVEN: DECISION TO PARTICIPATE IN PROSECUTION

*[Ask only if relevant]*

In this next section of the interview, I would like to talk about your experiences with the prosecution (by prosecution, I mean the court charges him with a crime and tries to show he is guilty) of your case.

Q35. Who did you talk to about whether or not you wanted to participate in prosecution? What did you talk about? How did that influence your decision?

Q36. What did you want to happen with your case?

*(Probe: Did you want your case to be prosecuted? Why/ why not?)*

Q37. What were your thoughts about continuing with prosecution? (any concerns?)

## SECTION EIGHT: EXPERIENCES WITH PROSECUTION

Q38. What was your experience with prosecution like?

What was it like to talk with the prosecutors/attorney?

*[Ask only if relevant]*

*TOPIC PROBES:*

- a. *Experience with prosecutor/prosecution*
- b. What did the prosecutor do that was good?
- c. What did the prosecutor do that was not so good? What do you wish had been different with the prosecutor?
- d. What did you need from the prosecutor that you didn't get?

Q39. Was anyone with you when you talked with the prosecutors?

*(Probe: Who? What was it like to having them there?)*

### **ASK ONLY IF SOMEONE WAS WITH THEM**

Q40. Do you feel your prosecutor paid attention to what *you* wanted/what *you* said/what *you* thought? (or was he/she paying more attention to your parents, guardian?) How did that make you feel?

Q41. Looking back at your experience with prosecution, what would you have liked to have known before going through with it?

Q42. What should prosecutors know about working with teens?

## SECTION NINE: OUTCOME OF THE CASE

*[Ask section only if relevant]*

Q41. What was the last thing that happened with your case?

Q42. How did you know about what was happening with your case?

*(Probe: What was good about that? What was not so good about that?)*

Q43. How did you feel about \_\_\_\_\_(the outcome)?

**Q44. IF COURT HEARINGS (and if they were ever in court room)**

*COURT HEARINGS PROBES:*

a. How did you feel when the nurse testified?

b. How did you feel when pictures of your injuries were being shown in court?

c. Was a [rape crisis center] or court advocate there to support you?

1. What did they do that was good?

2. What was not so good about them? What did you wish they didn't say? What do you wish they had done differently?

3. What did you need from them that you didn't get?

## SECTION TEN: OTHER HELP-SEEKING

Thank you for telling me about your experiences with SANE and the police and/or prosecutors. Now I would like to talk to you about other services/programs you might have contacted after the assault.

Q45. Have you contacted any other programs or services after the assault? (e.g., counseling, support groups, clinic, doctors, STD services, etc.)

Q46. How did you end up getting these services? (Why did you contact them?)

Q47. What was it like getting these services?

## SECTION ELEVEN: DEMOGRAPHIC INFORMATION

Thank you so much for sharing your experience with me. Everything you shared with me today will be very helpful. I would like to ask you questions about yourself to get better picture of the people we are interviewing. Remember this will also be kept confidential.

Q48. What is your gender?

Q49. What is your race/ethnicity?

Q50. How old are you?

Q51. What is the highest grade in school that you completed?

## SECTION TWELVE: CLOSING

**We are almost done! We've talked for a long time and about many different issues related to the assault, and now I would just like to ask some final questions about your experiences and what it was like to do this interview.**

Q52. What has helped you the most after the assault? (probe: What has been the most healing to you?)

Q53. Based on your experiences, what would you say or do for another teenage girl who has just been sexually assaulted?

**We're always in the process of making this interview better, so I'd also like to get your honest feedback on the interview. Don't worry—you won't hurt my feelings.**

Q54. What has it been like for you to talk about the assault with me? What is like for you to be a part of this study? (What did it mean to you to do this interview?)

Q55. Are there questions I should have asked you but didn't? Is there a topic that I should have asked you more about? Less about?

Q56. Can you tell me some ways that this interview can be better (more appropriate) for teenage girls?

**Thank you very much for your time. I appreciate you sharing your experiences. Do you have any questions for me?**

[provide compensation and resource packet]

**APPENDIX C-3:**

**Study 2 Coding Sheet**

### Adolescent Sexual Assault: Study 2 Coding Sheet

ID Number \_\_\_\_\_

Coder \_\_\_\_\_

Site \_\_\_\_\_

**Missing:** Information is not in the record when it should be.

**Unknown:** According to the record, the victim didn't know, didn't think so, didn't remember, or couldn't/wouldn't say, or question was not asked in the record for this case.

**Victim Characteristics**

Variable	Circle/ Enter Code	Comments
<b>Age</b> ( <i>Actual age in years</i> )	999= Missing	
<b>Gender</b>	0= Male 1= Female  999= Missing	
<b>Race/Ethnicity</b>	1= White/Caucasian 2= African American 3= Latino/a 4= Native American 5= Bi-/ Multi-racial 6= Other ( <i>write in the other</i>	<b>If Other, Race/Ethnicity:</b>

	<p><i>race/ethnicity in comments)</i></p> <p>999= Missing</p>	<p>888= N/A (no 'other' race)</p> <p>999= missing</p>
<p><b>Mental Disability</b> (<i>write in type of mental disability in comments)</i>)</p>	<p>0=No</p> <p>1=Yes</p> <p>888 = Unknown</p> <p>999 = Missing</p>	<p><b>Type of Mental Disability:</b></p> <p>888= N/A (no disability)</p> <p>999=missing</p> <p><i>Note: Post-hoc coded as serious mental illness (yes/no), developmental delay (yes/no), or learning disability (yes/no).</i></p>
<p><b>Physical Disability</b> (<i>write in type of physical disability in comments)</i>)</p>	<p>0=No</p> <p>1=Yes</p> <p>888 = Unknown</p> <p>999 = Missing</p>	<p><b>Type of Physical Disability:</b></p> <p>888= N/A (no disability)</p> <p>999=missing</p>
<p><b>Zip code of victim's address</b></p>	<p>999= Missing</p>	<p><i>Note: the zip code was looked up in census data, and the median income for that geographic region was used as a proxy for victim income</i></p>
<p><b>Tanner Stage</b> <b>(Genitalia Only)</b></p>	<p>999= Missing</p>	<p><b>Enter Stage:</b></p>

**Case Characteristics**

Variable	Circle Code/ Enter Data	Comments
<p><b>Incident Date and Time</b>  <i>(round time to the nearest quarter of an hour)</i></p>	<p><b>Date:</b></p> <p>888= Unknown            999= Missing</p> <p><b>Time:</b></p> <p>888= Unknown            999= Missing</p>	
<p><b>Exam Date and Time</b>  <i>(round time to the nearest quarter of an hour)</i></p>	<p><b>Date:</b></p> <p>888= Unknown            999= Missing</p> <p><b>Time:</b></p> <p>888= Unknown            999= Missing</p>	
<p><b>Time between assault and medical exam</b> <i>(in hours)</i></p>		

	<p>888= Unknown</p> <p>999= Missing</p>	
<p><b>Calendar days between assault and medical exam</b></p>	<p>0= Same day as assault</p> <p>1= One day after assault</p> <p>2= Second day after assault</p> <p>3= Third day after assault</p> <p>4= Fourth day after assault</p> <p>5= Other (<i>write number of days in comments</i>)</p> <p>888= Unknown</p> <p>999= Missing</p>	<p><b>If Other, Number of Days:</b></p> <p>888= N/A (no 'other' days)</p> <p>999=missing</p>
<p><b>Number of Offenders</b></p>	<p><b>Enter number here:</b></p> <p>888= Unknown</p> <p>999= Missing</p>	
<p><b>Multiple Offenders</b></p>	<p>1= Yes</p> <p>0= No</p> <p>888= Unknown</p> <p>999= Missing</p>	
<p><b>Victim relationship to offender</b> (<i>write in what the nurse wrote down in the comment section</i>)</p>	<p>1= Stranger</p> <p>2= Acquaintance</p> <p>3= Intimate</p> <p>4= Familial</p>	<p><b>Victim Relationship to Offender:</b></p>

	<p>5= Other</p> <p>6= Multiple Assailants with varying relationships</p> <p>888= Unknown</p> <p>999= Missing</p>	999=missing
<b>Victim relationship to offender</b>	<p>1 = Stranger</p> <p>2 = Known to Victim</p> <p>3= Multiple Assailants with varying relationships</p> <p>888= Unknown</p> <p>999= Missing</p>	
<b>Physical force use in the assault</b>	<p>0 = Physical force not used</p> <p>1 = Physical force used</p> <p>888= Unknown</p> <p>999= Missing</p>	
<b>Weapon use in the assault</b>	<p>0= Weapon not used</p> <p>1= Weapon used</p> <p>888= Unknown</p> <p>999= Missing</p>	
<b>Physical force use in the assault</b>	<p>0= Physical force not used</p> <p>1= Physical force used</p>	

	<p>888= Unknown</p> <p>999= Missing</p>	
<p><b>Victim Drugged</b> (found in history and/or drug use questions)</p>	<p>0= No</p> <p>1= Yes</p> <p>2= Not Sure (thinks she might have)</p>	
<p><b>Victim consumed ALCOHOL before or during the sexual assault</b> (found in alcohol use question OR in history/narrative)</p>	<p>0=No</p> <p>1=Yes</p> <p>888= unknown</p> <p>999= Missing/ no indication anywhere</p>	
<p><b>Victim consumed DRUGS before or during the sexual assault</b> (found in drug use question OR in history/narrative)</p>	<p>0=No</p> <p>1=Yes</p> <p>888= unknown</p> <p>999= Missing/ no indication anywhere</p>	
<p><b>Victim's report of sexual contact</b></p>	<p>1 = Victim states that sexual contact occurred</p> <p>2 = Victim is unsure whether sexual contact occurred</p> <p>3= Victim denies sexual contact occurred/states that sexual contact did not occur</p>	

	999= Missing	
<b>Victim assented/ wanted sexual contact</b>	0= No 1= Yes  777 = N/A (states no sexual contact)  888= Unknown  999= Missing	
<b>Previous Consensual Sex (within 72/96 hours)</b>	0= No 1= Yes  777= N/A (past time frame)  888= Unknown  999= Missing	
<b>Victim Recanted to the Nurse</b>	0= No 1= Yes  888= Unknown/Not clear	
<b>Type of sexual assault: Vaginal Penetration</b>	0= No 1= Yes  777= N/A(male victim)  888= Unknown  999= Missing	
<b>Type of Sexual assault: Oral Sex</b>	0= No 1= Yes  888= Unknown  999= Missing	

<p><b>Type of sexual assault:</b> Offender's Genitals/ Victim's Mouth</p>	<p>0= No 1= Yes  888= Unknown 999= Missing</p>	
<p><b>Type of sexual assault:</b> Offender's Mouth on Victim's Genitals</p>	<p>0= No 1= Yes  888= Unknown 999= Missing</p>	
<p><b>Type of sexual assault:</b> <b>Anal Penetration</b></p>	<p>0= No 1= Yes  888= Unknown 999= Missing</p>	
<p><b>Type of sexual assault:</b> <b>Fondling</b></p>	<p>0= No 1= Yes  888= Unknown 999= Missing</p>	
<p><b>Assailant Ejaculated</b></p>	<p>0= No 1= Yes  888= Unknown 999= Missing</p>	

**Post-Assault Actions**

<p><b>Shower/bathed</b></p>	<p>0= No 1= Yes</p> <p>777= N/A past time 888= Unknown 999= Missing</p>	
<p><b>Douched</b></p>	<p>0= No 1= Yes</p> <p>666=N/A male 777= N/A past time 888= Unknown 999= Missing</p>	
<p><b>Urinated</b></p>	<p>0= No 1= Yes</p> <p>777= N/A past time 888= Unknown 999= Missing</p>	
<p><b>Defecated</b></p>	<p>0= No 1= Yes</p> <p>777= N/A past time 888= Unknown 999= Missing</p>	
<p><b>Brushed teeth</b></p>	<p>0= No 1= Yes</p> <p>777= N/A past time 888= Unknown</p>	

	999= Missing	
<b>Liquid in Mouth/Ate</b> (rinse, swish, gargle, drank, ate)	0= No 1= Yes  777= N/A past time 888= Unknown 999= Missing	
<b>Genital wipe/wash</b>	0= No 1= Yes  777= N/A past time 888= Unknown 999= Missing	
<b>Remove/insert tampon</b>	0= No 1= Yes  666=N/A male 777= N/A past time 888= Unknown 999= Missing	

**Medical Forensic Evidence: Physical, Non-Anogenital Injuries (Type of Injury)**

Variable	Circle Code	Number of injuries	Comments
<b>Redness/erythema</b>	0= No  1= Yes   888= No exam/victim declined  999= Missing	777= numerous   888= No exam/victim declined  999= Missing	
<b>Tear/laceration</b>	0= No  1= Yes   888= No exam/victim declined  999= Missing	777= numerous   888= No exam/victim declined  999= Missing	
<b>Bruising/hematoma</b>	0= No  1= Yes   888= No exam/victim declined	777= numerous   888= No exam/victim	

	999= Missing	declined  999= Missing	
<b>Abrasion/scratch</b>	0= No  1= Yes  888= No exam/victim declined  999= Missing	777= numerous  888= No exam/victim declined  999= Missing	
<b>Point of Tenderness</b> <i>(describe location in comment box)</i>	0= No  1= Yes  888= No exam/victim declined  999= Missing	777= numerous  888= No exam/victim declined  999= Missing	<b>Location(s) of Point of Tenderness:</b>  888= N/A (no point of tenderness)
<b>Other injury</b> <i>(write type of injury in comment box)</i>	0= No  1= Yes  888= No exam/victim declined	777= numerous	<b>Type of Other Injury:</b>  888= N/A (no other injury)

	999= Missing	888= No exam/victim declined  999 = Missing	
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**Medical Forensic Evidence: Physical, Non-Anogenital Injuries (Injury Characteristics)**

Variable	Circle Code/ Enter Data	Number of Injuries	Comments
<b>Bleeding/Hemorrhage</b>	0= No  1= Yes   888= No exam/victim declined  999= Missing	777= numerous  888= No exam/victim declined  999 = Missing	
<b>Oozing injury</b>	0= No  1= Yes   888= No exam/victim declined  999= Missing	777= numerous  888= No exam/victim declined	

		999 = Missing	

**Medical Forensic Evidence: Hymen Injury (Type of Injury)**

Variable	Circle Code	Number of injuries	Comments
<b>Redness/ Erythema</b>	0= No  1= Yes   666 = no exam due to no genital contact  777=N/A (male)  999=missing	 666 = no exam due to no genital contact  777=numerous  888=N/A(male)  999 = Missing	
<b>Tear/laceration/jagged</b>	0= No  1= Yes   666 = no exam due to no genital contact  777=N/A (male)  999=missing	 666 = no exam due to no genital contact  777=numerous  888=N/A(male)  999 = Missing	
<b>Bruising/hematoma</b>	0= No  1= Yes   666 = no exam due to no genital contact  777=N/A	 666 = no exam due to no genital contact  777= numerous  888=N/A (male)	

	(male) 999=missing	999 = Missing	
<b>Abrasions</b>	0= No 1= Yes  666 = no exam due to no genital contact 777=N/A (male) 999=missing	666 = no exam due to no genital contact 777=numerous 888=N/A (male) 999 = Missing	
<b>Other injury</b> ( <i>write type of injury in comment box</i> )	0= No 1= Yes  666 = no exam due to no genital contact 777=N/A (male) 999=missing	666 = no exam due to no genital contact 777=numerous 888= N/A (male) 999=Missing	<b>Type of other injury:</b>  888= N/A (no other injury)

**Medical Forensic Evidence: Hymen Injury (Injury Characteristics)**

Variable	Circle Code/ Enter Data	Number of Injuries	Comments
<b>Bleeding/hemorrhagic</b>	0= No 1= Yes		

	<p>666 = no exam due to no genital contact</p> <p>777=N/A (male)</p> <p>999=missing</p>	<p>666 = no exam due to no genital contact</p> <p>777=numerous</p> <p>888=N/A (male)</p> <p>999=Missing</p>	
<b>Oozing injury</b>	<p>0= No</p> <p>1= Yes</p> <p>666 = no exam due to no genital contact</p> <p>777=N/A (male)</p> <p>999=missing</p>	<p>666 = no exam due to no genital contact</p> <p>777= numerous</p> <p>888= N/A (male)</p> <p>999=Missing</p>	

**Medical Forensic Evidence: Anogenital Injury excluding Hymen Injuries (Type of Injury)**

Variable	Circle Code	Number of injuries	Comments
<b>Redness</b> (erythema)	0= No 1= Yes  666 = no exam due to no genital contact  999=missing	666 = no exam due to no genital contact 777=numerous 999=Missing	
<b>Tear/laceration</b>	0= No 1= Yes  666 = no exam due to no genital contact  999=missing	666 = no exam due to no genital contact 777= numerous 999=Missing	
<b>Bruising/hematoma</b>	0= No 1= Yes  666 = no exam due to no genital contact  999=missing	666 = no exam due to no genital contact  777= numerous 999=Missing	
<b>Abrasions</b>	0= No 1= Yes  666 = no	666 = no exam due	

	exam due to no genital contact 999=missing	to no genital contact 777= numerous 999=Missing	
<b>Point of Tenderness</b> <i>(describe location in comment box)</i>	0 = No 1 = Yes  666 = no exam due to no genital contact 999=missing	666 = no exam due to no genital contact 777=numerous 999=Missing	<b>Location of Point of Tenderness:</b>  888= N/A (no point of tenderness)
<b>Other injury</b> <i>(write type of injury in comment box)</i>	0= No 1= Yes  666 = no exam due to no genital contact 999=missing	666 = no exam due to no genital contact 777= numerous 999=Missing	<b>Type of other injury:</b>  888= N/A (no other injury)

**Medical Forensic Evidence: Anogenital Injury excluding Hymen Injuries (Injury Characteristics)**

Variable	Circle Code/ Enter Data	Number of Injuries	Comments
<b>Bleeding/hemorrhagic</b>	0= No 1= Yes  666 = no exam due to no genital contact 999=missing	666 = no exam due to no genital contact 777= numerous	

		999=Missing	
<b>Oozing injury</b>	0= No 1= Yes  666 = no exam due to no genital contact 999=missing	666 = no exam due to no genital contact 777= numerous 999=Missing	

Variable	Circle Code/Enter Data	Comments
<b>Foreign matter</b> ( <i>write in type of foreign matter in comment box</i> )	0= No 1= Yes  999= Missing	<b>Type of foreign matter:</b>  999= missing 888= N/A (no foreign matter)